Medical Affairs Advisory Committee Meeting
October 16, 2019

Members Present: Feyi Adunbi, Jawad Al-Khafaji, John Allen, Ajjai Alva, Nithya Arun, RJ Batas, Sami Malek, Suomya Rangarajan, Rishindra Reddy (Chair)

Guests Present: None

Presenters: David Miller, M.D.
Chief Clinical Officer – UH/CVC,
Medical Director for Strategy and Business Development - UMHS,
Professor & Chief, Dow Division of Health Services Research, Department of Urology

Vikas Parakh, M.D.
Associate Chief Clinical Officer – UH/CVC,
Medical Director, Capacity Management – UMHS,
Professor, Internal Medicine

Topic of Discussion: Adult Hospital Capacity Management: Risks, Progress, Challenges & Opportunities

Dr. Runge asked people to introduce themselves as this was our first meeting of the Academic year and we had new members.

Dr. Reddy opened the meeting and welcomed everyone.

Dr. Miller introduced himself and briefly provided an overview, before introducing Dr. Vikas and the work that he has been doing.

Current State & Trends:

- As Michigan Medicine creates partnerships across the state, some of the factors in doing so: more beds, care closer to people's homes and care in lower cost areas.
- Our current adult inpatient capacity exceeds 92% on average, and 100% in the mornings.
- We will outgrow space in a few years at CS Mott Children's & Von Voigtlander Women's Hospitals.
- In the state of Michigan, we are the only hospital with capacity issues. But among our peer AMCs (Hopkins, Colorado, Yale, etc.), they are encountering the same issues.
- Current deficit is ~40-60 beds, until opening of Clinical Inpatient Tower in 2024.

5 Year Trend: Rising Activity and Complexity = Capacity Challenge

- The Case Mix Index, for resource use is up from 1.9 to 2.4. Where the average is 1.0
- # of days' inpatient stays have increased.
- Emergency roll over has increased

Risks of our Current State

- Soumya Rangarajan shared that if we develop relationships with more subacute care facilities, we may be able to open up more beds.
- ED vs urgent care, 30% of patients are transferred to clinic visits.

- Dr. Runge posed the question of 'to grow or not grow'? He shared that Michigan Medicine is behind in consolidating with other health systems. University of Minnesota did not grow, and is now trying to catch up. There are 2.5 million ambulatory care visits a year.
- Operationally, if we look at how, when, and type of procedures; we have been able to shorten stays; for example, total joint replacements, OB/GYN, etc. Becoming a 24/7 operation, will balance and smooth peaks, but it may not be best for patients, with testing and little time to rest and recuperate.
- Feyisetan Adunbi asked if clinics & ED are using social workers to triage and help with keeping the wrong patients out, to elevate backlog of patient waits? John Allen shared that they are partnering with Joshua Brewster, Director of Social Work & Spiritual Care, and are developing a strategy in each primary clinic to do therapy and case management, also the are trying to develop the right numbers of social workers.

FY19 Capacity Accomplishments: Adult Hospitals

- Open Medicine unit at SJMAA, provided approximately 25 net beds gained. No access to OR at St. Joe, but still having ongoing conversations.

FY20 Priorities: Adult Hospitals

- Shift appropriate low-acuity bedded surgical cases to Chelsea and Brighton. Chelsea is at 40% capacity currently. We have more access to Chelsea. What service lines to add?
- A strategic question was asked of Dr. Runge. When patients are admitted to St. Joe Chelsea, do we have a plan to offer more services/specialist? Dr. Runge shared that Chelsea is less rigid than IHA, so they are looking into that.

Next Step in Capacity Management: Command Center (similar to NASA)

Dr. Parakh shared that he has done site visits at:

- Yale is currently using Epic system.
- Hopkins has been working on this for four years.
- Colorado is at phase 1 of a home grown system.
- Michigan Medicine we are building a team, that is a central hub with predictive analytics across related departments, and the ED has central input, etc.

At the end of the meeting, Dr. Runge apologized for the heavy use of acronyms. At the next meeting he suggested that we go over or provide information on them.