Quality Journey for Emergency Medicine

Session #QU6, February 19, 2017

Pawan Goyal, MD, FHMSS, CPHIMS, Associate Executive Director, Quality American College of Emergency Physicians (ACEP)
Speaker Introduction

Pawan Goyal, MD, FHIMSS, CPHIMS
Associate Executive Director, Quality
American College of Emergency Physicians (ACEP)
Conflict of Interest

Pawan Goyal, MD, FHIMSS, CPHIMS

Has no real or apparent conflicts of interest to report.
Conflict of Interest

Pawan Goyal, MD, FHIMSS, CPHIMS

Salary:
Royalty:
Receipt of Intellectual Property Rights/Patent Holder:
Consulting Fees (e.g., advisory boards):
Fees for Non-CME Services Received Directly from a Commercial Interest or their Agents (e.g., speakers' bureau):
Contracted Research:
Ownership Interest (stocks, stock options or other ownership interest excluding diversified mutual funds):
Other: No Conflict of Interest what so ever.
Agenda

• Quality Journey for Emergency Medicine

• Clinical Emergency Data Registry (CEDR) Overview

• Emergency Quality Network (E-QUAL) Overview

• Open Q&A Session
Learning Objectives

• Identify how hospital emergency departments will be impacted by the CMS Quality Payment Program
• Leverage Emergency Health Care learning collaborative for best practices
• Develop strategies for identifying and meeting benchmarking goals for care delivery improvement in the emergency setting
An Introduction of How Benefits Were Realized for the Value of Health IT

Include one slide at the beginning of the presentation that links and frames the presentation to demonstrate the benefits realized for one or more STEPS™ value categories. Use metrics where possible.

Please see STEPS™ slide templates & guidelines for detailed instructions on utilizing the STEPS™ framework in your HIMSS17 presentation.
2013 National ED Statistics

ED Average Volume Increases
Patient Flow Predictable

- EMS
- 80/1000 Population

General Population use of the ED
- Total use 445 / 1000 Population
- 83% Walk-Ins
- 17% Arrival by EMS

Walk-Ins
- 365/ 1000 Population

- Transfer 2%
- Admit 17%
- Treat & Release 81%
- LBTC 2%
### What is the ED Payor Mix?

<table>
<thead>
<tr>
<th>Payor</th>
<th>% of ED Visits, 2012</th>
<th>% of ED Visits, 1995</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>33%</td>
<td>44%</td>
</tr>
<tr>
<td>Medicaid, CHIP</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Medicaid plus Medicare</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>Medicare</td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td>Self Pay</td>
<td>14%</td>
<td>17%</td>
</tr>
<tr>
<td>Worker Comp</td>
<td>1%</td>
<td>4%</td>
</tr>
</tbody>
</table>
Trending and Planning for Flow Ahead:

- 2.5% more patients per year
- Injury is shrinking at 29.5% of ED Patient Load
- Highest injury rates are over age 75
- The ED is seeing older, complex, high acuity medical patients
- Mental Health patients are a burden on EDs
- Increasing use of ultrasounds and MRI scans
- Volume changes are driving ED design and need for renovation
- ED Patient Intake continues to improve, Door to Provider (physician or APP) less than 30 minutes
- Most ED’s have implemented CPOE’s
- Boarding is big driver of flow problems for ED’s
  - Accounts for 40% of the admitted patient’s time in the ED
Operations Challenges

- Mental Health Patients drain ED staff and space
- Violence against ED staff, and in the streets
- Geriatrics enters even young metro areas
- Dialysis and other special needs patients
- Flow of all patients (83% not admitted)
- Flow of Admitted Patients. Bed Command Centers are needed
- Disaster Preparedness in all ED’s
- Lower volume (0-40K) EDs continue to operate efficiently
- The high acuity patients and EMS are bypassing them
- The ED’s 40K to 60K are the crux of ED leadership now
- The EDs in the 60K to 100K cohorts are stressed
ED Median Length of Stay

- All ED Patients: 180 minutes
- Treat & Release: 155 minutes
- Admit: 188 minutes
- Decision to Upstairs: 115 minutes
- Arrival to Decision: 188 minutes
- Total Patients: 304 minutes
- 38% of patients spend 115 minutes from arrival to decision to upstairs.
Diagnostic Testing Evolving in the ED

• More diagnostic EKGs and MRI scans
• EKG used 25 times per 100 patients seen
• Plain xray 44 procedures per 100 patients seen
• MRI scans 1.2 per 100 patients seen
• CT scans 21 procedures per 100
• Ultrasound 6 per 100
Emergency Physician Performance

- PQRS and VBM are the current ways CMS measures and incentivizes physician practice, moving to MACRA, MIPS, and G-PRO
- Quality Measures evolving, although still some life in claims-based measures
- ACEP Qualified Clinical Data Registry (QCDR) called the Clinical Emergency Data Registry (CEDR)
- ED Patient Experience of Care Survey (ED CAPHS) (Maybe 2017)
The Value of Emergency Care

• In the House of Medicine
  o To primary care
  o To the specialists
• To the Community
• To the Payors
• The Call for Transparency
  o Time of care
  o Safety and quality
  o ED patient experience of care survey
  o Cost and VALUE
Responding to ACA: The Story about the Value of EM

- Manage the unscheduled care episodes
- Find and utilize excess capacity
- Restore honesty in pricing system
- Appropriate utilization and pricing of ancillary, xrays, labs
- Prepare for disasters
- Have a history of quality service and prevention
- Focus on safety and transparency
- Build a case for Value / Cost effectiveness
CEDR: A Qualified Clinical Data Registry

- QCDRs such as CEDR are an important pathway to participation in the Merit-based Incentive Payment System (MIPS)
- QCDRs are one of the limited methods for reporting the three non-CMS calculated areas of MIPS:
  - Quality (formerly PQRS)
  - Clinical Performance Improvement Activities
  - Advancing Care Information (formerly Meaningful Use)
- Measures used by QCDRs may also be used to assess performance, population management, long term clinical outcome data collection, performance and clinical process improvements
- Professionals may also receive confidential feedback on performance through QCDRs
Advantages of participating in CEDR

• Revenue
• Protect your revenue: avoid negative -4% payment penalty for 2017 year
• Enhance your Medicare revenue through bonus incentive (up to 9%)
• Potential increased revenue from private payers
• Quality reporting
• Physicians can get Quality/PQRS credit for reporting more meaningful measures

• Measures created by emergency physicians for emergency physicians
• Participation can cover all of the quality measure reporting requirements
• CMS Modifier requirements are met
• Joint Commission Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) processes compliance
Advantages of participating in CEDR

• Accountability
  – Movement to electronic registries is more accurate, secure and cost-effective
  – CEDR allows an accountable way to back up data provided to CMS
  – CEDR enables hospitals to track and improve eMeasures

• Meaningful Use: MACRA/MIPS Advancing Clinical Information
  – Hospitals may receive credit under the Advance Clinical Information portion of MIPS for reporting via specialized registry

• Physician Maintenance of Certification
  – Maintenance of Certification Part IV activities (in conjunction with an American Board of Emergency Medicine approved MOC program)
Advantages of participating in CEDR

Pick Your Pace in MIPS

If you choose the MIPS path of the Quality Payment Program, you have three options:

- Don’t Participate
  Not participating in the Quality Payment Program:
  If you don’t send in any 2017 data, then you receive a 4% payment adjustment.

- Submit Something
  Test:
  If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

- Submit a Partial Year
  Partial:
  If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment.

- Submit a Full Year
  Full:
  If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment.

The size of your payment will depend both on how much data you submit and your performance results.
Advantages of participating in CEDR

Adjustments by Payment Year (payment year is based on the data reported from 2 years before)

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</thead>
<tbody>
<tr>
<td>Base Update</td>
<td>Jan – Jun: 0.5</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>Base Conversion Factor Update of 0.0% per year</td>
<td>0.25%*</td>
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</tr>
<tr>
<td>Electronic Health Record Incentive Program</td>
<td>EHR Incentives continue under current law</td>
<td>EHR Meaningful Use Incorporated into MIPS</td>
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<tr>
<td>Physician Quality Reporting System</td>
<td>PQRs continues under current law</td>
<td>Quality reporting incorporated into MIPS</td>
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<tr>
<td>Physician Value-Based Payment Modifier</td>
<td>VBM Continues under current law</td>
<td>Parts of VBM incorporated into MIPS</td>
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</tr>
<tr>
<td>&quot;Merit Based&quot; Incentive Payment System (MIPS)**, ***</td>
<td>N/A</td>
<td>(±) 4%</td>
<td>(±) 5%</td>
<td>(±) 7%</td>
<td>(±) 9%</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Alternative Payment Models</td>
<td>N/A</td>
<td>5% lump sum bonus on the previous year’s covered professional services for “qualifying APM participants” ****</td>
<td>0.0%</td>
<td>0.75%</td>
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</tr>
</tbody>
</table>
Advantages of participating in CEDR

Adjustments by Payment Year (payment year is based on the data reported from 2 years before)

<table>
<thead>
<tr>
<th>QPP/MIPS Penalties For Failure to Report</th>
<th>2017 Performance Year for the 2019 Payment Adjustment Under MIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>+/- 4.0%</td>
</tr>
<tr>
<td></td>
<td>For positive adjustments, Sec. may increase/decrease the adjustment factor by a scaling factor of up to 3.0 in order to ensure budget neutrality.</td>
</tr>
<tr>
<td></td>
<td><strong>Additional exceptional performance bonus: 0.5% - 10%</strong></td>
</tr>
<tr>
<td></td>
<td>Total amount allocated for exceptional bonus in a given year shall not exceed $500,000,000</td>
</tr>
<tr>
<td>Final MIPS Composite Score</td>
<td>Level of Participation</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------</td>
</tr>
</tbody>
</table>
| ≥ 70 points               | Full reporting across all eligible MIPS performance categories | Positive adjustment  
Eligible for additional exceptional performance bonus:  
70 points = 0.5% → 100 points = 10% |
| 4- 69 points              | Report more than 1 Quality measure;  
Attest to more than 1 Improvement Activity; and/or  
Report "more than required" ACI measures | Positive adjustment  
Not eligible for exceptional performance bonus |
| 3 points                  | Report 1 Quality measure; or  
Attest to 1 Improvement Activity; **OR**  
Report “required” ACI measures | Avoid penalty; neutral payment adjustment |
| 0 points                  | Submit nothing          | Negative payment adjustment of -4% |
Translating MIPS Total Composite Score Points into Payment Adjustments

Performance Threshold: 3 points for 2017

Max Negative Adjustment
Zero Adjustment
Positive adjustment on Linear Sliding Scale
Max Positive Adjustment

0

100
# MIPS Overview

<table>
<thead>
<tr>
<th>Category</th>
<th>What do you need to do?</th>
<th>2017 Category Weight</th>
</tr>
</thead>
</table>
| Quality Replaces the Physician Quality Reporting System (PQRS)         | **Most participants:** Report up to 6 quality measures, including an outcome measure, for a minimum of 90 days.  
**Groups using the web interface:** Report 15 quality measures for a full year.  
**Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Track 1 or the Oncology Care Model:** Report quality measures through your APM. You do not need to do anything additional for MIPS quality. | 60%                  |
| Improvement Activities (IA) New Category                                | **Most participants:** Attest that you completed up to 4 improvement activities for a minimum of 90 days.  
**Groups with fewer than 15 participants or if you are in a rural or health professional shortage area:** Attest that you completed up to 2 activities for a minimum of 90 days.  
**Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model:** You will automatically earn full credit.  
**Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or Oncology Care Model:** You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.  
**Participants in any other APM:** You will automatically earn half credit and may report additional activities to increase your score. | 15%                  |
| Advancing Care Information (ACI) Replaces the Medicare EHR Incentive Program also known as Meaningful Use | Fulfill the required measures for a minimum of 90 days:  
- Security Risk Analysis  
- e-Prescribing  
- Provide Patient Access  
- Send Summary of Care  
- Request/Accept Summary of Care  
Choose to submit up to 9 measures for a minimum of 90 days for additional credit.  
**OR**  
You may not need to submit Advancing Care Information if these measures do not apply to you. | 25%                  |
CEDR Technical Implementation

• Choose data collection method
  – PULL: Usually 9-10 weeks
  – PUSH*: A minimum of 10-11 weeks using standard data file format (.xml, CCDA, .xls/.xlsx)
  – * The time it takes to complete the Push methodology varies significantly across hospitals, depending on the format and quality of the data, the amount of ED IT resources, and the level of engagement of the participating ED staff

• CEDR collects structured and unstructured data
• Natural language processing software is used to read unstructured data
• CEDR team will work with ED IT team to collect data
• ED Clinical Lead will ensure accurate data mapping and measures calculation
Data Pull Scenario
Data Push Scenario
CEDR Technical Output

• Groups will be given access to their dashboard and view their data
• Groups/EDs can query their data
• Groups/EDs can measure performance across measures for multiple locations and providers

• Dashboard is accessible via an ACEP login
• Physicians can view their individual performances and determine which measures they want to report
## CEDR Dashboard - Measure View

### Table of Measures

<table>
<thead>
<tr>
<th>ID</th>
<th>Measure Description</th>
<th>Domain</th>
<th>Performance</th>
<th>Registry Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 65 Years and Older</td>
<td>Safety</td>
<td>100%</td>
<td>55.9%</td>
</tr>
<tr>
<td>2</td>
<td>Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years</td>
<td>Safety</td>
<td>100%</td>
<td>55.9%</td>
</tr>
<tr>
<td>3</td>
<td>Coagulation Studies in Patients Receiving with Dextran with or Without Coagulopathy or Bleeding</td>
<td>Efficiency</td>
<td>100%</td>
<td>55.9%</td>
</tr>
<tr>
<td>4</td>
<td>Appropriate Emergency Department Utilization of CT for Pulmonary Embolism in Patients with Acute Pulmonary Embolism</td>
<td>Efficiency</td>
<td>100%</td>
<td>55.9%</td>
</tr>
<tr>
<td>5</td>
<td>Pregnancy Test for Female Abortion Patients</td>
<td>Safety</td>
<td>100%</td>
<td>55.9%</td>
</tr>
<tr>
<td>6</td>
<td>Tobacco Screening and Cessation Intervention</td>
<td>Compliance</td>
<td>100%</td>
<td>55.9%</td>
</tr>
<tr>
<td>7</td>
<td>Septic Management: Septic Shock - Lactate Level Measurement</td>
<td>Clinical</td>
<td>100%</td>
<td>55.9%</td>
</tr>
<tr>
<td>8</td>
<td>Septic Management: Septic Shock - Antibiotics Ordered</td>
<td>Clinical</td>
<td>100%</td>
<td>55.9%</td>
</tr>
<tr>
<td>9</td>
<td>Septic Management: Septic Shock - Fluid Resuscitation</td>
<td>Clinical</td>
<td>100%</td>
<td>55.9%</td>
</tr>
<tr>
<td>10</td>
<td>Septic Management: Septic Shock - Nutrition Support</td>
<td>Clinical</td>
<td>100%</td>
<td>55.9%</td>
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<tr>
<td>11</td>
<td>Septic Management: Septic Shock - Lactate Level Measurement</td>
<td>Clinical</td>
<td>100%</td>
<td>55.9%</td>
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<tr>
<td>12</td>
<td>Septic Management: Septic Shock - Lactate Level Measurement</td>
<td>Clinical</td>
<td>100%</td>
<td>55.9%</td>
</tr>
</tbody>
</table>
CEDR Dashboard - Measure Detail
<table>
<thead>
<tr>
<th>QPP</th>
<th>Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>66</td>
<td>Appropriate testing for children with pharyngitis</td>
</tr>
<tr>
<td>91</td>
<td>Acute Otitis Externa (AOE): Topical Therapy</td>
</tr>
<tr>
<td>93</td>
<td>Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use</td>
</tr>
<tr>
<td>116</td>
<td>Antibiotic treatment for adults with acute bronchitis: avoidance of inappropriate use</td>
</tr>
<tr>
<td>187</td>
<td>Stroke and Stroke Rehabilitation: Thrombolytic Therapy (tPA)</td>
</tr>
<tr>
<td>254</td>
<td>Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain</td>
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<tr>
<td>255</td>
<td>Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure</td>
</tr>
<tr>
<td>317</td>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
</tr>
<tr>
<td>326</td>
<td>Atrial Fibrillation and Atrial Flutter: Chronic Anti coagulation Therapy</td>
</tr>
<tr>
<td>415</td>
<td>ED Utilization of CT for Minor Blunt Head Trauma for Patients Ages 18+ Years</td>
</tr>
<tr>
<td>416</td>
<td>ED Utilization of CT for Minor Blunt Head Trauma for Patients Ages 2-17 Years</td>
</tr>
<tr>
<td>419</td>
<td>Overuse Of Neuroimaging For Patients With Primary Headache And A Normal Neurological Examination</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>eCQM</th>
<th>Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>QPP066-CMS146v5</td>
<td>Appropriate Testing for Children with Pharyngitis</td>
</tr>
<tr>
<td>QPP317-CMS22v5</td>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
</tr>
<tr>
<td>2017 Measure ID</td>
<td>Measure Title</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>ACEP 19</td>
<td>Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older</td>
</tr>
<tr>
<td>ACEP 20</td>
<td>Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years</td>
</tr>
<tr>
<td>ACEP 21</td>
<td>Coagulation Studies in Patients Presenting with Chest Pain with No Coagulopathy or Bleeding</td>
</tr>
<tr>
<td>ACEP 22</td>
<td>Appropriate Emergency Department Utilization of CT for Pulmonary Embolism</td>
</tr>
<tr>
<td>ACEP 23</td>
<td>Anti-coagulation for Acute Pulmonary Embolism Patients</td>
</tr>
<tr>
<td>ACEP 24</td>
<td>Pregnancy Test for Female Abdominal Pain Patients</td>
</tr>
<tr>
<td>ACEP 25</td>
<td>Tobacco Screening and Cessation Intervention</td>
</tr>
<tr>
<td>ACEP 26</td>
<td>Sepsis Management: Septic Shock: Lactate Level Measurement</td>
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<tr>
<td>ACEP 27</td>
<td>Sepsis Management: Septic Shock: Antibiotics Ordered</td>
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<tr>
<td>ACEP 28</td>
<td>Sepsis Management: Septic Shock: Fluid Resuscitation</td>
</tr>
<tr>
<td>ACEP 29</td>
<td>Sepsis Management: Septic Shock: Repeat Lactate Level Measurement</td>
</tr>
<tr>
<td>ACEP 30</td>
<td>Sepsis Management: Septic Shock: Lactate Clearance Rate ≥ 10%</td>
</tr>
<tr>
<td>ACEP 31</td>
<td>Emergency Medicine: Appropriate Foley Catheter Use in the Emergency Department</td>
</tr>
<tr>
<td>ACEP 32</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Adult Patients</td>
</tr>
<tr>
<td>ACEP 33</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Adult Patients in Supercenter EDs (80k +)</td>
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</table>
Non-QPP Measures (continued)

<table>
<thead>
<tr>
<th>2017 Measure ID</th>
<th>Measure Title</th>
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<tbody>
<tr>
<td>ACEP 35</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Adult Patients in High Volume EDs (60k-79,999)</td>
</tr>
<tr>
<td>ACEP 36</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Adult Patients in Average Volume EDs (40k-59,999)</td>
</tr>
<tr>
<td>ACEP 37</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Adult Patients in Moderate Volume EDs (20k-39,999)</td>
</tr>
<tr>
<td>ACEP 38</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Adult Patients in Low Volume EDs (19,999 and less)</td>
</tr>
<tr>
<td>ACEP 39</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Adult Patients in Freestanding EDs</td>
</tr>
<tr>
<td>ACEP 40</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Pediatric Patients</td>
</tr>
<tr>
<td>ACEP 41</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Pediatric Patients in Supercenter EDs (80k +)</td>
</tr>
<tr>
<td>ACEP 43</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Pediatric Patients in High Volume EDs (60k-79,999)</td>
</tr>
<tr>
<td>ACEP 44</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Pediatric Patients in Average Volume EDs (40k-59,999)</td>
</tr>
<tr>
<td>ACEP 45</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Pediatric Patients in Moderate Volume EDs (20k-39,999)</td>
</tr>
<tr>
<td>ACEP 46</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Pediatric Patients in Low Volume EDs (19,999 and less)</td>
</tr>
<tr>
<td>ACEP 47</td>
<td>ED Median Time from ED arrival to ED departure for discharged ED patients for Pediatric Patients in Freestanding EDs</td>
</tr>
<tr>
<td>ACEP QI01</td>
<td>Sepsis Management: Septic Shock: Blood Cultures Ordered</td>
</tr>
<tr>
<td>ACEP QI02</td>
<td>Emergency Medicine: Appropriate Use of Imaging for Recurrent Renal Colic</td>
</tr>
</tbody>
</table>
EMRs/Data Systems that CEDR has worked with

- EPIC Cerner
- Meditech
- Allscripts
- PICIS
- Merge Financials
- Wellsoft
- Tsystem
- MEDHOST EDIS
- Paragon WebStation
- Soarian EDIS
- Medpoint
- Forerun
<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
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<tbody>
<tr>
<td>Number of Providers</td>
<td>262</td>
<td>800+</td>
<td>2,000+</td>
</tr>
<tr>
<td>Number of Patient Visits</td>
<td>458,263</td>
<td>2M+</td>
<td>8M+</td>
</tr>
<tr>
<td>Number of ED Engaged</td>
<td>14</td>
<td>70</td>
<td>282+</td>
</tr>
<tr>
<td>Number of EMR/EDIS</td>
<td>4</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Performance Measures</td>
<td>27</td>
<td>42</td>
<td>44</td>
</tr>
</tbody>
</table>
CEDR HIPAA & Security Features

- CEDR standards exceed industry standards for data security and management
- All data is handled in accordance with HIPAA requirements
- Data is encrypted while in motion and at rest

- Stringent security policies exceeding industry standard
  - Registry staff can only access data in a clean environment
  - Physical restrictions regarding usage of smart phones in work areas
  - Portable drives are banned
  - Restricted access to public e-mail systems
CEDR Hosting and Technology Environment

- AWS Cloud environment is SSAE-16, PCI-DSS, FISMA, ISO 27001, SOC-I, II, III certified.
- Access to FIGmd Corporate Headquarters is controlled by video monitoring, Biometric scan systems at each door, visitor registration, and badge access.
- FIGmd, Inc. has designed HIPAA and Security Awareness Training Program for entire workforce.
- Limit uses & disclosures of PHI to the "minimum necessary"
- Internal Audits and Security reviews on going basis.
- All required policies and procedures are created and controls are in place.
Drive to transform clinical practice

Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

Historical Performance

- 2011: 0% FFS linked to quality, 68% Alternative payment models
- 2014: ~20% FFS linked to quality, 80% Alternative payment models

Goals

- 2016: 30% FFS linked to quality, 85% Alternative payment models
- 2018: 50% FFS linked to quality, 90% Alternative payment models

Legend:
- Alternative payment models (Categories 3 - 4)
- FFS linked to quality (Categories 2 - 4)
- All Medicare FFS (Categories 1 - 4)
Support more than 150,000 clinicians in their practice transformation work

Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients

Reduce unnecessary hospitalizations for 5 million people

Generate $1 to $4 billion in savings to the federal government and commercial payers

Sustain efficient care delivery by reducing unnecessary testing and procedures

Build the evidence base on practice transformation so that effective solutions can be scaled
## Practice Transformation

<table>
<thead>
<tr>
<th>Individual Patient</th>
<th>Treating Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fragmented Care</td>
<td>Coordinated Care</td>
</tr>
<tr>
<td>Payer-driven change</td>
<td>Provider-driven</td>
</tr>
<tr>
<td>Volume-based $</td>
<td>Value-based $</td>
</tr>
</tbody>
</table>

*But where does Emergency Medicine Fit in?*
Mission

“engage emergency clinicians and leverage emergency departments to improve clinical outcomes, coordination of care and to reduce costs”
Emergency Quality Network Focus Areas

• Improving outcomes for patients with sepsis
• Reducing avoidable imaging in low risk patients by implementation of ACEP’s Choosing Wisely recommendations
  – High-cost imaging for low back pain
  – Head CT scan after minor head injury
  – Chest CT for pulmonary embolus
  – Abdominal CT for renal colic
  – Head CT for syncope
• Improving the value of ED evaluation for low risk chest pain by reducing avoidable testing and admissions
Goal: National Impact

• Support widespread implementation early recognition and treatment interventions to save 60,000 lives
• Reduce one million imaging studies by supporting clinicians and patients in implementing ACEP’s Choosing Wisely™ recommendations

• Save over $200 million by improving the value of care for ED patients with low-risk chest pain by:
  – Improving appropriateness of noninvasive cardiac diagnostic testing
  – Improving care coordination to reduce hospitalization rates
Why Join E-QUAL?

- Earn Clinical Practice Improvement Activity credit for CMS MIPS program
- Submit and receive benchmarking data
- Feature your ED’s QI efforts to hospital leaders and payers
- Gain access to toolkits including best practices, sample guidelines, and key talking points
- Get access to high-quality eCME for FREE
- Earn American Board of Emergency Medicine (ABEM) Maintenance of Credits (MOC) credit (LLSA and Part IV Activities)
What is a Learning Collaborative?

### Recruitment & Enrollment
- Readiness Assessment Survey
- Submit provider NPIs & group tax ID number

### Learning Period (6-9 months)
- Monthly Webinars
- Podcasts
- Publicize guidelines and materials
- Benchmarking data
- Office Hours

*Time Commitment 1.5 hours per month

### Wrap Up
- Data Reports
- Summary Report
- Lessons Learned
- Earn “High” weight Clinical Practice Improvement Activity credit for CMS MIPS program
- eCEM & MOC credit
- Meet CMS PQRS requirements
- Re-enrollment
## Recruitment and Engagement

**Goal:** E-QUAL will engage over 2,000 EDs and 24,000 emergency clinicians over 4 years

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,250</td>
<td>12,000</td>
<td>5,250</td>
<td>1,500</td>
<td>24,000</td>
</tr>
<tr>
<td>ED</td>
<td>ED</td>
<td>ED</td>
<td>ED</td>
<td>ED</td>
</tr>
<tr>
<td>clinicians</td>
<td>clinicians</td>
<td>clinicians</td>
<td>clinicians</td>
<td>clinicians</td>
</tr>
</tbody>
</table>

**January 2017 Recruitment – 25,802 emergency clinicians!**
Aligning Levers for Change
## Timeline – Sign Up!

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Wave</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis Initiative Wave II</td>
<td>II</td>
<td>January 2017</td>
</tr>
<tr>
<td>Avoidable Imaging Initiative Wave II</td>
<td>II</td>
<td>March 2017</td>
</tr>
<tr>
<td>Chest Pain Initiative Wave I</td>
<td>I</td>
<td>Spring 2017</td>
</tr>
</tbody>
</table>

**Required:** Complete E-QUAL Quality Improvement Readiness Assessment Survey - 10 minutes

**Required:** submit provider NPIs and group Tax ID Number (TIN) to ensure registration in TCPI program with CMS
A Summary of How Benefits Were Realized for the Value of Health IT

Include one slide at the end of the presentation that links and frames the presentation to demonstrate the benefits realized for one or more STEPS™ value categories. Use metrics where possible.

Please see STEPS™ slide templates & guidelines for detailed instructions on utilizing the STEPS™ framework in your HIMSS17 presentation.
### Select Meaningful and Attainable Quality Metrics

- Core Measures
- HCAHPS
- Readmissions and Complications
- Length Of Stay
- Mortality
- High Volume, High Cost, High Risk Conditions
- Disease State Management
- Clinical Efficiencies
Reflect Hospital Priorities in Selection of Initiatives

- High Volume, High Cost, High Risk Conditions
- Evidence-Based Medicine
- Guidelines and Protocols
- Evidence-Based Order Sets
- Key Process Indicators
- Clinical Outcomes
- Physician Profiling
Maintain Data Integrity to Support Performance Evaluation

- Timely
- Reliable
- Sample size validation
- Risk adjusted
- Physician attribution
Population Health Management

Care Management Model

Risk Stratification
Predictive Modeling
Clinical Guidelines

Integrated, standardized workflow management and monitoring

Seamless Patient Experience Across the Continuum

Wellness/Preventive Care
Primary Care/PCMH
Specialty Care
Community-based Services
Pharmacies
Behavioral Health
Urgent Care
Emergency Services
Hospital Care
Post-acute Care/Home Care
End-of-life Care

Patient Identified
Patient Needs Assessed
Care Plan Developed
Care Plan Implemented
Care Plan Monitored
Clinically Integrated Care

Pillar 1: Collaborative leadership
- Governance body
- Compliant legal structure
- Payer strategy
- Culture change

Pillar 2: Aligned incentives
- Physician compensation
- Program infrastructure
- Physician support

Pillar 3: Clinical programs
- Disease programs
- Care protocols
- Clinical metrics
- Population health management

Pillar 4: Technology infrastructure
- Health information exchange
- Patient longitudinal record
- Disease registry
- Patient portal
For More Information

• Contacts:
  – pgoyal@acep.org
  – 469-499-0299