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Avoidable Imaging Initiative

Traumatic Brain Injury CT Prediction Rules in Children

Optimizing Uptake of Clinical Decision Support in the Electronic Health Record

Data Collection- CEDR and Quality/Performance Measures

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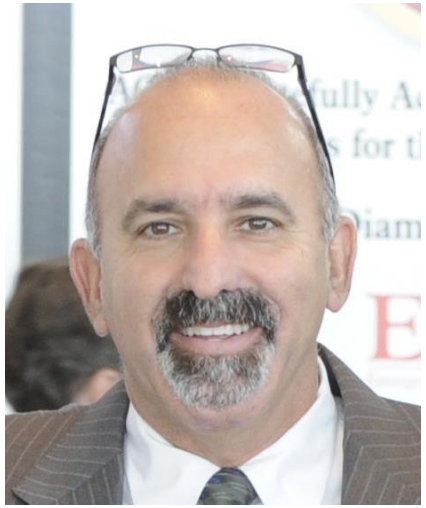
Presenters



Nate Kuppermann, , M.D., M.P.H.

Peter Dayan, M.D.

Arjun Venkatesh, M.D., MBA, MHS

Dustin Ballard, M.D., M.B.E.

David Vinson, M.D.

Traumatic Brain Injury CT Prediction Rules in Children:

Generating/Validating the Evidence, then Translating to Practice

Nathan Kuppermann, MD, MPH

Departments of Emergency Medicine and Pediatrics
University of California, Davis School of Medicine

Peter Dayan, MD, MSc

Division of Pediatric Emergency Medicine
Columbia University Medical Center
Morgan Stanley Children's Hospital

E-QUAL Avoidable Imaging Webinar
November 17th, 2016

Disclosure

- No financial relationships or conflict of interests related to this talk

Objectives

- Briefly review the PECARN head trauma CT prediction rules derivation / validation
- Describe how PECARN is translating the TBI Prediction Rules into practice

The PECARN Head Injury Study

Goal: to derive a clinical decision rule to accurately identify children at near zero risk of clinically important traumatic brain injury after blunt trauma with high accuracy and wide generalizability

Outcome Definition

Clinically-important TBI (ciTBI)

- Death from TBI
- Neurosurgical procedure
- Intubation for ≥ 24 hours for head injury
- Positive CT in association with hospitalization ≥ 2 nights

The PECARN TBI Rules (derived and validated)

Children are at very low risk of clinically-important traumatic brain injury (TBI) if they meet all criteria in age-specific rule:

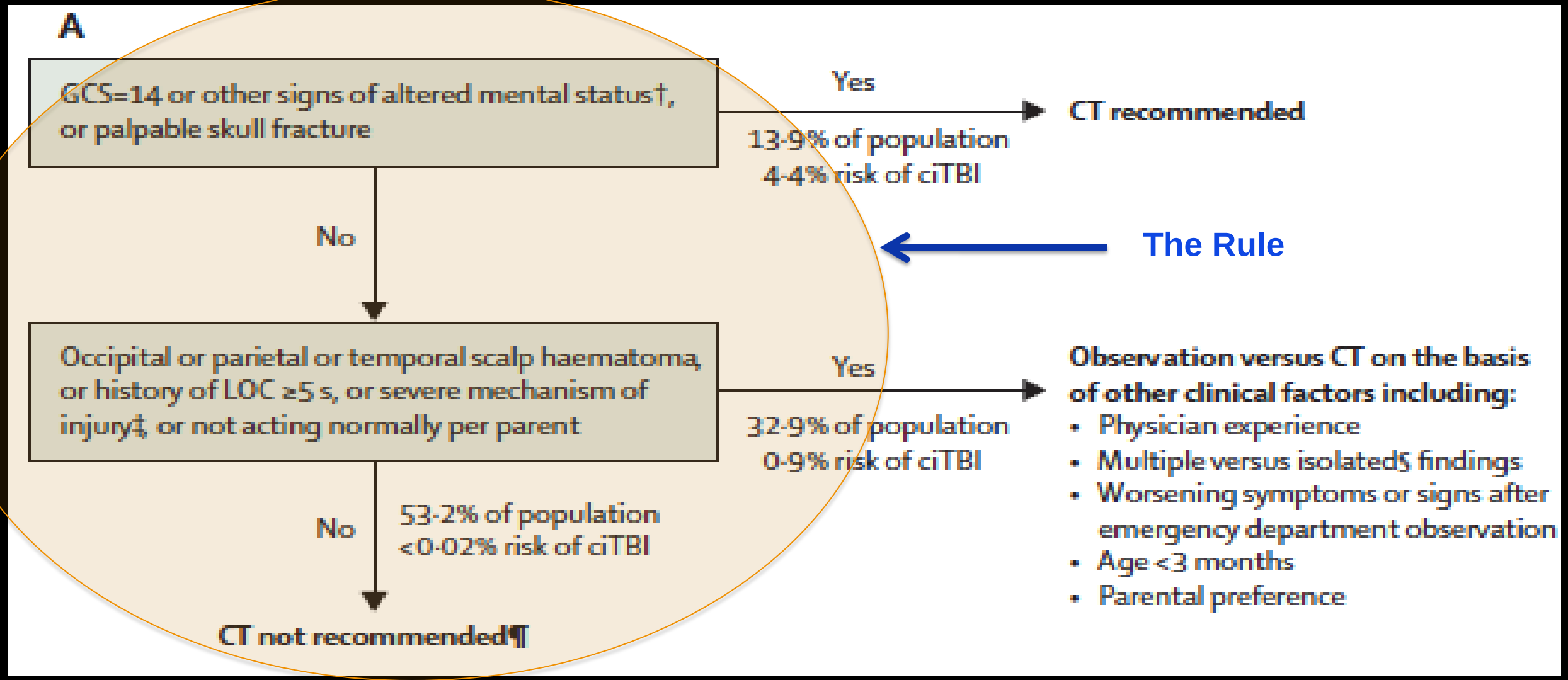
Children < 2 years

1. Severe mechanism of injury
2. History of LOC ≥ 5 sec
3. GCS = 14 or other signs of altered mental status
4. Not acting normally per parent
5. Palpable skull fracture
6. Occipital/parietal/temporal scalp hematoma

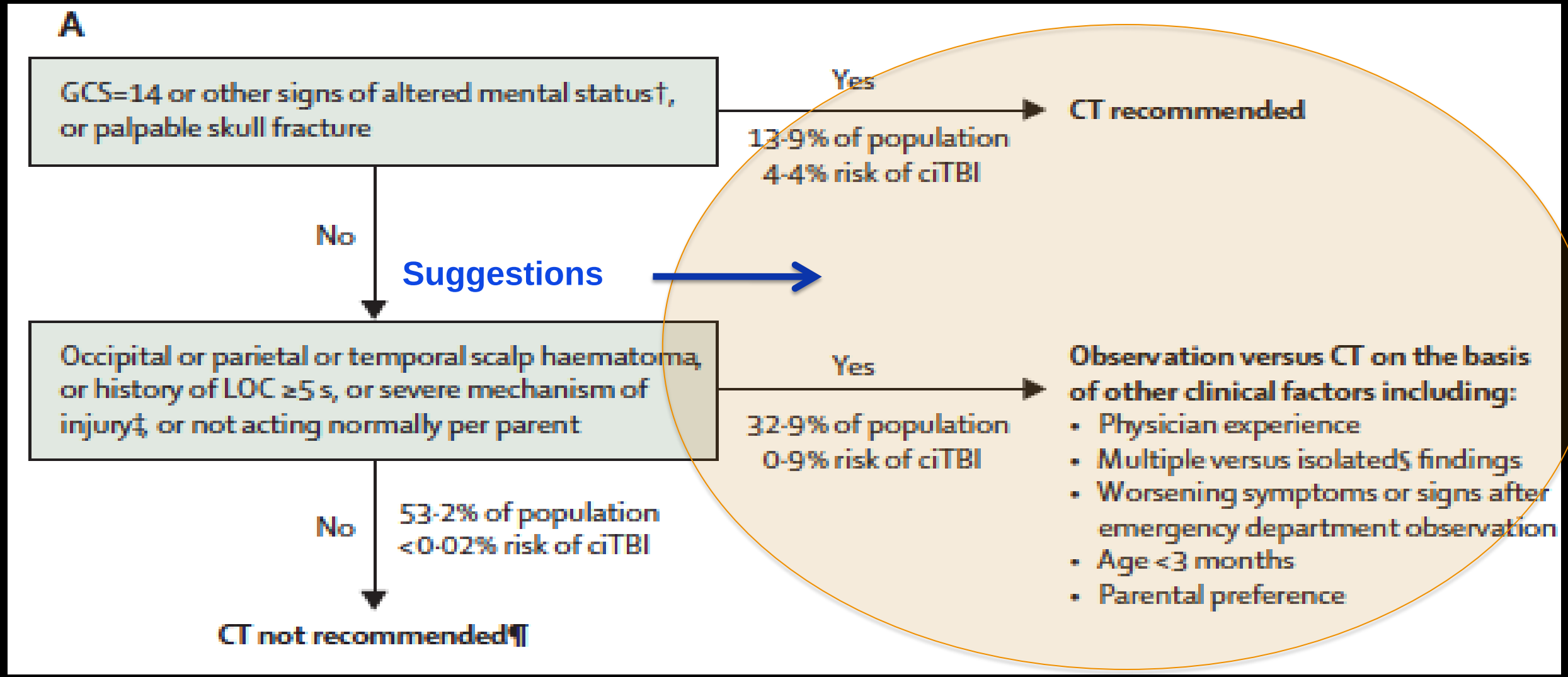
Children 2-18 years

1. Severe mechanism of injury
2. History of LOC
3. GCS = 14 or other signs of altered mental status
4. History of vomiting
5. Severe headache in the ED
6. Signs of basilar skull fracture

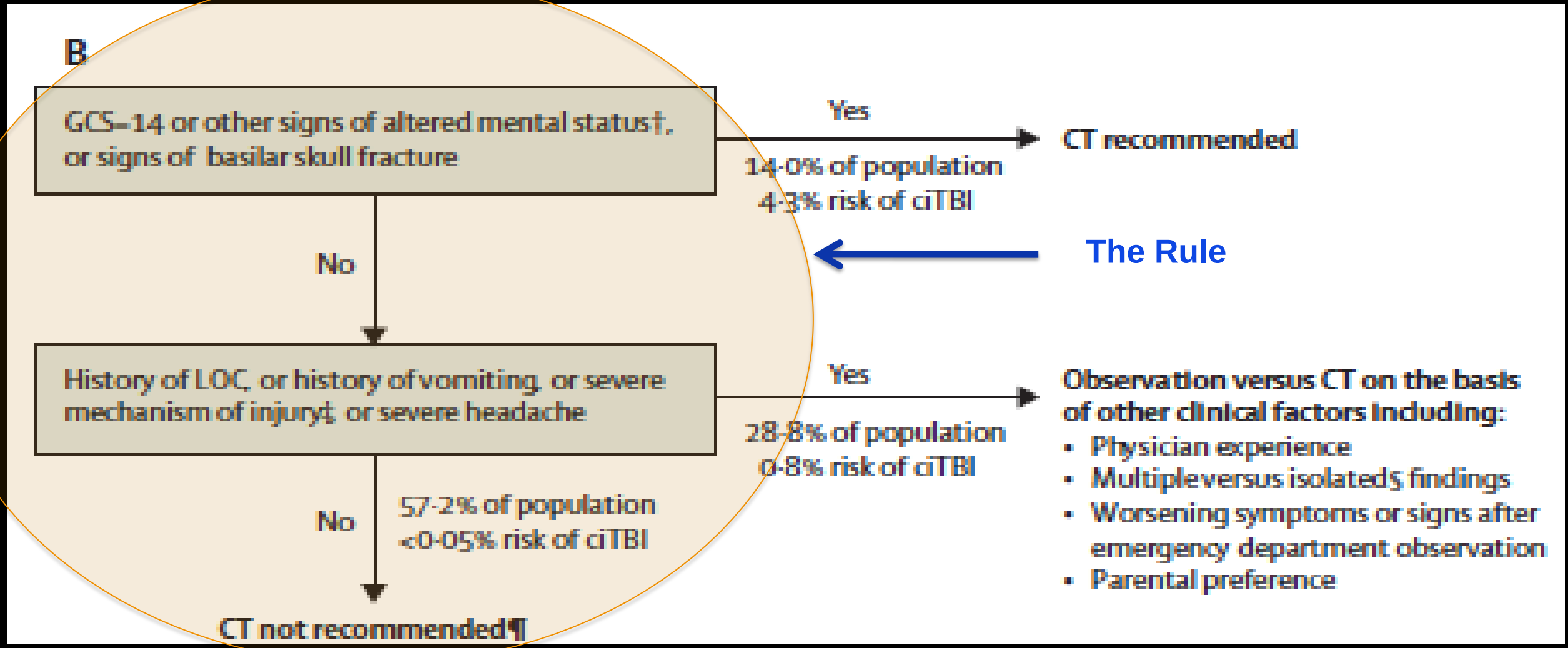
Recommendations for children younger than 2



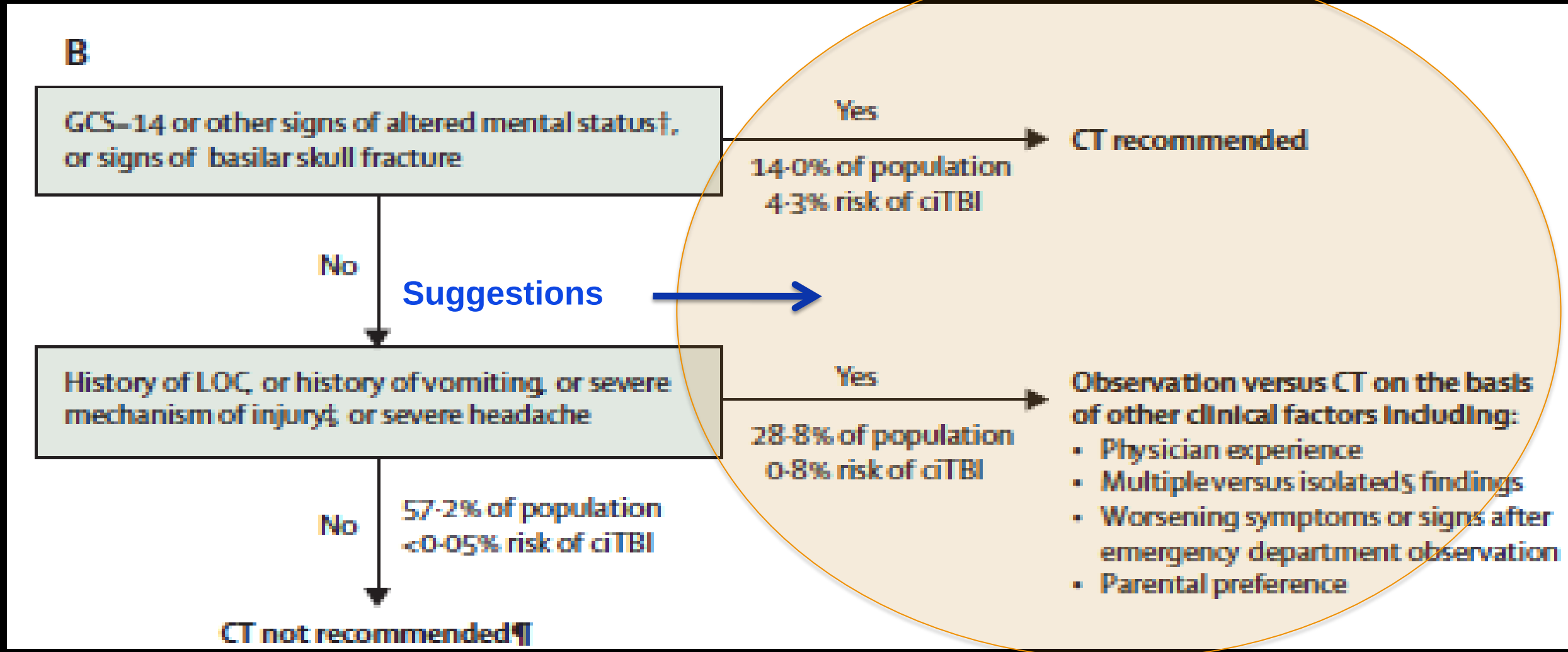
Recommendations for children younger than 2



Recommendations for children 2 years and older

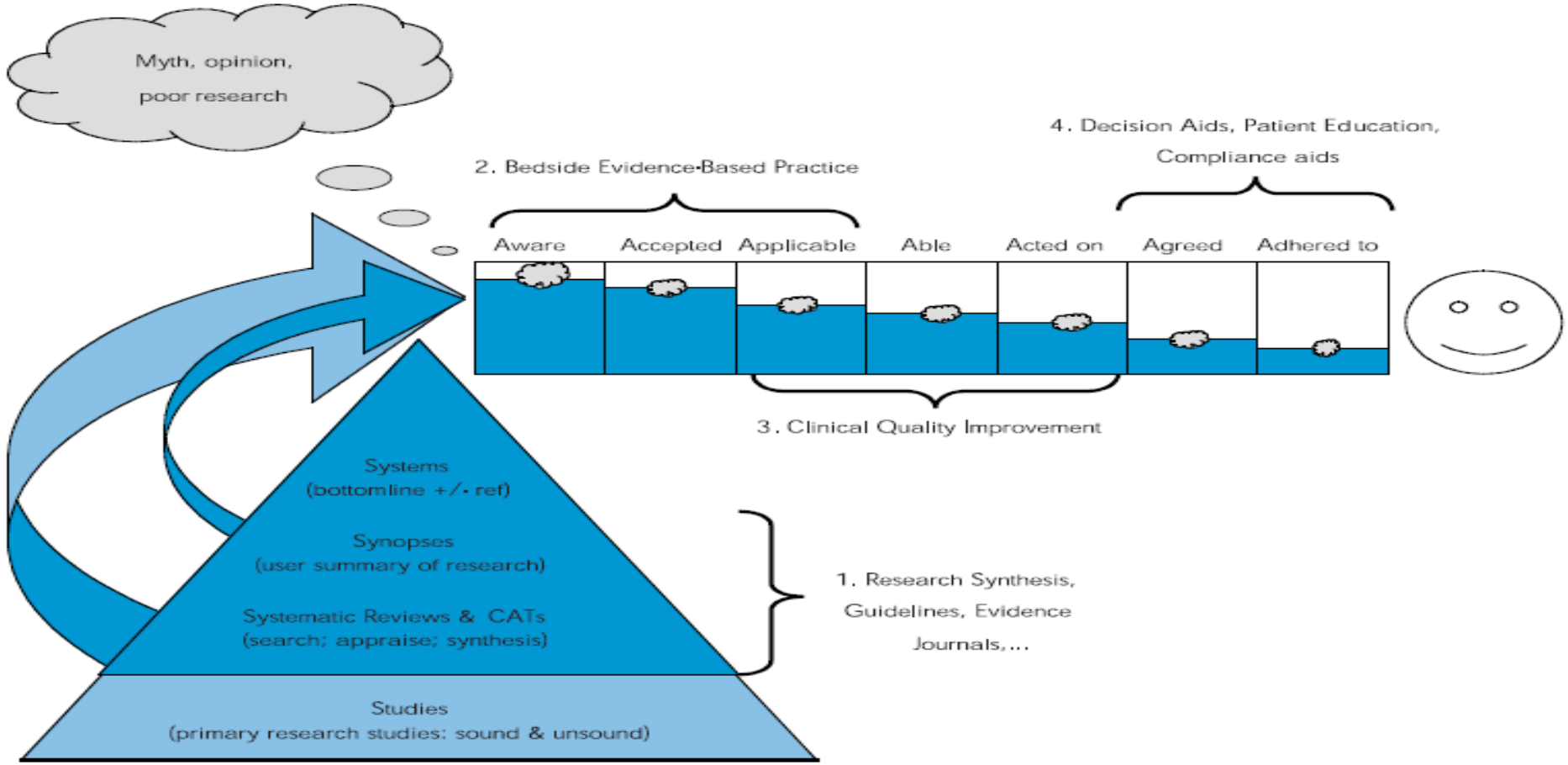


Recommendations for children 2 years and older



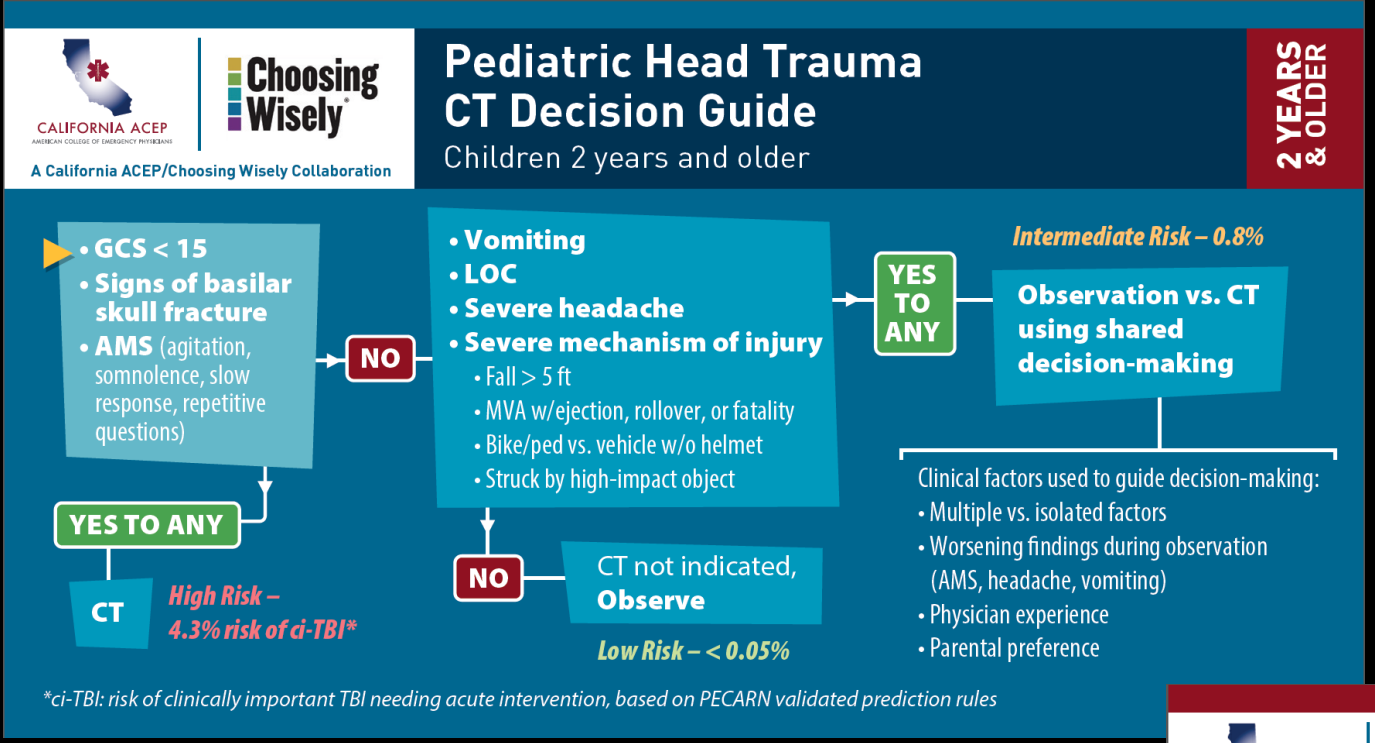
How to get clinicians to use the prediction rules?

Knowledge Translation Pipeline



The research-to-practice pipeline. New research, of varying soundness, is added to the expanding pool and enters practice both directly or is reviewed, summarised, and systematised (delay) before entering practice, with leakage occurring at each of several stages between awareness and patient outcome. Different knowledge translation disciplines focus on different parts of the pipeline (1–4).

Glasziou and Haynes, 2005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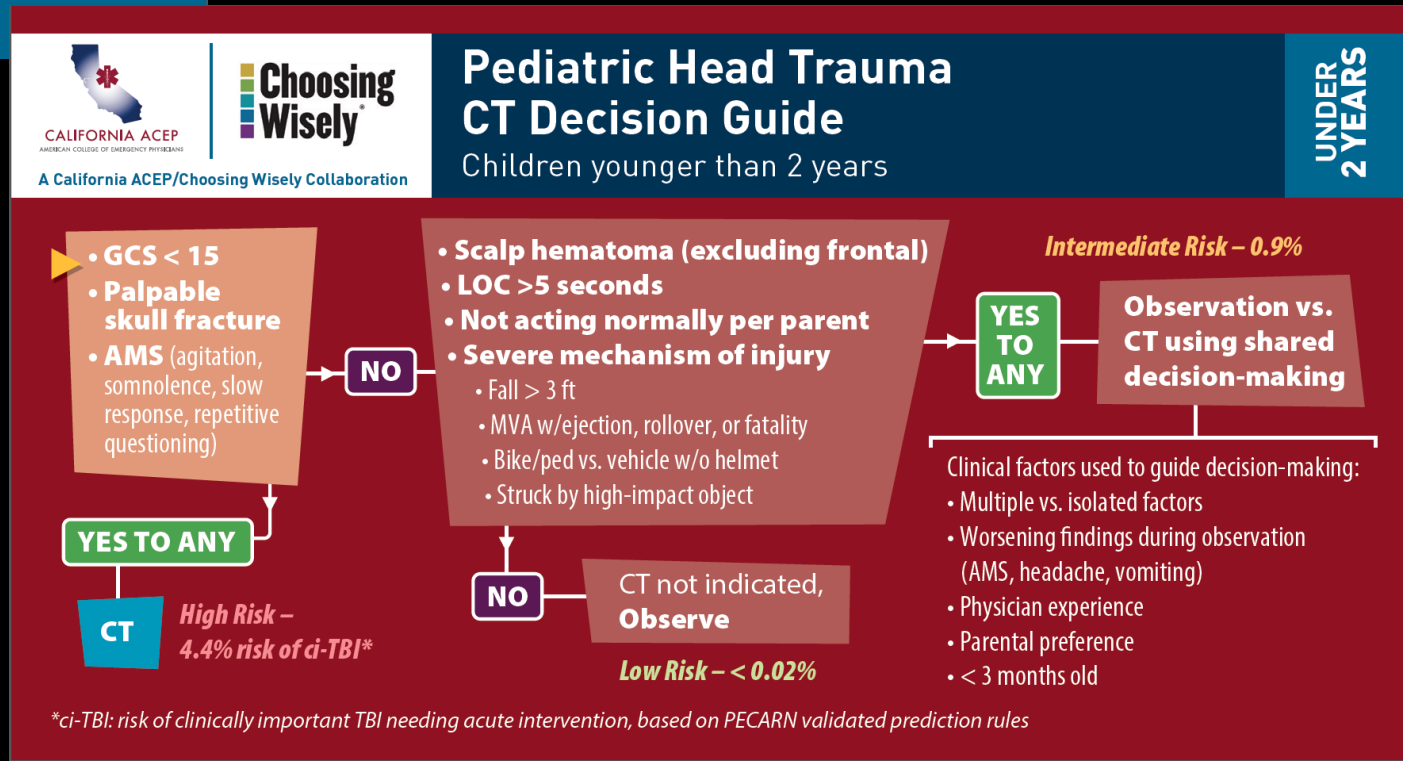
Choosing Wisely
A California ACEP/Choosing Wisely Collaboration
Pediatric Head Trauma
CT Decision Guide
Children 2 years and older
2 YEARS & OLDER
• GCS < 15
• Signs of basilar skull fracture
• AMS (agitation, somnolence, slow response, repetitive questions)
NO
• Vomiting
• LOC
• Severe headache
• Severe mechanism of injury
• Fall > 5 ft
• MVA w/ejection, rollover, or fatality
• Bike/ped vs. vehicle w/o helmet
• Struck by high-impact object
YES TO ANY
Intermediate Risk – 0.8%
Observation vs. CT using shared decision-making
Clinical factors used to guide decision-making:
• Multiple vs. isolated factors
• Worsening findings during observation (AMS, headache, vomiting)
• Physician experience
• Parental preference
YES TO ANY
CT
High Risk – 4.3% risk of ci-TBI*
NO
CT not indicated, Observe
Low Risk – < 0.05%
*ci-TBI: risk of clinically important TBI needing acute intervention, based on PECARN validated prediction rules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Choosing Wisely
A California ACEP/Choosing Wisely Collaboration
Pediatric Head Trauma
CT Decision Guide
Children younger than 2 years
UNDER 2 YEARS
• GCS < 15
• Palpable skull fracture
• AMS (agitation, somnolence, slow response, repetitive questioning)
NO
• Scalp hematoma (excluding frontal)
• LOC >5 seconds
• Not acting normally per parent
• Severe mechanism of injury
• Fall > 3 ft
• MVA w/ejection, rollover, or fatality
• Bike/ped vs. vehicle w/o helmet
• Struck by high-impact object
YES TO ANY
Intermediate Risk – 0.9%
Observation vs. CT using shared decision-making
Clinical factors used to guide decision-making:
• Multiple vs. isolated factors
• Worsening findings during observation (AMS, headache, vomiting)
• Physician experience
• Parental preference
• < 3 months old
YES TO ANY
CT
High Risk – 4.4% risk of ci-TBI*
NO
CT not indicated, Observe
Low Risk – < 0.02%
*ci-TBI: risk of clinically important TBI needing acute intervention, based on PECARN validated prediction rules

Implementation of the PECARN Traumatic Brain Injury Prediction Rules for Children Using Computerized Clinical Decision Support:
A Multi-center Trial

Traumatic Brain Injury – Knowledge Translation Study Group; for the Pediatric Emergency Care Applied Research Network (PECARN), the Clinical Research on Emergency Services and Treatment (CREST) network, and Partners HealthCare System

This study was supported by the American Recovery and Reinvestment Act-Office of the Secretary (ARRA OS): Grant #S02MC19289-01-00. PECARN is supported by the Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), Emergency Medical Services for Children (EMSC) Program through the following cooperative agreements: U03MC00001, U03MC00003, U03MC00006, U03MC00007, U03MC00008, U03MC22684, and U03MC22685

Aims

Primary: To determine whether implementing the PECARN TBI prediction rules using an intervention centered around computerized clinical decision support (CDS) decreases CTs in children with minor blunt head trauma at very low risk of ciTBIs

Secondary: To determine whether CDS that provides risk data for ciTBI for all children with minor blunt head trauma decreases CT use

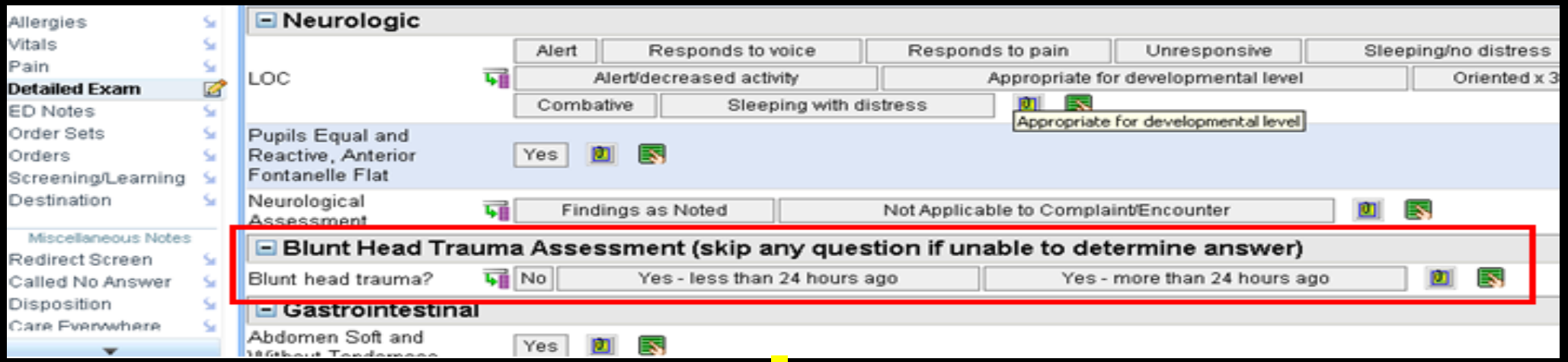
Methods

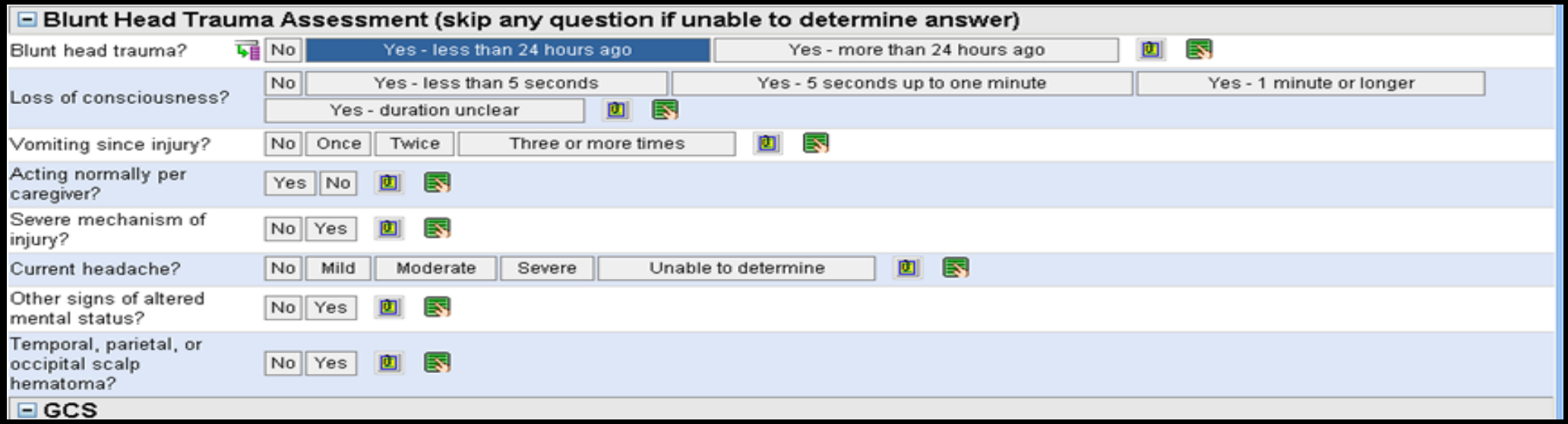
Computer-Based Decision Support Development and Pilot

- Perform focus groups
- Perform ED work flow assessments
- Develop EHR blunt head injury template
- Develop CDS
- Pilot testing

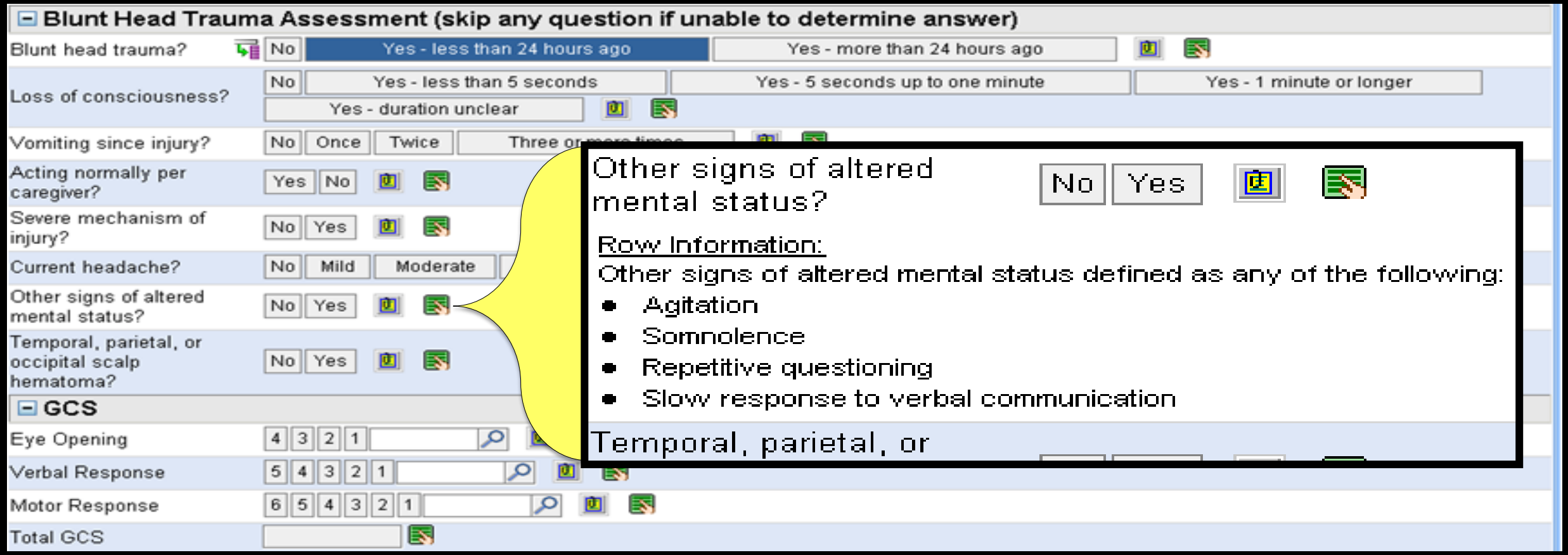
Methods

Patient assessment





Blunt Head Trauma Assessment



Methods

Clinical decision support

- Clinician received a statement no matter what was entered *(clear in focus groups)*

- Formatted similarly across statements
  - Recommendation
  - Risk estimate of clinically-important TBI
  - Management options (if relevant)

Traumatic Brain Injury Risk: Child less than 2 years

RECOMMENDATION: A head CT is not recommended for this patient based on the absence of any of the PECARN prediction rule variables.

Risk Estimate: The risk of clinically-important traumatic brain injury for patients less than 2 years is < 1/5000

Importantly, the PECARN rules were based on attending initial evaluations (not based on subsequent evaluations over time).

The age-specific PECARN rule findings documented are:

Loss of consciousness?:	No	10/05/12 1521 : THAM, ERIC
Acting normally per caregiver?:	Yes	10/05/12 1521 : THAM, ERIC
Mechanism of injury?:	Mild	10/05/12 1521 : THAM, ERIC
Total Glasgow Coma Scale score:	15	10/05/12 1521 : THAM, ERIC
Other signs of altered mental status?:	No	10/05/12 1521 : THAM, ERIC
Scalp hematoma?:	None	10/05/12 1521 : THAM, ERIC
Palpable skull fracture or unclear on the basis of swelling or distortion of the scalp?:	No	10/05/12 1521 : THAM, ERIC

If the above clinical findings are incorrect, please revise.

Note: The PECARN prediction rules do not apply to patients with: bleeding diatheses, ventricular (e.g. "VP") shunts, known brain tumors, or pre-existing neurological disorders complicating your clinical assessment.

Click here to view the PECARN prediction rule manuscript (Lancet)

Click to provide a revised risk assessment

Results

- Lower than expected baseline CT rates
  - Secular trends
- Modest, variable decreases in CT rates for patients at very-low risk and for all with minor head trauma
- No missed ciTBIs in patients at very-low risk

Conclusions

- Computerized CDS helps to safely decrease CT rates
- Provision of both recommendations and risk information helpful
  - Some clinicians want “directive” assistance
  - Others want risks for shared decision-making
- Unanticipated diffusion of information and secular trends likely decreased impact
- Novel methods for dissemination always needed

TORCIDA BRASIL
PERCUSSÃO

BRASIL

Optimizing Clinical Decision Support in the Electronic Health Record

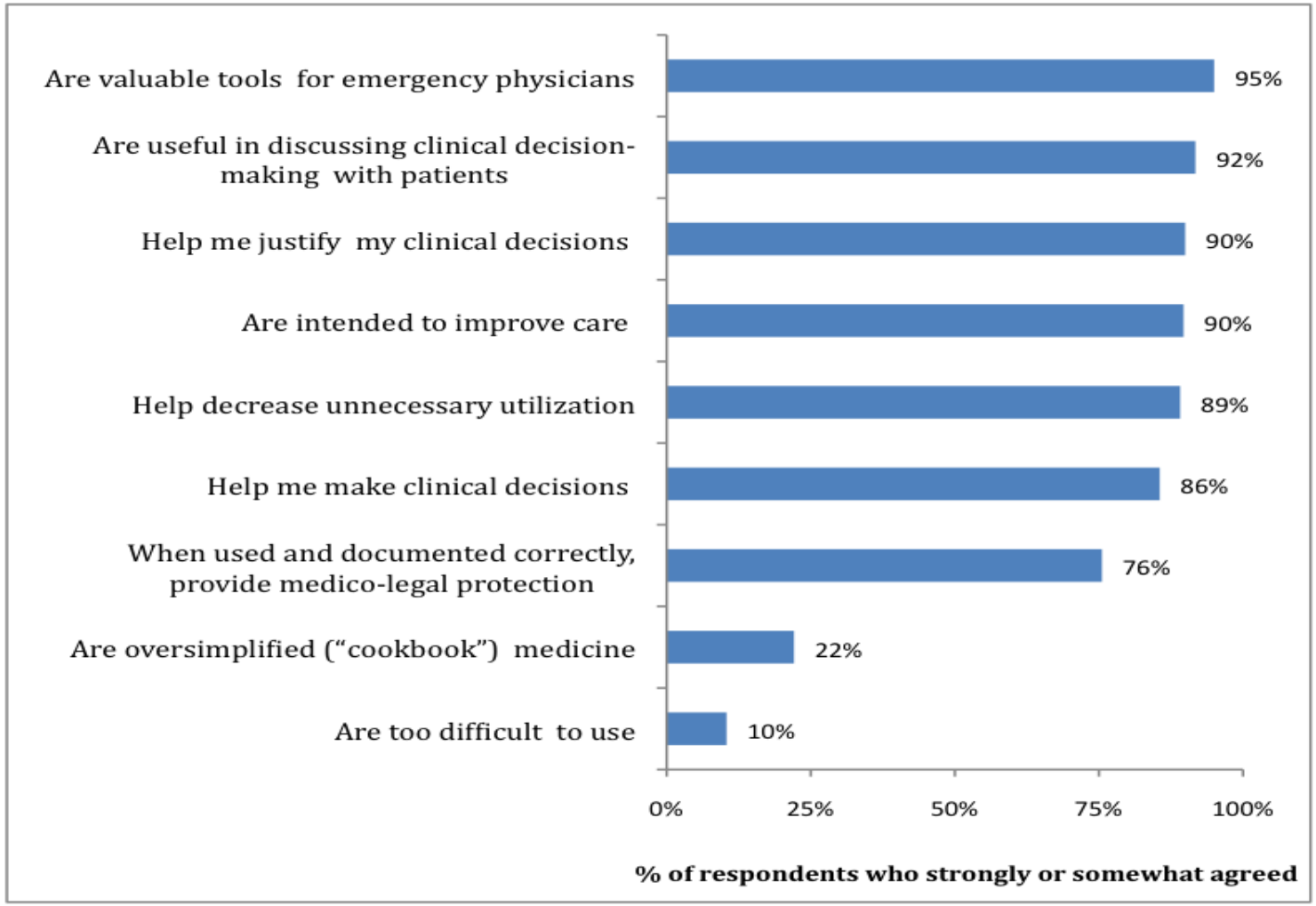
Dustin W. Ballard & David R. Vinson
http://kpcrest.net

Background

- **Implementation science** is a new field of emphasis
- Historically, **knowledge translation** has taken a decade or longer to diffuse
- **Clinical decision support (CDS) through the EHR** holds promise
- **Adoption** of clinical decision support tools by clinicians is **often limited by technical and workflow barriers**

CREST NETWORK
CLINICAL RESEARCH ON EMERGENCY SERVICES AND TREATMENTS

Physician Survey on Clinical Prediction Rules



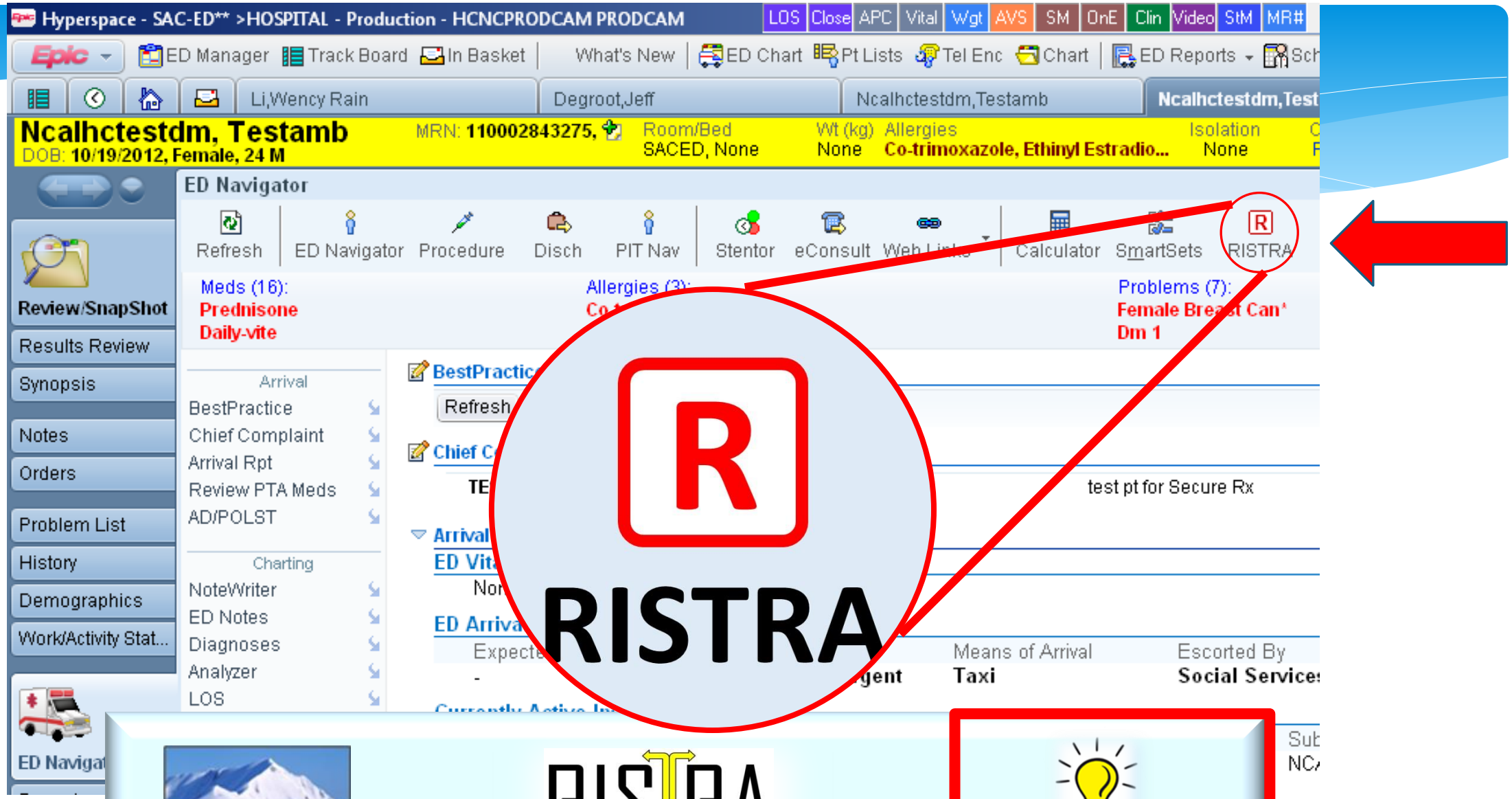
RISTRA (RIsk STRAtification)

Multiple Clinical Qs

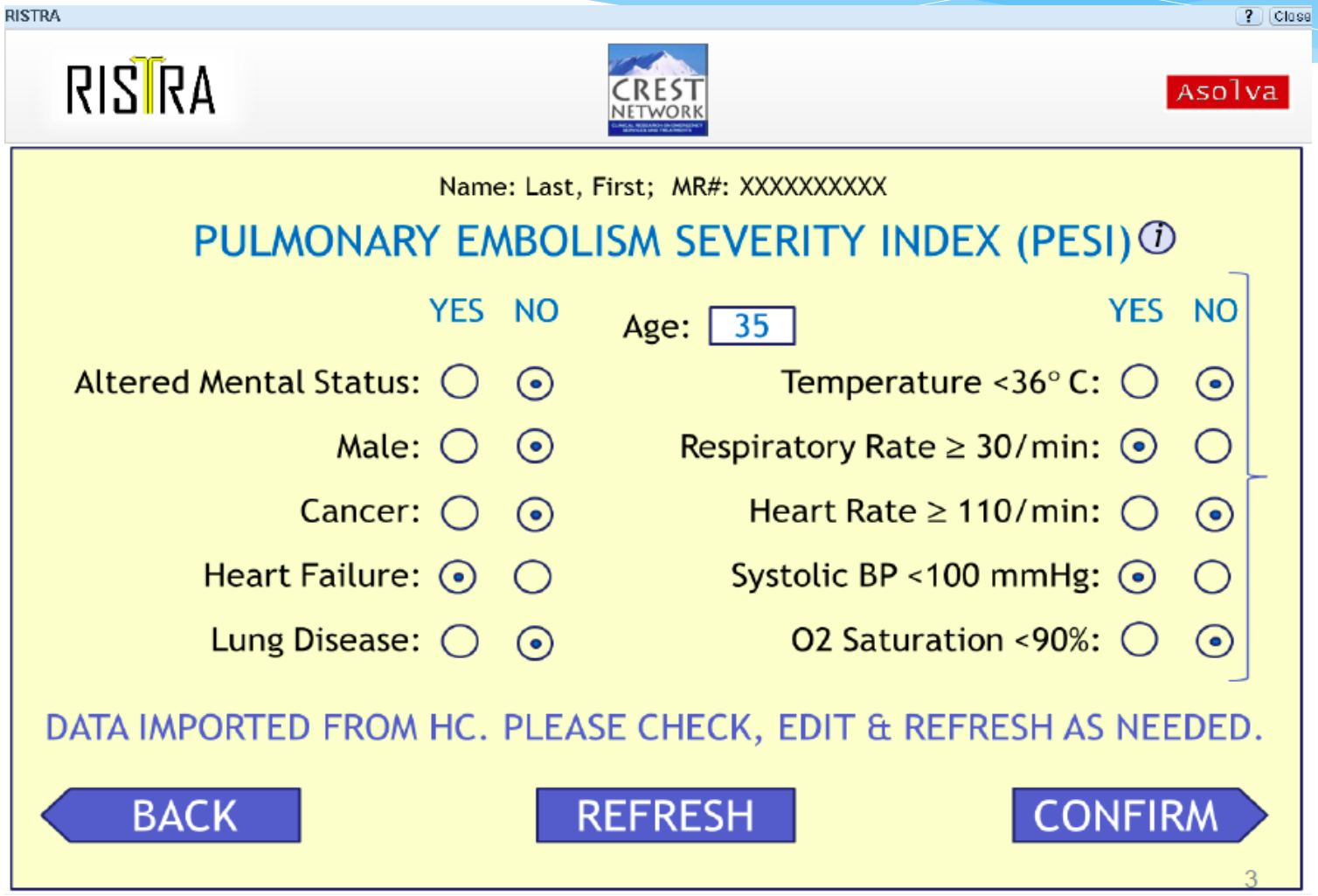
- Adult chest pain
- Pediatric Abd Pain
- Atrial fibrillation
- Others…

Assisting site-of-care decision-making

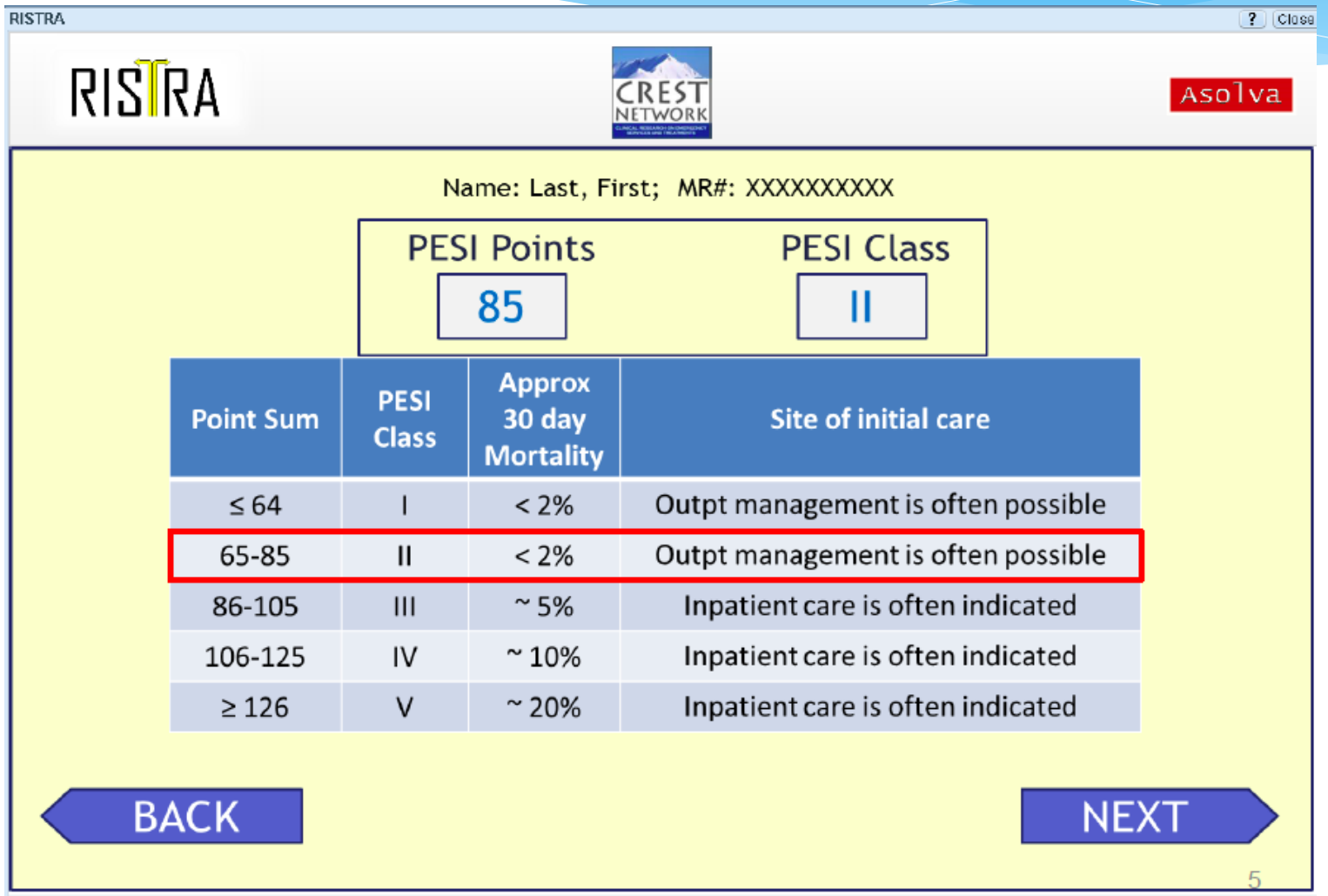
- **Background**
  - Most ED pts with PE are **hospitalized** despite evidence
  - We **need help** identifying pts who are low risk
    - Pulmonary Embolism Severity Index (**PESI**)
    - 11 weighted variables
  - We used RISTRA **to integrate an auto-populating electronic PESI** into our clinical workflow


Hyperspace - SAC-ED** >HOSPITAL - Production - HCNCPRODCAM PRODCAM
ED Manager
Track Board
In Basket
What's New
ED Chart
Pt Lists
Tel Enc
Chart
ED Reports
Ncalhctestdm, Testamb
DOB: 10/19/2012, Female, 24 M
MRN: 110002843275,
Room/Bed
SACED, None
Wt (kg)
None
Allergies
Co-trimoxazole, Ethinyl Estradio...
Isolation
None
ED Navigator
Refresh
ED Navigator
Procedure
Disch
PIT Nav
Stentor
eConsult
Calculator
SmartSets
RISTRA
Meds (16):
Prednisone
Daily-vite
Problems (7):
Dm 1
Review/SnapShot
Results Review
Synopsis
Notes
Orders
Problem List
History
Demographics
Work/Activity Stat...
Arrival
BestPractice
Chief Complaint
Arrival Rpt
Review PTA Meds
AD/POLST
Charting
NoteWriter
ED Notes
Diagnoses
Analyzer
LOS
test pt for Secure Rx
Means of Arrival
Taxi
Escorted By
Social Service
R
RISTRA
CREST NETWORK
CLINICAL RESEARCH ON EMERGENCY SERVICES AND TREATMENTS
RISTRA
A Risk Stratification Tool
KAISER PERMANENTE
INNOVATION FUND
FOR TECHNOLOGY

CDS


RISTRA
? Close
RISTRA
CREST NETWORK
Asolva
Name: Last, First; MR#: XXXXXXXXXX
PULMONARY EMBOLISM SEVERITY INDEX (PESI)
YES NO
Age: 35
YES NO
Altered Mental Status:
Male:
Cancer:
Heart Failure:
Lung Disease:
Temperature <36° C:
Respiratory Rate ≥ 30/min:
Heart Rate ≥ 110/min:
Systolic BP <100 mmHg:
O2 Saturation <90%:
DATA IMPORTED FROM HC. PLEASE CHECK, EDIT & REFRESH AS NEEDED.
BACK
REFRESH
CONFIRM
3

CDS


RISTRA
Close
RISTRA
CREST NETWORK
Asolva
Name: Last, First; MR#: XXXXXXXXXX
PESI Points
85
PESI Class
II
Point Sum | PESI Class | Approx 30 day Mortality | Site of initial care
≤ 64 | I | < 2% | Outpt management is often possible
65-85 | II | < 2% | Outpt management is often possible
86-105 | III | ~ 5% | Inpatient care is often indicated
106-125 | IV | ~ 10% | Inpatient care is often indicated
≥ 126 | V | ~ 20% | Inpatient care is often indicated
BACK
NEXT
5

Two Concurrent Studies

- **What Factors Increase Tool Use? (14 EDs)**
  - **10 "active" EDs** w/on-site champions = intervention
    - Tool access with serial education, iterative physician-specific audits, incentives for first 3 enrollments
  - **4 "passive" EDs** w/ neither champion nor promotion
    - Tool access and only an initial education session
- **Pragmatic Implementation Study (21 EDs)**
  - 10 active EDs vs 11 non-active
  - **Compare rates** of home discharge and safety outcomes

Results of USE study (n=662)

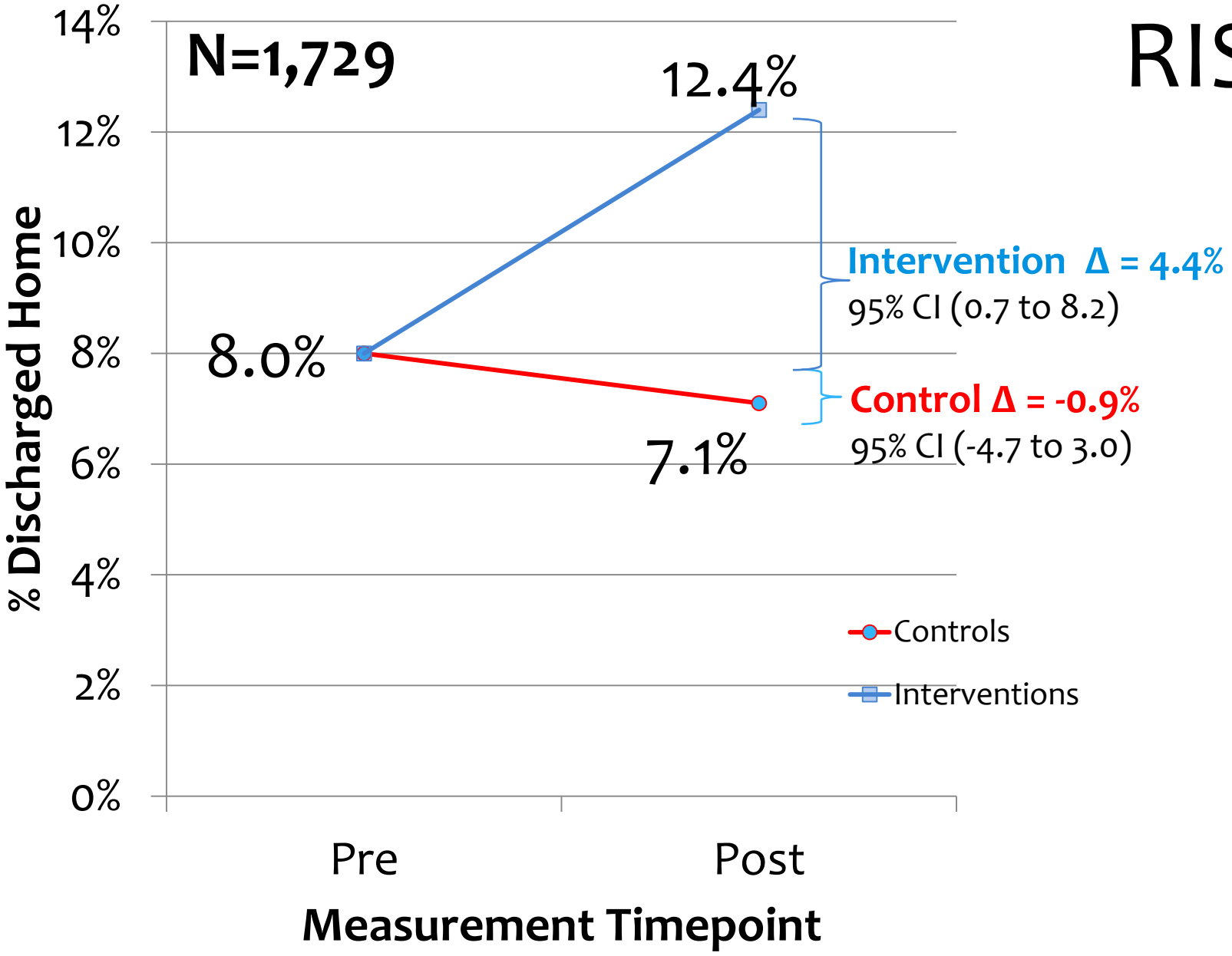
67% vs. 13%

	Characteristics		Reference	OR	95% CI	
Facility	**Site**	Active	Passive	31.1	11.7	83.0
	Low ED Volume	Yes	No	1.7	1.1	2.7
	Acuity 1 Patient	Yes	No	1.2	0.7	2.3
Provider	**Sex**	Female	Male	0.9	0.5	1.6
	Age	40+	<40	0.6	0.4	1.1
	Clinical Load	5+	<5	0.9	0.6	1.4
Patient	**PESI Class**	I, II	III+	1.7	1.1	2.5

Compared to mean facility ED census

Lower PE Severity = more likely to activate

RISTRA Impact



Safety outcomes were **unchanged**

- 5d PE-related return visit rate (6.5%)
- 30d all-cause mortality (0.7%)

Conclusions

- Performing active on-site tool promotion significantly increased odds of e-CDS tool activation

- Active promotion of an eCDS tool with an auto-populating PESI increased home DC rates without increasing 5d return visits or 30d mortality

THANK YOU VERY MUCH

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Clinical Emergency Data Registry (CEDR) Imaging Measures

November 17, 2016

Dr. Arjun Venkatesh MD, MBA, MHS

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Disclosures

- Centers for Medicare and Medicaid Innovation: ACEP TCPI
- Contracted with Centers for Medicare and Medicaid Services to develop hospital outcome and efficiency measures

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Disclaimer

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Alphabet Soup

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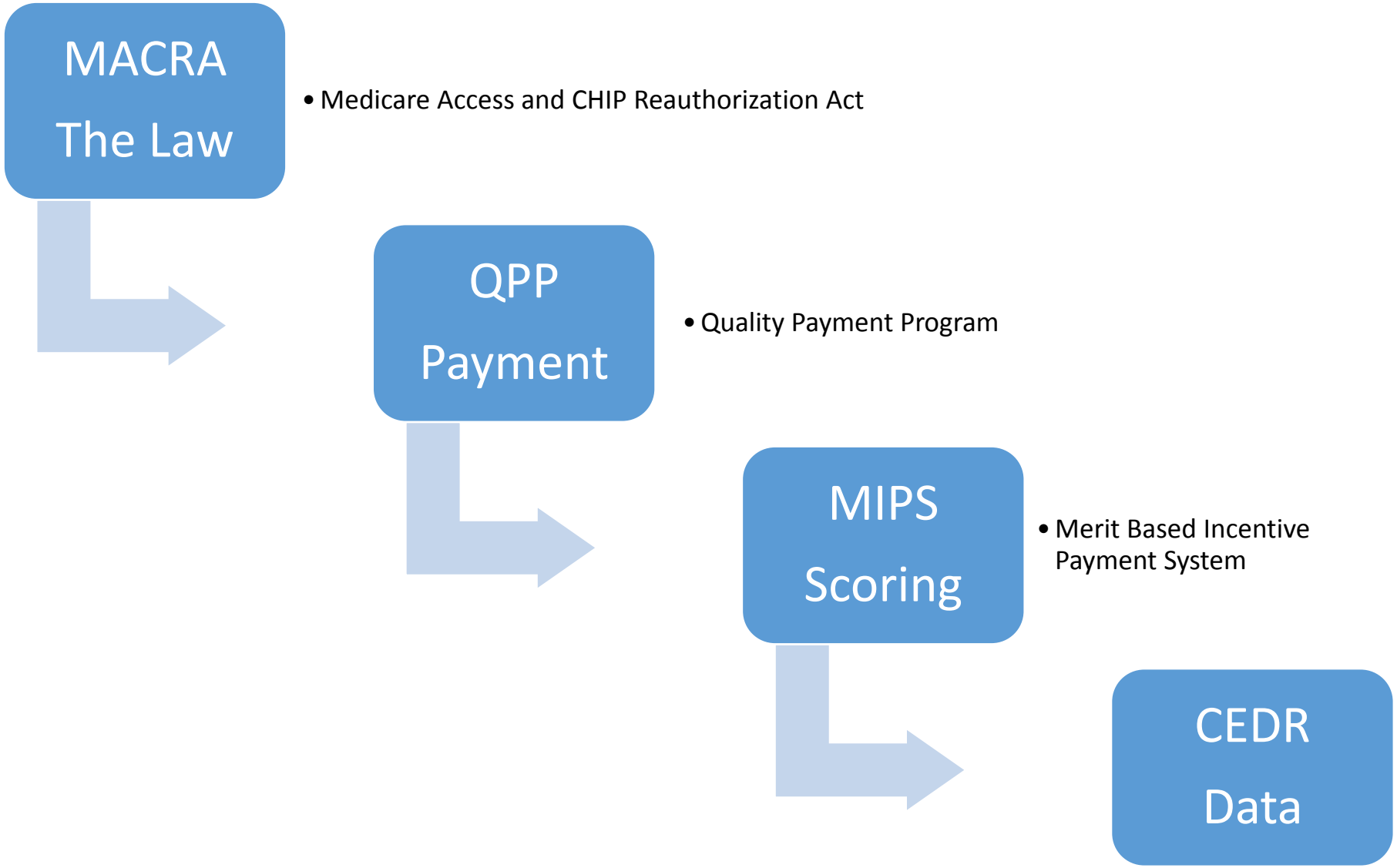

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CEDR CLINICAL EMERGENCY DATA REGISTRY

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What is a QCDR?

- QCDRs such as CEDR are quality reporting registries for the CMS Merit-based Incentive Payment System (MIPS)
- QCDRs are an alternative to “claims based reporting”
- QCDRs include unique quality measures
- QCDRs are approved by supported by CMS to:
  - Move quality measure development to clinicians
  - Give “credit” for several MIPS scoring categories

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CEDR CLINICAL EMERGENCY DATA REGISTRY

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What is CEDR?

- Developed by ACEP to support emergency clinician participation in MIPS
- First and only emergency medicine specialty registry at a national level
- Successfully reported for physicians in 13 EDs during its 2015 pilot
- Facilitate emergency care research through the identification of practice patterns, trends and outcomes in emergency care

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CEDR Participation

	2015	2016
Number of Providers	262	797
Number of Patient Visits	458,263	780,513*
Number of ED Engaged	13	36
Number of EMR/EDIS	4	14
Performance Measures	27	42

***In Progress – Anticipated 1.7 million patient visits**

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What is an eCQM

- eCQM = electronic clinical quality measure
- Uses structured EHR data to ensure clinically relevant quality measures
- Uses a standard language
  - Value Set Authority Center (VSAC)
  - Measure Authoring Tools
- Requires mapping between CEDR and your hospital-based EHR

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Mappable EHRs

EMR			
Agility	EyeDoc EMR	Maxim Eyes SQL	NextGen
AI Med	EYEMD EMR	MD Office	Open EMR
AllMeds	GE Centricity	MDIntelleSys	Origin
Allscripts*	GEMMS	MDsuite	Practice Partners **
Amazing Charts	Glow Stream	MedEvolve	Practice Studio
American Medical Software	gMed	Medflow	Prime Clinical System
Aprima	Greenway Intergy**	MEDHOST EDIS	PrognoCIS**
Cerner**	Greenway/Primesuite	Medics DocAssistant	Pulse EHR**
Chart Maker Clinical	HCIT	MedInformatix	Quickview EMR
ChartLogic**	iFA**	Medisoft**	RheumDocs**
Chartmaker Medical Suite	iMedicWare (cloud based)	Meditech	SoapWare
Compulink	IMS	Medstreaming	SRS EHR
Custom EHR	Integrity	Merge Financials	SuiteMed IMS
Cybax EHR	Intergy / Sage	MicroMD	TriMed EHR
DigiDMS	IO Practiceware	Misys (Allscripts)**	TSystem
eClinicalWorks*	Key Chart	MOSAIQ	UniCharts**
eMDs**	Lytec MD	My Vision Express	Varian - Aria
eMedRec	MacPractice MD	NeoMed	VersaForm**
EPIC**	Management Plus	Netconnect**	VersaSuite
Exam Writer	Mastermind EHR	NexTech	Vitera EMR

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CEDR CLINICAL EMERGENCY DATA REGISTRY

Imaging Measures

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- Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older
- Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years
- Appropriate Emergency Department Utilization of CT for Pulmonary Embolism

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Head CT Adult

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Percentage of emergency department visits for patients aged 18 years and older who presented within 24 hours of a minor blunt head trauma with a Glasgow Coma Scale (GCS) score of 15 and who had a head CT for trauma ordered by an emergency care provider who have an indication for a head CT

Numerator	Emergency department visits for patients who have an indication for a head CT
Denominator	All emergency department visits for patients aged 18 years and older who presented within 24 hours of a minor blunt head trauma with a Glasgow Coma Scale (GCS) score of 15 and who had a head CT for trauma ordered by an emergency care provider

Denominator Exclusions	• Ventricular shunt
	• Brain tumor
	• Multisystem trauma
	• Pregnancy
	• Currently taking any of the following antiplatelet medications*:
	  • ASA/dipyridamole
	  • clopidogrel
	  • prasugrel
	  • ticlopidine
	  • ticagrelor
	  • Cilostazol

E·QUAL EMERGENCY QUALITY NETWORK

CEDR CLINICAL EMERGENCY DATA REGISTRY

Head CT Adult

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Indications

Minor Trauma and..	LOC or amnesia and ….
• Severe headache • Vomiting • Age 65 years and older • Physical signs of a basilar skull fracture (signs include haemotympanum, “raccoon” eyes, cerebrospinal fluid leakage from the ear or nose, Battle’s sign) • Focal neurological deficit • Coagulopathy • Thrombocytopenia • Currently taking any of the following anticoagulant medications*: • apixaban, argatroban, bivalirudin, dabigatran, dalteparin, desirudin, enoxaparinm fondaparinux, heparin, lepirudin, low molecular weight heparin, rivaroxaban, tinzaparin, warfarin • Dangerous mechanism	• Headache • Age 60 years and older, and less than 65 years • Drug/alcohol intoxication • Short-term memory deficits • Evidence of trauma above the clavicles (physical location, any trauma to the head or neck [ie, laceration, abrasion, bruising, ecchymosis, hematoma, swelling, fracture]) • Posttraumatic seizure

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CEDR CLINICAL EMERGENCY DATA REGISTRY

Head CT Pediatric

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Percentage of emergency department visits for patients aged 2 through 17 years who presented within 24 hours of a minor blunt head trauma with a Glasgow Coma Scale (GCS) score of 15 and who had a head CT for trauma ordered by an emergency care provider who are classified as low risk according to the PECARN prediction rules for traumatic brain injury

Numerator	Emergency department visits for patients who are classified as low risk according to the Pediatric Emergency Care Applied Research Network (PECARN) prediction rules for traumatic brain injury.
Denominator	All emergency department visits for patients aged 2 through 17 years who presented within 24 hours of a minor blunt head trauma with a Glasgow Coma Scale (GCS) score of 15 and who had a head CT for trauma ordered by an emergency care provider.
Denominator Exclusions	• Ventricular shunt • Brain tumor • Coagulopathy • Thrombocytopenia

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Head CT Pediatric

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"Low risk"

- No signs of altered mental status (eg, agitation, somnolence, repetitive questioning, slow response to verbal communication)
- No signs of basilar skull fracture (signs include hemotympanum, "raccoon" eyes, cerebrospinal fluid leakage from the ear or nose, Battle's sign)
- No LOC
- No vomiting
- No severe mechanism (i.e., motor vehicle crash with patient ejection, death of another passenger, or rollover; pedestrian or bicyclist without helmet struck by a motorized vehicle; falls of more than 5 feet; or head struck by a high-impact object)
- No severe headache

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PE CT

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Percentage of emergency department visits during which patients aged 18 years and older had a CT pulmonary angiogram (CTPA) ordered by an emergency care provider, regardless of discharge disposition, with either moderate or high pre-test clinical probability for pulmonary embolism OR positive result or elevated D-dimer level.

Numerator	Emergency department visits for patients with either: Moderate or high pre-test clinical probability for pulmonary embolism* OR Positive result or elevated D-dimer level
Denominator	All emergency department visits during which patients aged 18 years and older had a CT pulmonary angiogram (CTPA) ordered by an emergency care provider, regardless of discharge disposition
Denominator Excluions	Pregnancy

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Hot Topics

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Metrics

- How will you get this clinical data?
- What if we the data is missing?
- Why aren't the measures risk adjusted?

CMS/MIPS

- Do I have to report these imaging measures?
- What about that HTN screening metric?
- Why not pick "easier" metrics?

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Coming Attractions

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- Avoidable CT imaging for adult emergency department patients with recurrent renal colic
- Avoiding imaging for adult emergency department patients with atraumatic back pain

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EQUAL Metrics

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Wave II Starts March 2017

- Simple utilization measures
- Require ED billing diagnosis and CT utilization data
- CT Utilization
  - Non contrast Head CT/100 ED trauma visits
  - Chest CT with IV contrast/100 ED visits
  - Non contrast Head CT/100 Syncope visits
  - Non contrast Abdomen CT/100 flank pain visits
  - Lumbar XR/CT/MRI/100 back pain visits
- CT Yield
  - Intracranial hemorrhages/Non-contrast Head CT
  - Pulmonary Embolism/Chest CT with IV contrast

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Avoidable Imaging Webinar:
Thursday, December 8
1:00pm-2:00pmEST

ACEP E-QUAL Network Resources and More Information:
www.acep.org/equal

Contact Nalani Tarrant (Project Manager):
ntarrant@acep.org