Value Based Care

INTRODUCTION

In today's challenging health care environment it is not enough for an emergency medicine practice to provide operational excellence, outstanding medical quality, and a remarkable patient experience. An emergency medicine practice must also be able to offer specific programs and services designed to enhance the financial well-being of its partner hospitals. Led by Dr. John Sverha, EMA's Chief Value Officer, these programs and services, which focus on both quality of care and expense reduction, support EMA's goal of delivering value based care.

EXPERTISE IN VALUE BASED STRATEGIES

EMA has developed a special degree of familiarity with value-based strategies. EMA was founded in Maryland over 40 years ago and, with contracts at six Maryland hospitals, is the largest provider of emergency medicine services in the state. Practicing emergency medicine in the state of Maryland provides a unique opportunity to develop and perfect value-based strategies. Maryland has been the recipient of a CMS waiver since 1977 and over the last several years has adopted Total Patient Revenue and Global Patient Revenue programs in which hospitals are heavily incentivized to reduce utilization while still meeting quality targets. The transition from "volume to value" has already occurred in Maryland, and EMA has been on the front lines of this transition with our hospital partners.

A hospital's transition to value-based care can occur only if its emergency department is aligned and engaged with this endeavor. The ED is uniquely positioned at the crossroads of inpatient and outpatient care and therefore caries a large value "footprint." The ED's most obvious impact on utilization is related to the decision on whether a patient requires hospitalization. In addition, decisions made in the emergency department often drive the value delivered to patients well downstream of their ED stay. For instance, state-of-the-art sepsis care in the ED has been shown to decrease ICU utilization, mortality, and hospital length of stay. In addition, the development of palliative care "triggers" in the emergency department insure that our ED patients benefit from timely palliative care consultation, which has been shown to improve both the patient experience and decrease costs.
Our expertise in value-based strategies is highlighted by our co-sponsorship with the Maryland Hospital Association of an educational conference on this topic. The conference is titled "Value Based Emergency Medicine Summit – Innovative Strategies for Managing Cost by Optimizing Your ED" and will be held in Baltimore, MD on March 13th, 2015. (link to conference website)

DATA ANALYTICS AND THE TRANSITION TO VALUE

A commitment to delivering value based care must be accompanied by a similar commitment to developing a data analytic infrastructure that allows tracking of utilization and quality metrics. EMA has invested heavily in it is own data analytic team and has developed a "value dashboard" for its sites. Given the challenges associated with abstracting data from multiple EMR's at multiple sites, EMA has engaged EMBI to assist in data acquisition and analysis. It is with their support that specialized reports related to admission utilization, CT utilization, and ED frequent users are made available to our site directors.

CARE STANDARDIZATION AND THE TRANSITION TO VALUE

Any discussion of value-based care must confront the issue of variability in care delivery. EMA's response to this issue is the EMA Clinical Operations Council (COC). The mission of the COC is to improve the quality, consistency, and cost efficiency of care provided through the utilization of evidence based medicine and patient safety principles. The COC produces guidelines on selected clinical conditions, which are then implemented at all EMA sites. Conditions suitable

to guideline develop are prioritized based on a variety of
factors that
include availability of evidence, degree of existing variability in practice, and impact on utilization and/or quality measures. The implementation of each guideline is followed by a rigorous audit program to insure uptake of the new guideline and allow feedback to individual providers.

Examples

- CT utilization dropped 10% at Calvert Memorial Hospital in the first year in which per provider CT utilization data was available at this site.
- Hospital admissions dropped 15% at both Calvert Memorial Hospital and Carroll Hospital Center after their transition to “Total Patient Revenue” status.
- Examples of conditions identified for care standardization include foley catheter utilization, DVT treatment, pediatric head injury, low risk chest pain, and sepsis.
- EMA recently received the “Minogue Award for Patient Safety Innovation” at the Maryland Patient Safety Conference for its efforts to standardize sepsis care and reduce hospital mortality at the UM Charles Regional Medical Center.