From: CEDR <cedr@acep.org>

Sent: Friday, September 7, 2018 9:07 AM

To: Ethan Killgore

Subject: CEDR Newsletter - August 2018

A Newsletter for CEDR Members

ACEP CEDR Newsletter

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Featured Article

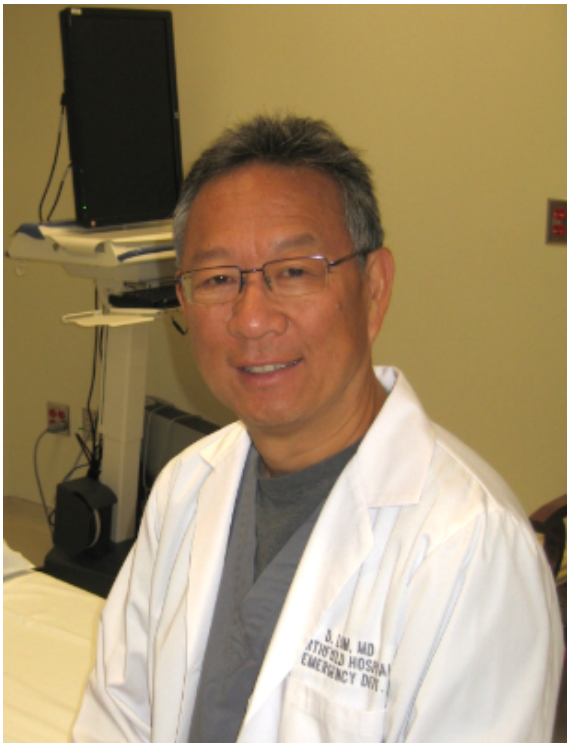
1. Editor's Note

Editor: Dr. Donald L Lum MD FACEP

Chair, CEDR Member Outreach, Recruitment, &

Marketing Subcommittee

“CEDR and Quality: What’s on the Dashboard and Under the Hood?”



As I stated to you in my first turn as editor in January the purpose of this newsletter is two-fold- 1. to show you the visible features of what’s happening “on the dashboard of CEDR” to guide real-time clinical care improvement and 2. understand what’s going on “under the hood” of CEDR’s evolving structure as a clinical quality data registry. It may seem that summer has put a mind blanket of heat, sun and vacations over many of us but CEDR team and leadership have been ramping up for another year of growth.

In this issue ACEP staff continue their updates to CEDR participant groups and members about progress on a number of fronts: Bill Malcolm on CEDR mid-year operations update, Nalani Tarrant on E-QUAL update, the CMS MIPS scores announcement, team spotlight, and message from Dr. Goyal, Associate Executive Director .

Also, CEDR committee members add their contributions: Stephen Epstein, outgoing chair, message and Don Lum on CEDR Marketing and Communication 3 Year Plan. Finally, Nick Genes, CEDR Committee member and Chair, ACEP Informatics Section, is jumpstarting a new series aptly named “Meet the Measures” to familiarize the practicing ED physician with the quality measures and provide practical guidance on each featured measure.

We welcome your feed back and input on future articles, topics and resources at **cedr@acep.org**

2. Outgoing Chair Message

Author: Dr. Stephen Epstein MD FACEP

Chair, CEDR Committee

The summer is usually a quiet time from the business of Washington, and even at CEDR the deadlines are fewer. But that doesn’t mean that there isn’t a lot happening. CMS recently released several new proposed rules that affect QCDRs like CEDR and the Quality Payment Program, as well as proposals that may affect E&M documentation. We’ve been poring through the various regulations and honing our responses.

In the interim, many of you are likely receiving your MIPS scoring for 2017. As you may remember, the bar for

participation in MIPS was very low for 2017 – just one measure needed to be reported to avoid a penalty. As a result, there were very few practices in the country that missed the bar and will have a -4% penalty assessed in 2019. Since the Quality Payment Program is revenue-neutral, it also means that there is very little money available for practices that were high performers.

While this may be disappointing this year, the work that went into getting up and running within CEDR will become ever more important as the requirements to avoid a downside penalty increase. This year's score should give you a good indication of your strengths and weaknesses and an opportunity to improve before the 2019 reporting period begins.

We are also hard at work protecting the current CEDR quality measures and developing new ones. We are meeting with CMS regarding sepsis measures (we would like to keep these are granular as possible to allow you to pinpoint areas for quality improvement), and have applied for a contract from CMS to develop new measures of particular relevance to emergency medicine. More information should be available this fall.

This is also my last column as chair of the CEDR committee. It's been a 3+ year run from the decision to develop CEDR to full implementation. Over that time, we have seen a new division of the College established for quality issues, and about a quarter of all emergency departments in the nation participating in CEDR (and more in our companion E-QUAL network) with more than 25 million patient encounters now documented in the master database. By providing a means to avoid CMS penalties, we have helped improve emergency care for the nation and saved millions of dollars for the specialty of emergency medicine as a whole. Now it's time for someone else to take CEDR to the next level, and I will be handing the reins to Abhi Mehrotra, MD, FACEP to do just that.

Finally, thanks to Pawan Goyal, Dean Wilkerson, and the ACEP Board of Directors, without whom this project would not have been possible, and in particular Jim Augustine, MD, FACEP who has maintained a vision for the future and been a tireless champion of CEDR and ACEP's quality work.

3. ACEP's Associate Executive Director of Quality

Author: Dr. Pawan Goyal

ACEP Associate Executive Director, Quality

Clinical Emergency Data Registry (CEDR) closed ACEP's Fiscal Year 2017-18 with a positive financial outcome. This has been great news for ACEP and its members that the ongoing investments have started to bear fruit.

While the 2018 performance period is only half way, team CEDR is in the thick of supporting 175+ ED Groups that have entrusted ACEP with their quality journey. CEDR has started to evolve from a CMS Quality Payment Program (QPP) Merit-based Incentive Payment System (MIPS) reporting tool to a data-driven quality improvement platform. With more than 25 million visits in CEDR data storage, it is not only the beginning of the big data journey for Emergency Medicine but also ACEP's humble beginning towards a long term Digital Transformation.

Our CEDR participants have demonstrated their trust in ACEP and continue to support its growth; ACEP staff has been taking care of its customers under the leadership of ACEP's Executive Director Dean Wilkerson, our visionary leaders Dr. Jim Augustine and Dr. Steve Epstein, and our newsletter editor and outreach chair, Dr. Don Lum.

Big data is a hot topic in the academic sector, and healthcare researchers are definitely not an exception. While

big data sources in Emergency Medicine continue to be largely unexplored, never before have the cold, hard numbers behind emergency medicine been more accessible. Join CEDR to unlock the data that will help your department and your practice!

4. Meet the Measures

Author: Dr. Nicholas Genes, MD, PhD

Chair, Emergency Medicine Informatics (EMI) Section

Meet the Measures: Pregnancy Test for Female Abdominal Pain Patients (ACEP-24)

At-a-glance details of the measure:

Formal title: Percentage of emergency department visits for female patients aged 14 through 50 years old who present to the ED with a chief complaint of abdominal pain who have had a pregnancy test (urine or serum) ordered

Domain: **Patient Safety** (as distinct from Patient Experience, Efficiency/Cost Reduction, Effective Care, and Population Health).

Type: **Process** (as opposed to Outcome, or Efficiency measure)

Welcome to the first edition of an ongoing series, where the quality measures supported by CEDR are explained and discussed. The purpose of this series is to peek under the hood of these quality measures, to help educate emergency physicians about their rationale, history, and what goes into each measure's calculation. I hope this will enable both practicing physicians in the ED and ED medical directors to choose appropriate quality measures for their practice, and helps them better document the critical data elements to optimize scoring of measure.

The first measure I chose to examine is ACEP-24 – pregnancy testing for female abdominal pain pages. This is among the simplest measures to calculate, and also among the least controversial – nothing changes the differential diagnosis of abdominal pain so much as a positive pregnancy test. No one wants to miss an ectopic or diagnose a pregnancy via CT scan. It's no surprise ACEP-24 has roots that go back a long way – it's based on an NQF submission from 2008, and includes citations from a 2000 ACEP policy and a 1989 Annals paper on the unreliability of patient history for determining pregnancy.

The challenge, however, is capturing patient histories and presentations, and physician behavior, in a way that CEDR can recognize - to facilitate an accurate calculation of the quality measure. You could write a detailed note about a patient's recent hysterectomy, or you could document that you dipped the patient's urine and checked the U-preg test yourself – but your EHR needs to capture this data discretely, and transmit that data to CEDR in a way that the registry can use to calculate the measure. When I say "discrete" data in this case, I mean an entry in the Past Medical History field of a chart, or the Orders area. Remember CEDR can't infer meaning from notes – the registry has to look in pre-defined areas of a chart to see if a case meets criteria and quality standards were met.

Let's take a look at ACEP-24's numerator, denominator and exclusions, and how that figures in to the Merit-based Incentive Payment System (MIPS) calculation.

The numerator is Emergency department visits for patients who have had a pregnancy test (urine or serum) ordered. That's fair, and it ought to be easy enough to capture orders from an EHR. But be wary of the point-of-care pregnancy test – like strep tests and guaiac tests, some POC pregnancy and UAs can be easy to perform without an electronic order. If this is a habit at your shop, this will hurt your numerator and thus, your overall performance.

The denominator for ACEP-24 is all emergency department visits for female patients aged 14 through 50 years old who present to the ED with a chief complaint of abdominal pain. This also seems fair, and straightforward. But make sure you're not artificially shrinking the denominator by eliminating a lot of related complaints – does your triage nurse pick a chief complaint from a narrow, well-defined drop-down list in your EHR, or are free-text entries allowed? Check your daily census to see if "abd. pain" and "distended belly" and "n/v with abdominal pain" are listed chief complaints – if so, it's likely the denominator CEDR would calculate for this measure is smaller that it should be – which could serve to artificially magnify the effect of the numerator.

The exclusions for this measure make sense – An EP shouldn't be expected to check a pregnancy test on a patient who has had a hysterectomy, or is post-menopause, or is obviously pregnant. But for these exclusions, do a chart review: where are you capturing information on hysterectomy, menopause, and pregnancy status? This information should exist in the patient's past medical and surgical history, or problem list, or some other discrete field (for instance, some EHRs can capture visits that occur during "episodes of pregnancy" that persist for a period of time, after a pregnancy is diagnosed). If it's not, you're missing key exclusions, inflating your denominator and likely making your practice look less safe than it is.

Performing well on these quality measures is important, when it comes to calculating MIPS scores. The Quality component of MIPS is a big fraction of the overall MIPS score – your practice is rewarded points based on performance over a historical benchmark. Also your ED could stand to gain significant bonus payments if the physicians are performing above a certain threshold in their quality measures – and could get penalized if they fall in the bottom quartile.

Fortunately, practices can choose which quality measures to report – so they should choose measures where they know they're accurately capturing the data that will lead to a favorable calculation.

When our CEDR study group looked at data elements from a random sampling of EDs, we found considerable variability in a few of the elements that went into the calculation of ACEP-24. Some sites just rarely seemed to capture a diagnosis of hysterectomy or menopause. Even the diagnosis of pregnancy varied – a few EDs seemed to have a rate less than 1%, while others reported 3-4% of their patients were pregnant. That variability may simply be explained by variations in the ED patient population – but if I was at an ED that didn't seem to report a lot of visits from pregnant patients, I'd be worried my EHR wasn't transmitting this data to CEDR in a discrete manner that CEDR could recognize. Maybe the ED docs know the patient is pregnant, and write about it in their notes, but unless pregnancy status is captured in a place like History or Problem List or Chief Complaint or Diagnosis, it's going to be missed by the registry.

So even though ACEP-24 seems straightforward – a reasonable and relatively simple quality measure – be sure you're capturing the right data elements in pre-defined places in your EHR. Particularly, make sure the point-of-care U-preg tests are documented discretely as orders, rather than a note. And make sure your exclusions like hysterectomy or current pregnancy are also documented discretely – otherwise your performance score may not reflect how you really practice.

5. CEDR Operations Update

Author: Bill Malcom, PMP

CEDR Program Director, ACEP

CEDR Operations Update

With half the 2018 reporting year behind us, the CEDR team continues to drive forward implementations for reporting on over 180 physician groups. Our challenge, as last year, continues to be the acquisition of data from hospitals. While I am glad to report that we are seeing more support in 2018, we still have groups that cannot get data from their Emergency Department systems. ACEP leadership works diligently with hospitals at both the local and enterprise level. Through this effort, a number of hospital systems agreed to share their data with CEDR in support of ED groups. For those groups where the hospital has not shared the data, CEDR is working with provider group billing systems to maximize any possible reporting opportunities in the MIPS program.

CMS has made significant changes in the MIPS program for 2018. These include full~~y~~ year reporting for the quality metrics, an increase to a minimum of 60% of data in the reports to achieve benchmark scoring, and inclusion of a Cost factor as 10% of the overall MIPS score. We've also been watching closely to see how CMS would respond to various requested changes prior to the final rule for 2018. The most impactful requested change~~s~~ was to reduce the quality category from a full year of data to a minimum of only 90 days. CMS released the preliminary rule for comment last month and it did not include any reduction of the timeframe required for quality metric data reporting. CMS could still decide to make such a change, but we believe it is less likely now. In addition, CMS indicated their intent in the preliminary rule to increase the minimum score for avoiding penalty from 15 in 2018 to 30 in 2019. This will increase the demand on reporting for provider groups, further driving the need for quality reporting programs like CEDR.

ACEP knows that EM provider groups will need more and more tools to allow them to compete with other specialties in the MIPS program. To prepare, ACEP has greatly expanded our measure development resources and worked diligently with CMS to ensure all our CEDR measures attain benchmarking for scoring in the MIPS program. We also use CEDR data research to provide metrics-driven reports supporting EM measures as valuable to patient outcomes, the practice of EM, and CMS drivers for quality measurement in the MIPS program.

As we get closer to the end of the year~~,~~ and the MIPS reporting period for 2018, some activities may help better prepare groups to do well. Reporting of Promoting Interoperability (PI), formally known as Advancing Care Information (ACI), may provide one of the best ways to maximize your MIPS score ~~is~~ in 2018. We found that those groups who could get ACI data in 2017 were able to score the maximum points in the category (25 of 25) in almost all cases. Provider groups may want to reach out to their hospital systems to inform them that the provider group would like this PI data for 2018 once the year is complete. This will give groups the option to report the PI data as part of their 2018 MIPS reporting, if the performance in the PI category provides an~~d~~ advantage to the scoring.

ACEP deeply appreciates the support of our CEDR participants in 2018. We could not have come this far without all your support. We will continue to provide webinars and training opportunities during the coming months, and I hope you will join us in these events. I also want to encourage you to meet with our CEDR team at Scientific Assembly in September.

6. CEDR Marketing and Communication 3 Year Plan

Author: Dr. Donald L Lum MD FACEP

Chair, CEDR Member Outreach, Recruitment, & Marketing Subcommittee

CEDR Marketing and Communication 3 Year Plan is unveiled

This article presents a brief introduction of the marketing and communication plan unveiled during the CEDR committee May 2018 meeting.

In the face of CEDR's continuing rapid growth a strategic plan has been developed to support its expansion for the next three years. It is currently a template of high-level objectives which are being translated into actionable strategies and tasks in the weeks ahead. Pankaj Kapoor, CEDR Sales and Operations manager, Dr. Pawan Goyal, ACEP Associate Executive Director, and Dr. Lum, CEDR Member Outreach, Recruitment, & Marketing Subcommittee Chair have been involved in its development.

The plan covers two broad areas- marketing and member communication.

Marketing includes recruitment of prospective ED participant groups to CEDR. The marketing plan aims to promote the CEDR brand through a distinctive logo, compelling tagline, and effective positive messaging. These components are all under current review by the CEDR management team.

Communication addresses the challenges for both enhanced outreach and communication among the growing network of CEDR participant groups. Staff projects 175 customer groups, 750 ED's, 12,000 providers and 20,000,000 ED visits in CEDR by end of 2018. We are focusing on multiple channels- website, newsletter, webinars, and articles/publications - to convey important information in a timely fashion. We are reviewing these same sources and internal CEDR components such as the dashboard to provide more outreach services.

The operations team and this sub-committee continue to use the feedback from the 2016 and 2017 participant experience surveys to inform improvement and enhancement of support and implementation services for our CEDR customers at all levels- the group, team and individual.

Another important priority is robust, interactive, real-time networking among the members of the CEDR community including the CEDR committee, ACEP CEDR staff, technology partner, Figmd, and the participant groups. A key step is the development of an online CEDR users group/community. The operations team is identifying key stakeholder sub-groups within the participating groups for the user's group, i.e. IT, hospital executives/upper management (C Suite), quality managers, physician leaders, EHR managers/revenue cycle co managers, and nurse managers. Currently, Dr. Lum and CEDR operations team are exploring the new ACEP platform ACEP engagED to see how it can be adapted and scaled to support such a user group and the larger CEDR participant group community.

7. CEDR Team Spotlight

Author: Dr. Pawan Goyal

ACEP Associate Executive Director, Quality

FREDERIK COENRAAD (CONRAD) SMIT, PMP

Please join me in welcoming our CEDR Director for Implementation and Product Innovation, Conrad Smit, to ACEP.

Conrad will be leading our rapidly growing CEDR portfolio of customer implementations, including data acquisition and management strategies, as well CEDR product innovation, thereby achieving successful program delivery and world-class customer experience. He will also be designing and building the next generation of

CEDR that will diversify CEDR capabilities beyond MIPS reporting into a robust research and analytics platform. ACEP has recently been awarded 3 grants from CMS, NIH, and Addiction Policy Forum that will diversify use of CEDR in the areas of data collection, quality measure validation, research, and analytics.

Conrad is a Senior Health IT and certified Project Management Professional. He brings 15+ years of experience in areas of programming, product management, project management, customer experience management, business analysis, software integration, new product implementations, and operations.

Conrad comes to us from Latric Systems, a Boston based Healthcare Solutions company, where he served as the Director of Project Management. Conrad is located in ACEP headquarters. Please stop by to say hello to him, when you are in ACEP headquarters.

8.1. Emergency Quality Network (E-QUAL)

Author: Nalani Tarrant

Senior Project Manager, Quality Collaboratives and Measure Development

Emergency Quality Network (E-QUAL)

The Emergency Quality Network (E-QUAL) was created in October 2015 with the support of the CMS Transforming Clinical Practice Initiative (TCPI), a 4-year effort by CMS to support both national medical specialty societies and local clinical practice networks in achieving better health at lower cost.

ED sites participate through 9-month long learning collaboratives, during which each site's selected Champion will complete a number of virtual quality improvement activities which include engaging all eligible providers through the sharing of E-QUAL webinars, podcasts, and generated performance data. This level of participation is aimed at helping clinicians target 'big' problems, develop the local capacity for quality improvement, and create momentum for practice transformation.

As of June 2018, over 800 Emergency Departments (EDs) and over 27,000 emergency clinicians have joined E-QUAL to participate in one of the three initiatives:

- Improving sepsis outcomes by supporting early recognition and resuscitation in the ED
- Reducing avoidable imaging by implementing ACEP's Choosing Wisely recommendations
- Improving value of care for low risk chest pain by reducing avoidable hospitalizations

E-QUAL launched two new programs recently this summer 2018.

- Opioid Initiative
- E-QUAL/CEDR rural/critical access grant

With support from the Addiction Policy Forum and Yale University, ACEP has received a three-year grant to fund the creation of an Opioid Initiative for dissemination through E -QUAL. The E-QUAL Opioid Initiative has recruited over 180 emergency departments (ED) nationwide to collaborate on opioid-focused interventions; develop a best-practice toolkit based on available evidence; collect data on quality of care; assess the current state of ED and hospital care; and study the effectiveness of engaging EDs in quality improvement efforts. ED sites will participate in a 6-month learning collaborative (June-December 2018), during which each site's selected champion will complete a number of virtual quality improvement activities which include engaging all eligible provides through the sharing of E-QUAL webinars, podcasts, and generated performance data.

E-QUAL offered a grant opportunity (one-time lump sum of $4000.00) to 25 rural/critical access ED sites to join E-QUAL and CEDR. The purpose of the grant is to maximize the success of the ED quality improvement projects and to help EDs build critical data access and capacity. E-QUAL hopes to offer a similar grant opportunity in 2019 (contingent upon grant funding). If your ED is in rural or an underserved area, you may be eligible for a grant in 2019.

For more information on E-QUAL, potential grant opportunities or how to enroll into the 2019 initiatives please contact the E-QUAL team at **equal@acep.org**

8.2. CMS MIPS Performance Feedback, Final Score, and Targeted Review

MIPS Performance Feedback and Final Score

If you participated in the Merit-based Incentive Payment System (MIPS) in 2017, your **MIPS performance feedback** and **final score** are now available for review on the **Quality Payment Program website**. The payment adjustment you will receive in 2019 is based on this final score. A positive, negative, or neutral payment adjustment will be applied to the Medicare paid amount for covered professional services furnished under the Medicare Physician Fee Schedule in 2019.

You can access your performance feedback and final score by going to the **Quality Payment Program website**. Logging in using your Enterprise Identity Management (EIDM) credentials; these are the same EIDM credentials that allowed you to submit your MIPS data. If you don't have an EIDM account, refer to **this guide** and start the process now

MIPS eligible clinicians or groups (along with their designated support staff or authorized third-party intermediary), including those who are subject to the APM scoring standard may request for CMS to review their performance feedback and final score through a process called targeted review.

When to Request a Targeted Review?

If you believe an error has been made in your 2019 MIPS payment adjustment calculation, you can request a targeted review until **September 30, 2018**. The following are examples of circumstances in which you may wish

to request a targeted review:

1. Errors or data quality issues on the measures and activities you submitted
2. Eligibility issues (e.g., you fall below the low-volume threshold and should not have received a payment adjustment)
3. Being erroneously excluded from the APM participation list and not being scored under APM scoring standard
4. Not being automatically reweighted even though you qualify for automatic reweighting due to the 2017 extreme and uncontrollable circumstances policy

Note: This is not a comprehensive list of circumstances. CMS encourages you to submit a request form if you believe a targeted review of your MIPS payment adjustment (or additional MIPS payment adjustment) is warranted.

How to Request a Targeted Review?

You can access your MIPS final score and performance feedback and request a targeted review by: Going to the **Quality Payment Program website**

Logging in using your Enterprise Identity Management (EIDM) credentials; these are the same EIDM credentials that allowed you to submit your MIPS data. Please refer to the **EIDM User Guide** for additional details.

If your targeted review request is approved, CMS will update your final score and associated payment adjustment (if applicable), as soon as technically feasible. CMS will determine the amount of the upward payment adjustments after the conclusion of the targeted review submission period. T**argeted review decisions are final and not eligible for further review.**

Please note: The final performance year for the Value-Based Modifier and Physician Quality Reporting System (PQRS) programs was 2016; therefore, CMS will no longer provide PQRS Feedback Reports or Quality and Resource Use Reports (QRURs). The final reports under these programs were provided in September 2017 and remain available for download through the end of this year.

Questions? If you have questions about your performance feedback or MIPS final score, please contact the Quality Payment Program by:

Phone: 1-866-288-8292/TTY: 1-877-715-6222 or Email: QPP@cms.hhs.gov For more information on performance feedback and targeted review, the following resources are available:

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We welcome your feed back and input on future articles and topics. You can either send email at **cedr@acep.org** or talk to Pankaj Kapoor CEDR, Sales and and Operations Director, ACEP at **pkapoor@acep.org** or call 469-499-0238

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