



# Avoidable Imaging Initiative Webinar

Empathy to Reduce Anticipated Negative Computerized Tomographic Imaging (ETRACT)  
PAMA and the Emergency Physician



# Presenters



Jeff Kline, MD



Jay Schuur, MD, MHS

# Empathy to Reduce Anticipated Negative Computerized Tomographic Imaging (ETRACTs)

Jeffrey A. Kline, MD on behalf of the ETRACTS group  
Professor, Department of Emergency Medicine and Cellular and  
Integrative Physiology  
Indiana University School of Medicine  
Indianapolis, IN  
@klinelab



**SCHOOL OF MEDICINE**  
INDIANA UNIVERSITY

# Background

We have a problem



**SCHOOL OF MEDICINE**

INDIANA UNIVERSITY

**Table 1. Emergency Health Care Clinician Survey Results and TEP Rankings**

Action	Practice Domain
1. Do not order CT of the cervical spine for patients after trauma who do not meet the NEXUS low-risk criteria or Canadian C-Spine Rule. <sup>c</sup>	Imaging
2. Do not order CT to diagnose PE without first risk stratifying for PE (pretest probability and D-dimer testing if low probability).	Imaging
3. Do not order MRI of the lumbar spine for patients with lower back pain without high-risk features.	Imaging
4. Do not order CT of the head for patients with mild traumatic head injury who do not meet New Orleans Criteria or Canadian CT Head Rule. <sup>d</sup>	Imaging
5. Do not order coagulation studies for patients without hemorrhage or suspected coagulopathy (eg, with anticoagulation therapy, clinical coagulopathy).	Laboratory



# Overtesting

- About 15% of all ED patients receive a CT scan
- Prevalence of PE+ decreased to 3-5% *Crichlow, Acad Emerg Med 2012; 19: 1219; Feng LB, Acad Emerg Med 2013, 20:1033.*
- Overtesting is an “assurance behavior” to achieve perception of normative practice *Studdert DM et al, JAMA, 2005, 293:2609; Lucas F.L. Circ Cardiovasc Qual Outcomes, 2010; 3:253*
- Fear of missing low probability diagnosis and medical malpractice contribute to the problem *Kanzaria HK et al, Acad Emerg Med 2015; 22:390.*



# Empathy

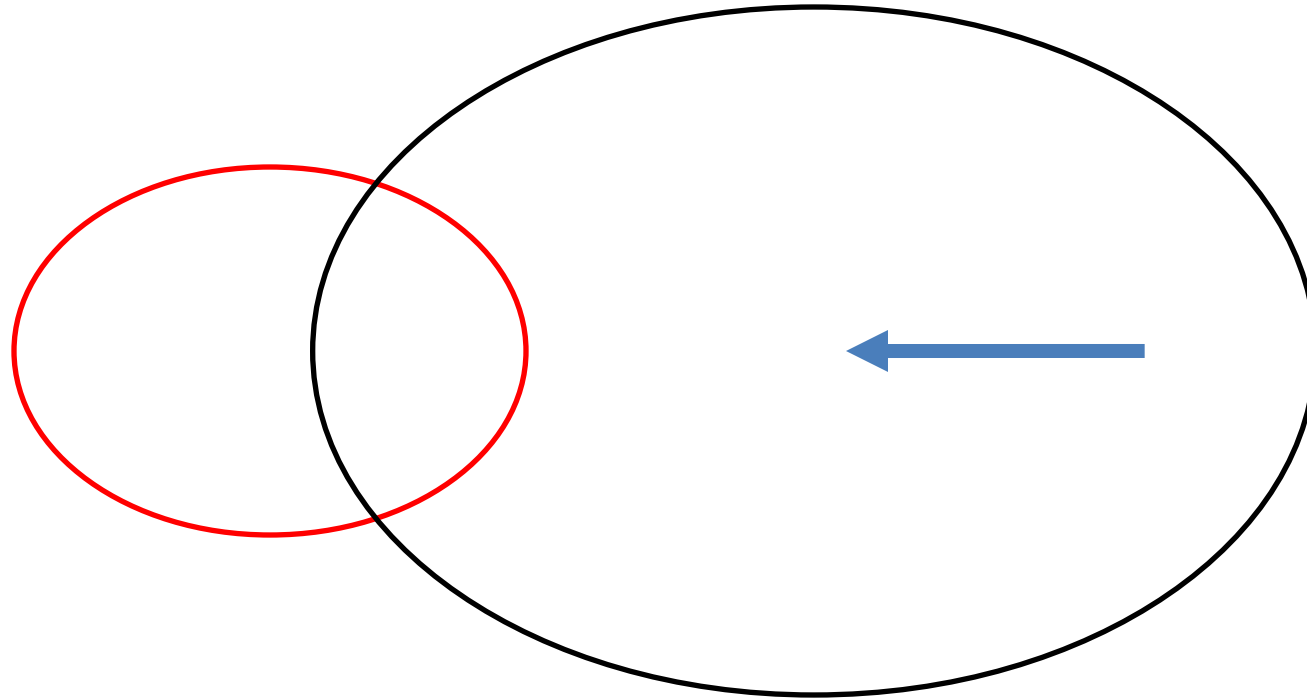
- Many academic definitions, but I argue that empathy is trait unique to each person
- “You never really know a man until you understand things from his point of view, until you climb into his skin and walk around in it.” *Lee, Harper. To Kill a Mockingbird. J.B. Lippincott & Co., 1960*
- Empathy is yours, not an administrators’ or researchers’ thing



SCHOOL OF MEDICINE

INDIANA UNIVERSITY

People  
with PE



People tested for  
PE





# Empathy

- Positively associated with improved outcomes in several settings. *Kelm Z, et al. Interventions to cultivate physician empathy: a systematic review. BMC Med Educ 2014;14:219.*
- Empathy may be an antidote to burnout *Lamothe M, et al. Outcomes of MBSR or MBSR-based interventions in health care providers: A systematic review with a focus on empathy and emotional competencies. Complement Ther Med. 201; 24:19-28*



# Overarching Hypothesis

A strategy that increases the perception of empathy in the patient and the provider can decrease unnecessary diagnostic testing



**SCHOOL OF MEDICINE**

INDIANA UNIVERSITY

# Empathy and Reassurance

- Reassurance has several dimensions.
  - Affective: empathy, emotional, “human connection”
  - Cognitive: explanations, mechanisms facts and numbers
- Does affective improve cognitive?

*Pincus T, et al. Cognitive and affective reassurance and patient outcomes in primary care: asystematic review. Pain. 2013 Nov;154(11):2407-16*



SCHOOL OF MEDICINE

INDIANA UNIVERSITY

# The study

- **Seven sites** (Charlotte NC, Jackson MS, Indianapolis IN, New York NY, Roanoke VA, San Francisco CA, Rochester MN)
- **Adult patients** undergoing CT abdomen, chest or head
- **Physician agrees** the CT is unlikely to show an emergent condition & CT is negative
- **Patients approached** near the end of care



1. Totally unimportant 2. Mostly unimportant 3. Slightly important 4. Important 5. Very important

“I have carefully considered what you told me about what brought you here today”

“I have thought about your past medical problems and what they mean today”

“The CT scan has a lot of radiation which may increase risk of cancer later in life”

“The CT scan requires contrast to be injected in your blood, which may put stress on your kidneys”

“I have thought about the cost of your medical care to you today”

“I have thought about your vital signs and your physical examination”



**SCHOOL OF MEDICINE**

INDIANA UNIVERSITY

“I have thought about what your [family member] said about your problem.”

“I have thought about how uncomfortable you look today”

“I have considered what your facial expressions have told me about how you feel ”

“I have thought about what your body language has told me about how you feel today”

“I have thought about what prior research tells me about your condition today”

What other issue would you want your doctor to discuss with you about your condition? Are there any other ways to say any of the above statements that would make you feel better?



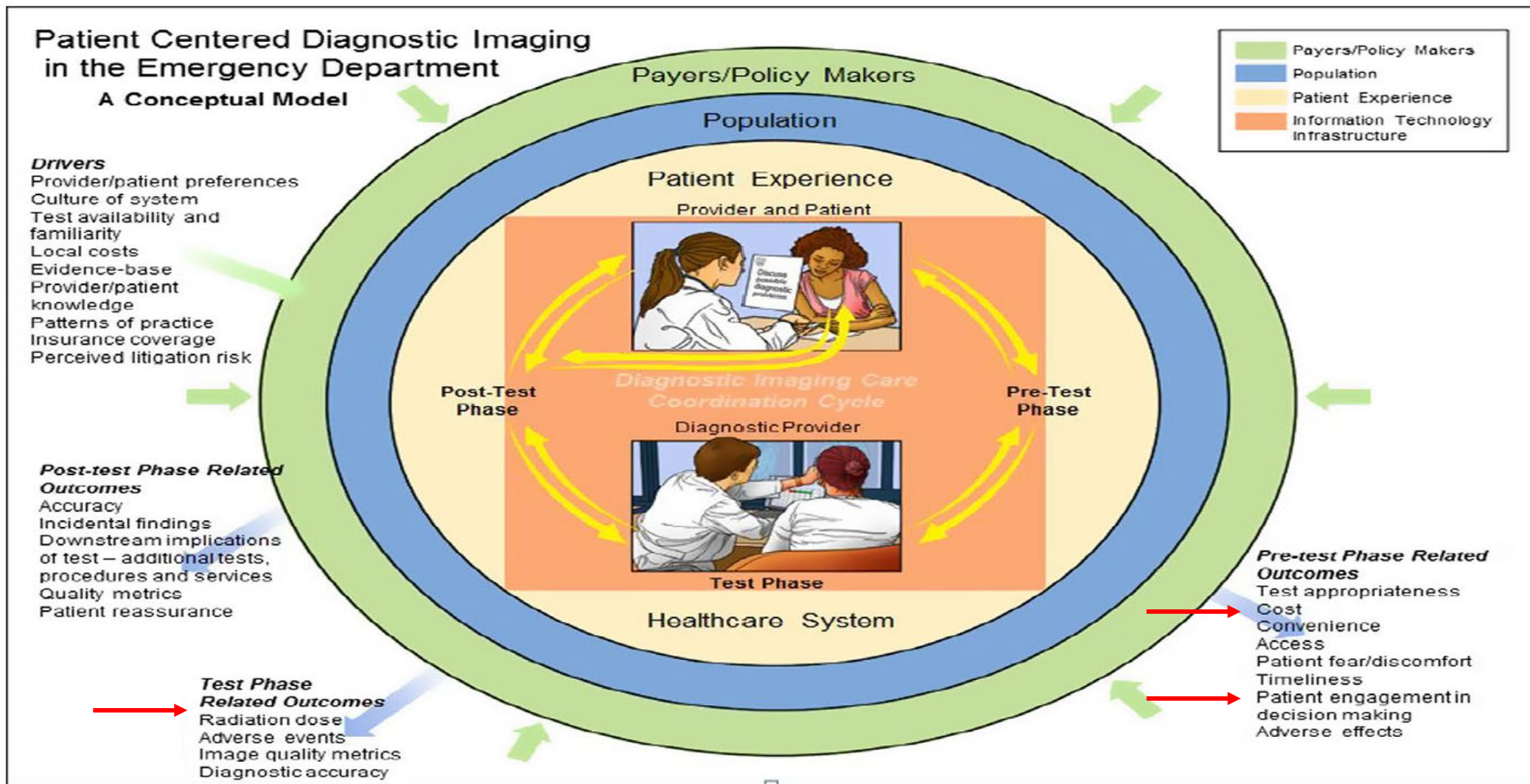
**SCHOOL OF MEDICINE**

INDIANA UNIVERSITY

# Theoretical construct of content

- Whole person approach
  - I have thought about you
- Medical competency
  - present and past medical history
- JPPPSE components
  - Family and daily life
- Medical risk and error
  - Radiation and contrast
- Compassion
  - Pain and appearance
- Cognitive reassurance
  - Vital signs
  - Prior research
  - Cost of care
- Individual preferences
  - Verbatim response





**Figure 1.** The emergency diagnostic imaging care coordination cycle: a conceptual model. Modified from Comfere et al.<sup>1</sup>





Trust in physicians scale

\* Seven-point response scale: 1 strongly disagree; 2 disagree; 3 slightly disagree; 4 neutral; 5 slightly agree; 6 agree; 7 strongly agree.

1. I doubt that my doctor really cares about me as a person.

2. My doctor is usually considerate of my needs and puts them first.

3. I trust my doctor so much that I always try to follow his/her advice.

4. If my doctor tells me something is so, then it must be true.

5. I sometimes distrust my doctor's opinion and would like a second one.

6. I trust my doctor's judgement about my medical care.

7. I feel my doctor does not do everything he/she should for my medical care.

8. I trust my doctor to put my medical needs above all other considerations when treating my medical problems.

9. My doctor is a real expert in taking care of medical problems like mine.

10. I trust my doctor to tell me if a mistake was made about my treatment.

11. I sometimes worry that my doctor may not keep the information we discuss private.

12. I can overcome most illness without help from a medically trained professional.

13. Home remedies are often better than drugs prescribed by a doctor.

14. If I get sick, it is my own behavior that determines how soon I get well again.

15. I understand my health better than most doctors do.



**SCHOOL OF MEDICINE**

INDIANA UNIVERSITY

## Jefferson Scale of Patient Perceptions of Physician Empathy

**Instructions:** We would like to know the extent of your agreement or disagreement with *each* of the following statements *about your physician named below*. Please use the following 7-point scale and write your rating number from 1 to 7 on the underlined space before each statement (1 means that you Strongly Disagree, and 7 means you Strongly Agree with the statement, a higher number indicates more agreement).

**1-----2-----3-----4-----5-----6-----7**  
**Strongly Disagree**

**Strongly Agree**

**Dr.(Name of the physician in here)**\_\_\_\_\_

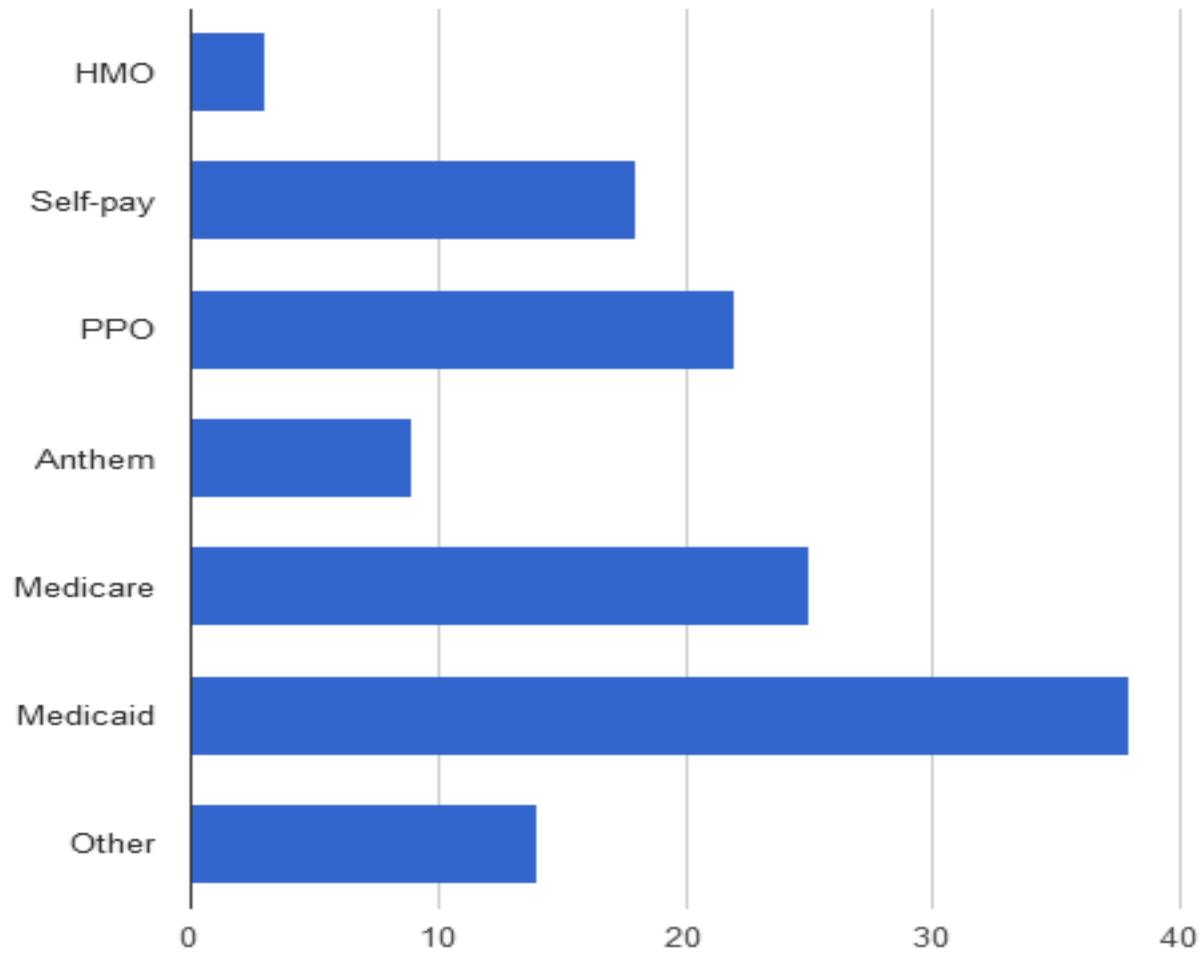
- 
1. \_\_\_ Can view things from my perspective (see things as I see them).
  2. \_\_\_ Asks about what is happening in my daily life.
  3. \_\_\_ Seems concerned about me and my family
  4. \_\_\_ Understands my emotions, feelings and concerns.
  5. \_\_\_ Is an understanding doctor.
- 

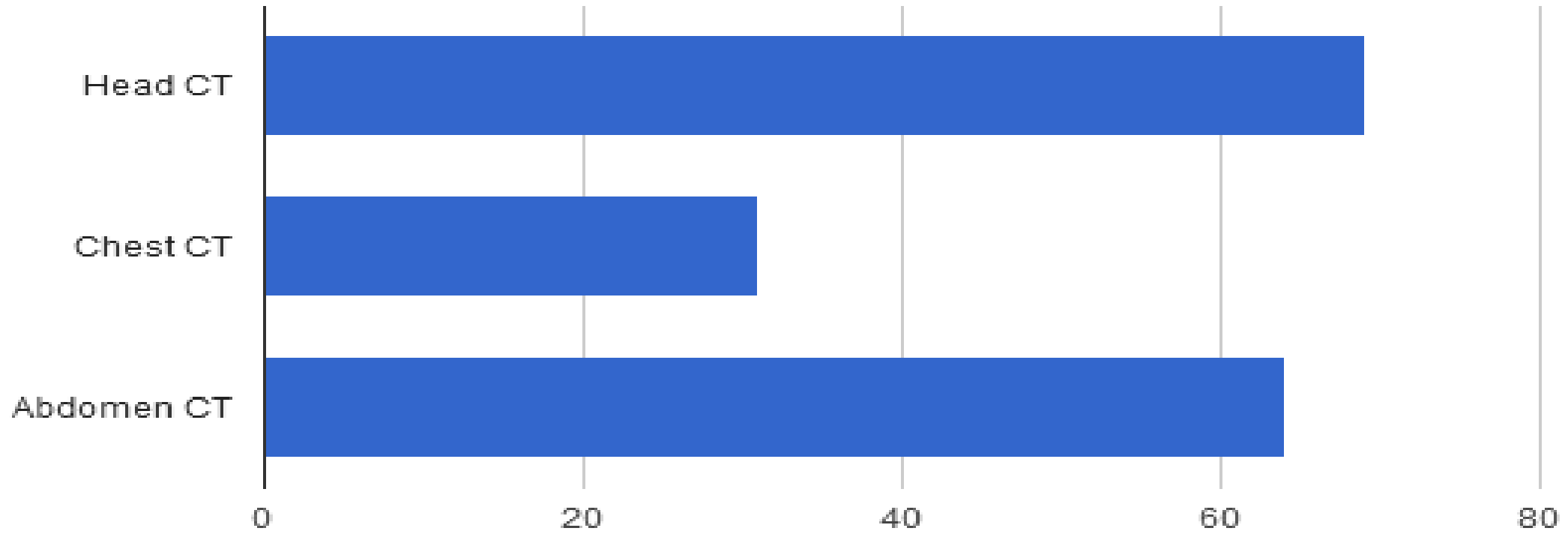


# Results

- 219 patients were enrolled
- 49±17 years, 46% Caucasian







**SCHOOL OF MEDICINE**

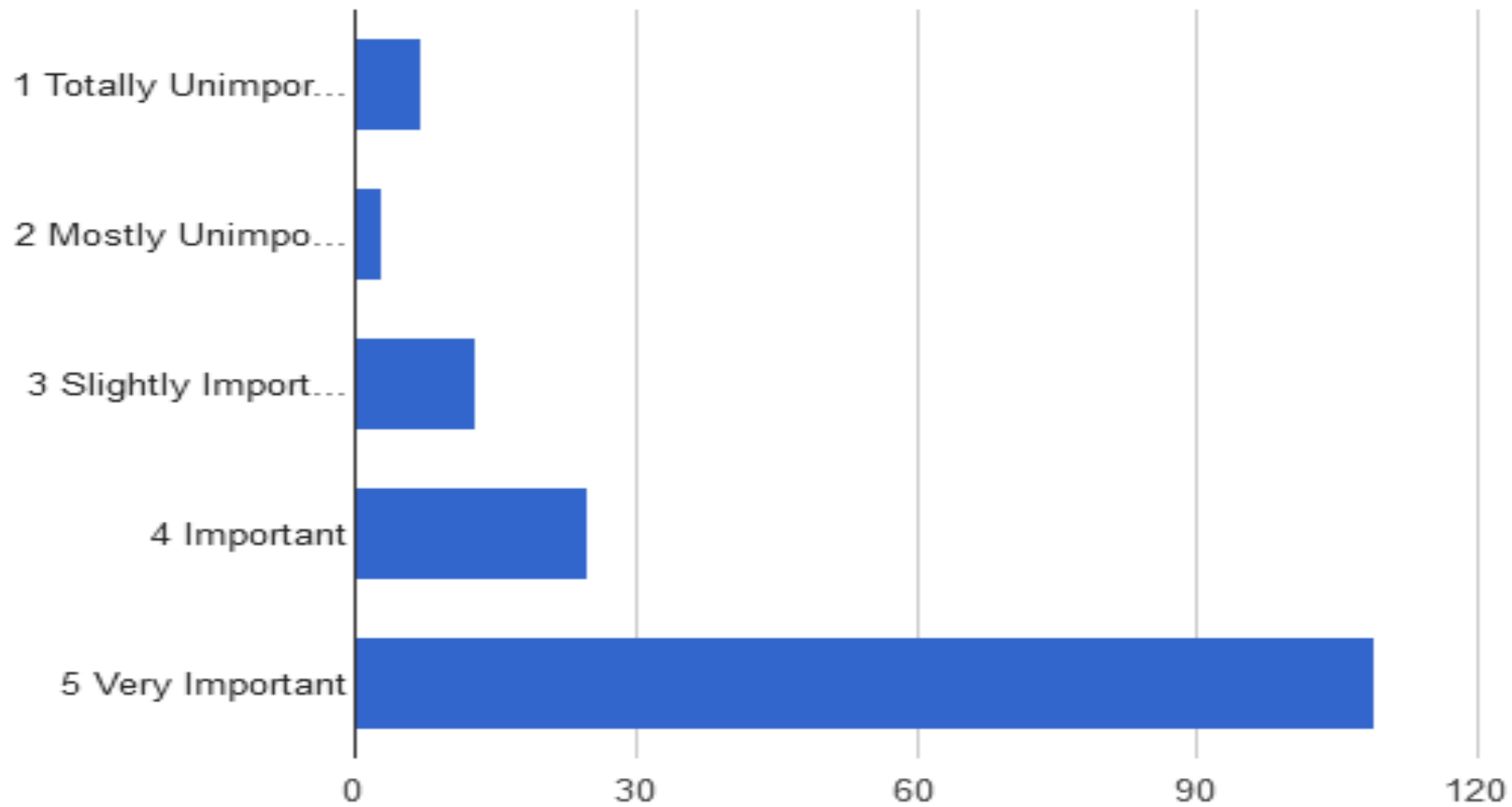
INDIANA UNIVERSITY

# Results: Best to worst

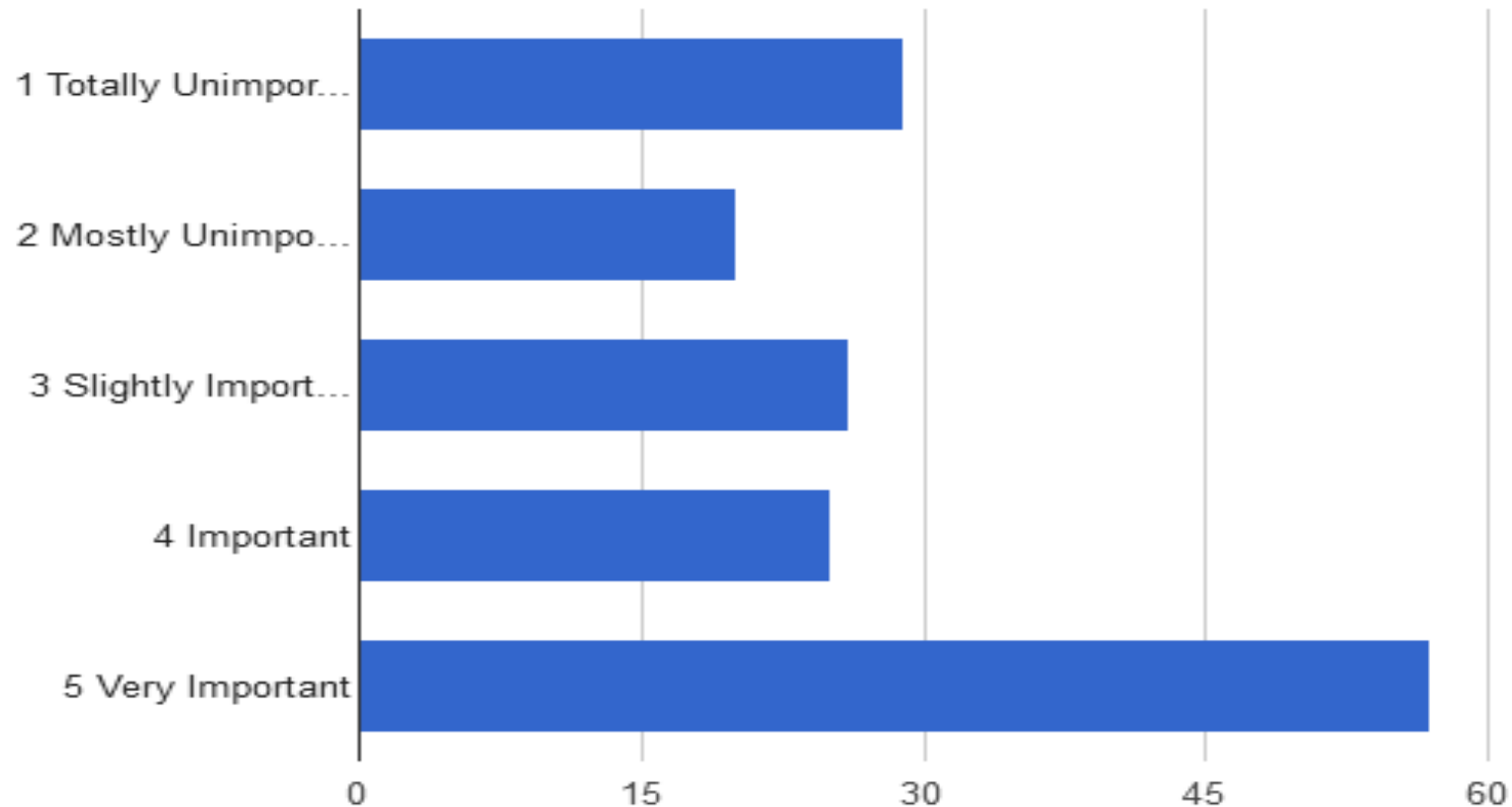
- BEST: Attention to “overall condition” (71%), “medical history” (66%), and “vital signs and physical examination” (63%)
- GOOD: “radiation and cancer risk” (58%) and “stress on your kidneys from dye” (59%)
- OK: “Facial expressions” (48%) and “body language” (53%).
- WORST: “what your family members said” (46%) and “cost of your medical care to you” (42%).



"I have carefully considered what you told me about what brought you here today"



"I have thought about the cost of your medical care to you today"





# Written comments

- 'I need them to recognize my pain'
- 'Looking at my history helps build trust. Letting me know tells me that you care about me and want to get the full picture'
- 'Tell me as much information as you have and break it down for me'
- 'Go over what they are looking for with the CT Go over plan of care and expected outcomes'



# What did they think of us?

## JPPPSE % strongest agreement

- My physician:
  - “can view things from my perspective” (58%)
  - “seems concerned about me and my family” (61%)
  - “understands my emotions feelings and concerns” (61%)
  - “is an understanding doctor” (76%),
  - “asks what is happening in my daily life” (47%)

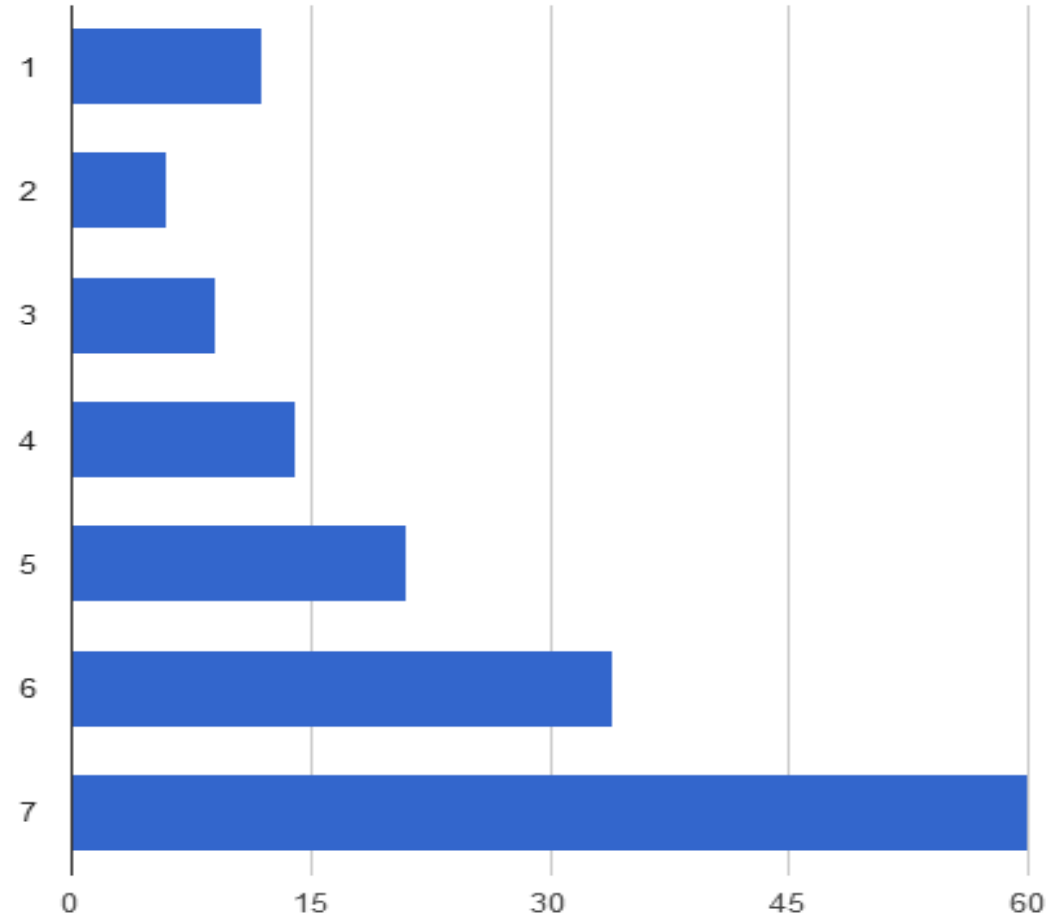


# JPPPSE continued

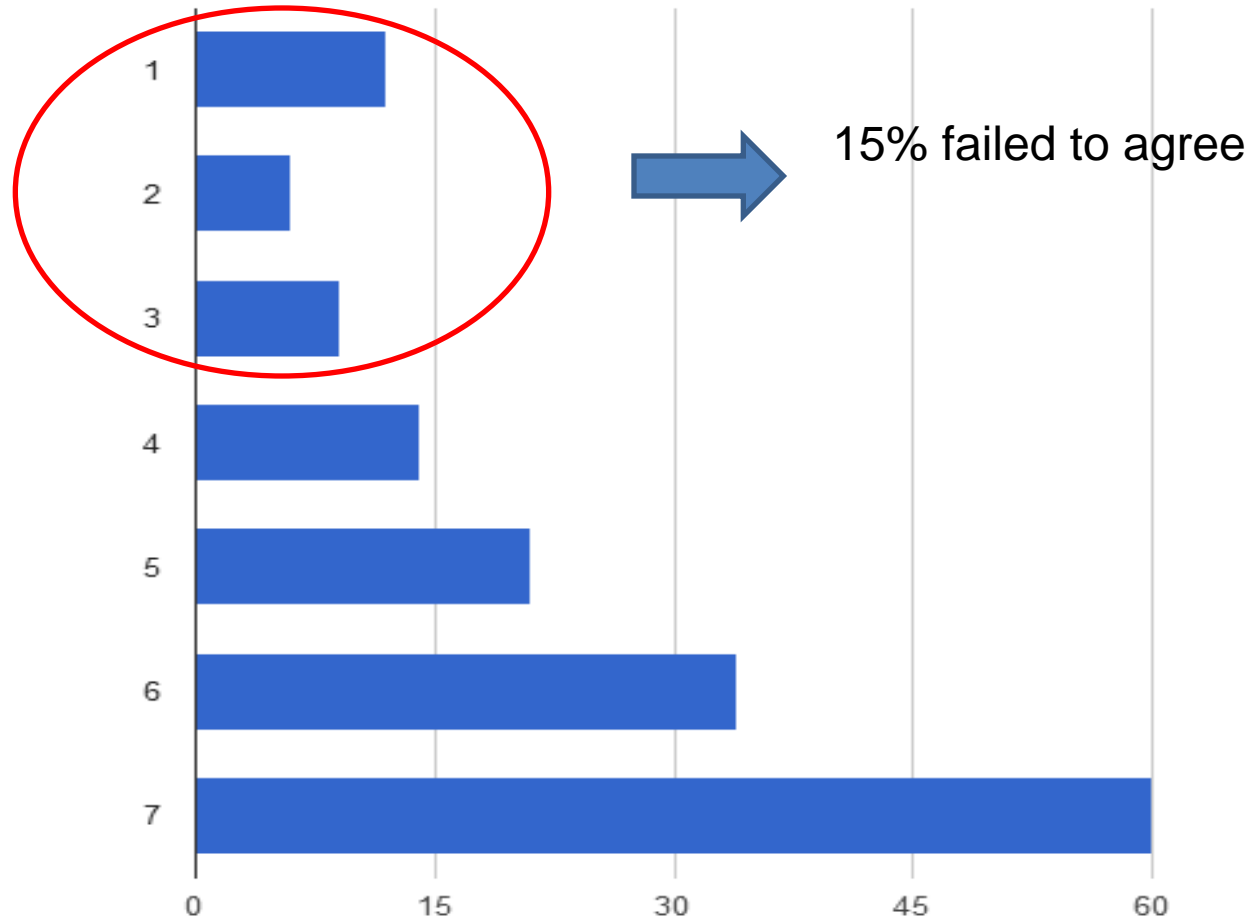
- No differences by sex ( $p=0.54$ ) or race ( $p=0.71$ ).
- Regional differences in “seems concerned about me and my family” ( $p=0.04$ ) and “understands my emotions feelings and concerns” ( $p=0.01$ ).



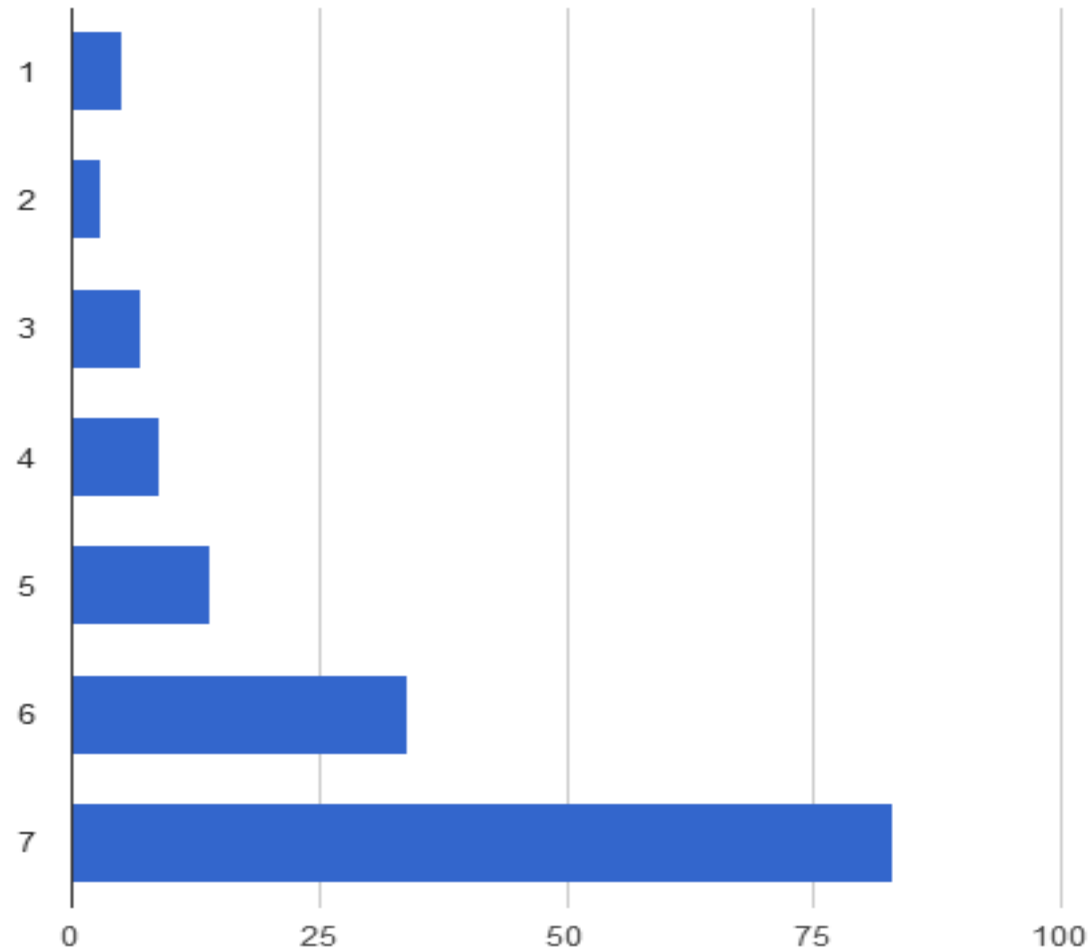
“My physician can view things from my perspective (see things as I see them)”



“My physician can view things from my perspective (see things as I see them)”



# “My physician is an understanding doctor”



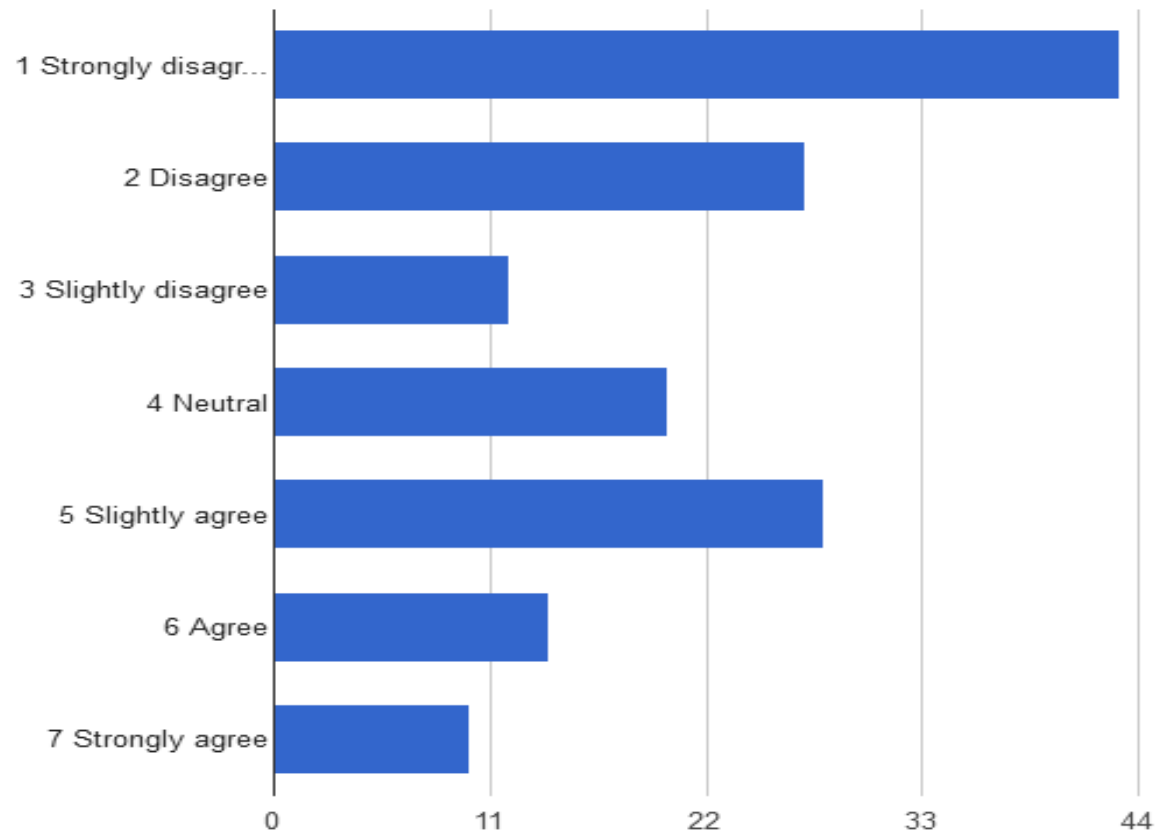
# Trust in Physicians scale

% with strongest response

- BEST: “I trust my doctor's judgement about my medical care” (47%)
- MID: “My doctor is a real expert in taking care of medical problems like mine” (40%)

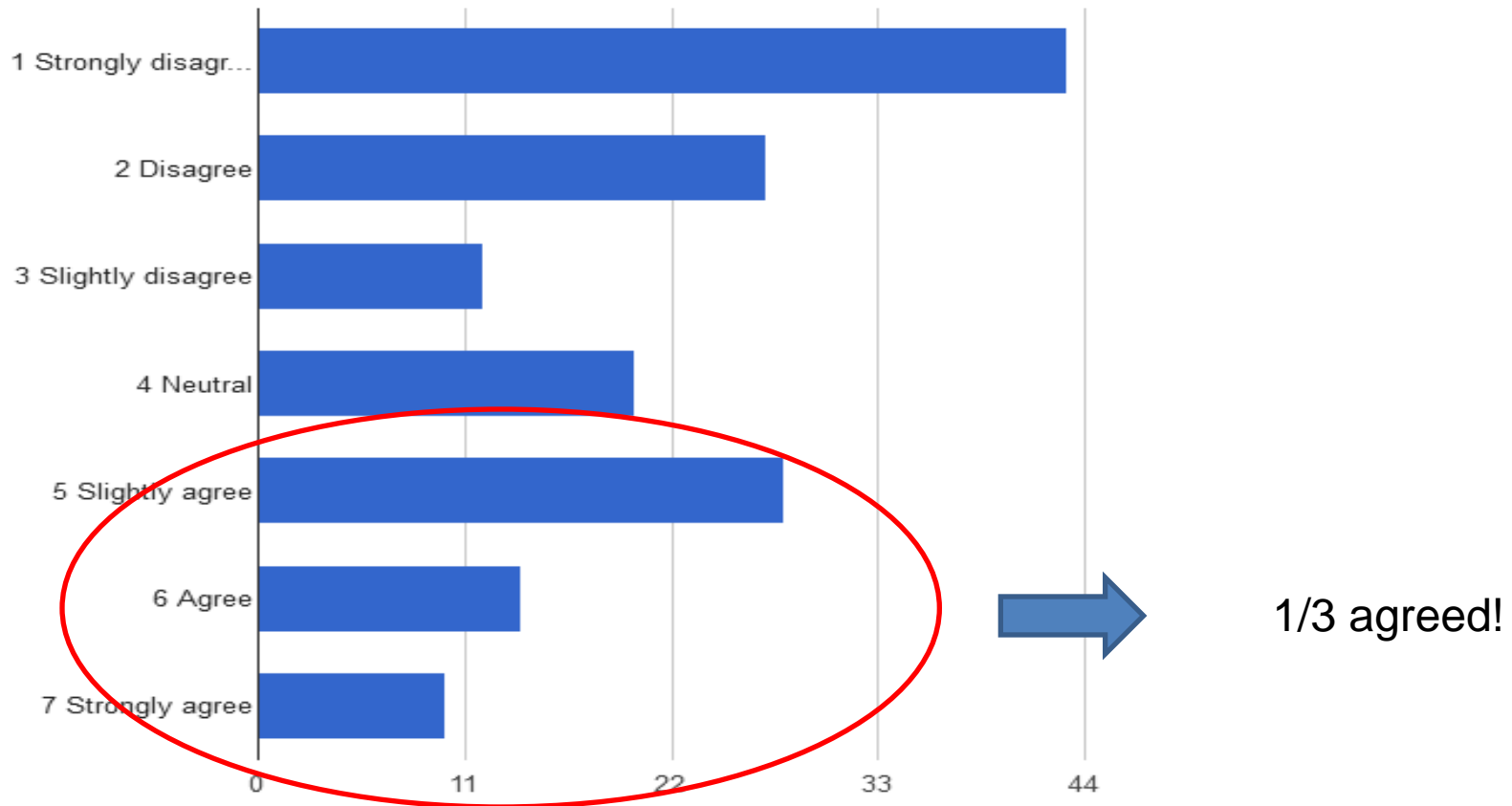


“I sometimes distrust my doctor's opinion and would like a second one”

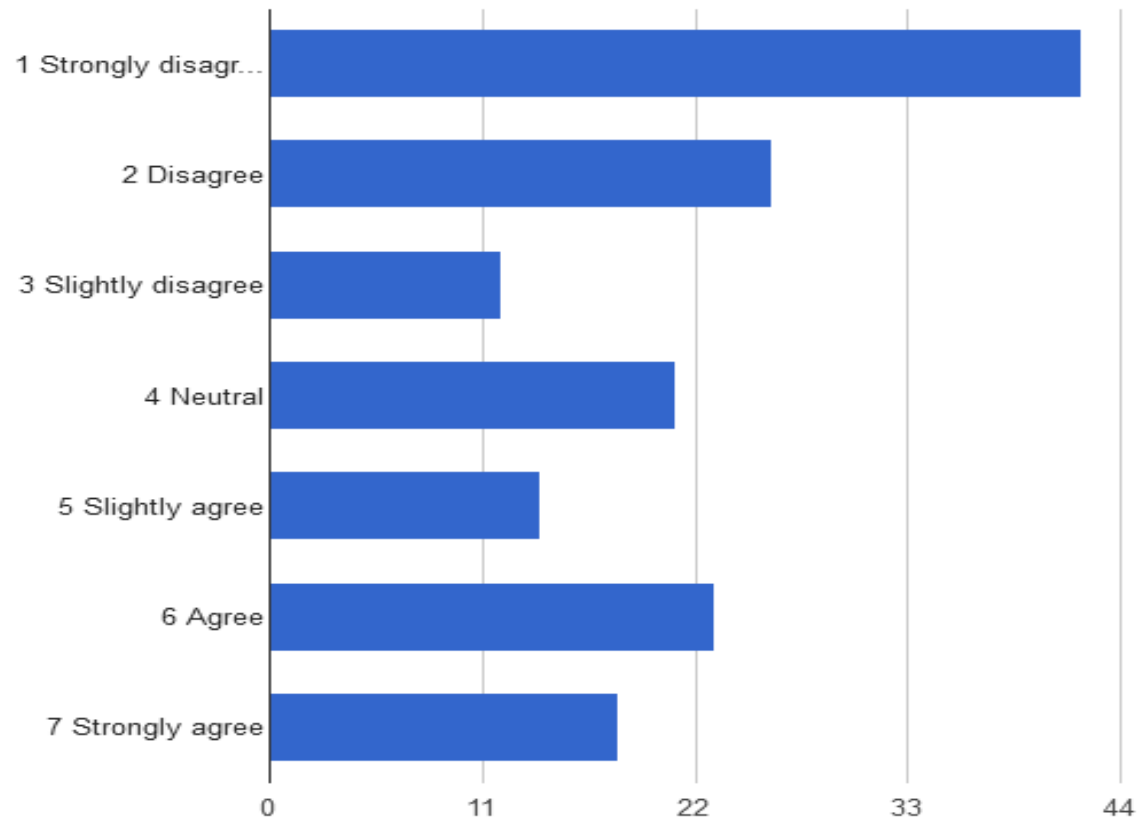




“I sometimes distrust my doctor's opinion and would like a second one”



# “I understand my health better than most doctors do”



# Summary

- Others have found increased empathy generally has positive effects
- We found simple phrases were well regarded
  - “I want to see this from your perspective”
  - “I have thought carefully about everything you have told me”
- About 15% indicate trust, but still want a second opinion



# Next steps

- Patient panel + physicians to build the components of a “script” or “narrative” and help inform study outcomes
- Pilot test in 30 patients
- Apply for PCORI funding with provisional plan to use a multicenter, stepped wedge design to compare against AIDET



# Study group



**SCHOOL OF MEDICINE**

INDIANA UNIVERSITY

**E·QUAL**

EMERGENCY  
QUALITY  
NETWORK

# PAMA and the Emergency Physician

or: How I Learned to Stop Worrying and Love  
Decision Support

**TCPi**

Transforming Clinical  
Practices Initiative

 American College of  
Emergency Physicians®

ADVANCING EMERGENCY CARE 

**Jeremiah Schuur, MD, MHS**

Brigham and Women's Hospital

Harvard Medical School

Boston, MA



**@JSchuurMD**

# Funding & Disclosures

## Investigator-initiated funding sources:

- *Center for Medicare and Medicaid Innovation: ACEP TCPI SAN:*
  - goal to reduce imaging for Renal colic, low back pain, CTPE, head CT
- *AHRQ: Reducing radiation exposure in renal colic*
- *Emergency Medicine Foundation: alternate payment models*
- *CRICO: Improving safety with use of EHR*

## Other funding:

- Associate Medical Director CRICO (Risk Management)
- Medical-legal review

# Agenda

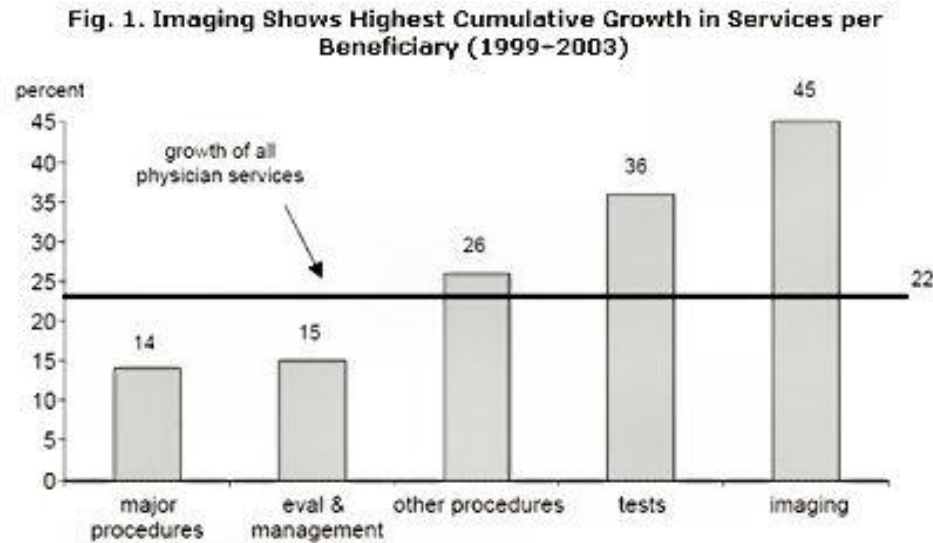
- Review motivation for policy to reduce imaging and improve appropriateness
- Explain PAMA's imaging provisions
- Review the evidence for & against clinical decision support (CDS)
- Review how PAMA will affect the Emergency Physician



# Why do policymakers care about imaging use?

- Cost

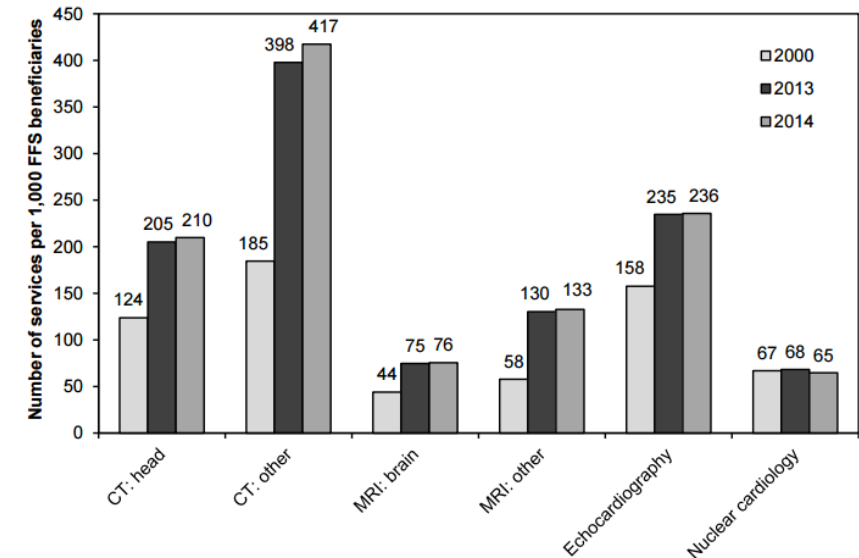
2005 MedPAC



Note—Includes all services in physician fee schedule.  
Source—MedPAC analysis of Medicare claims data.

2016 MedPAC

**Chart 7-18. Growth in the number of CT, MRI, and cardiac imaging services per 1,000 FFS beneficiaries, 2000–2014**



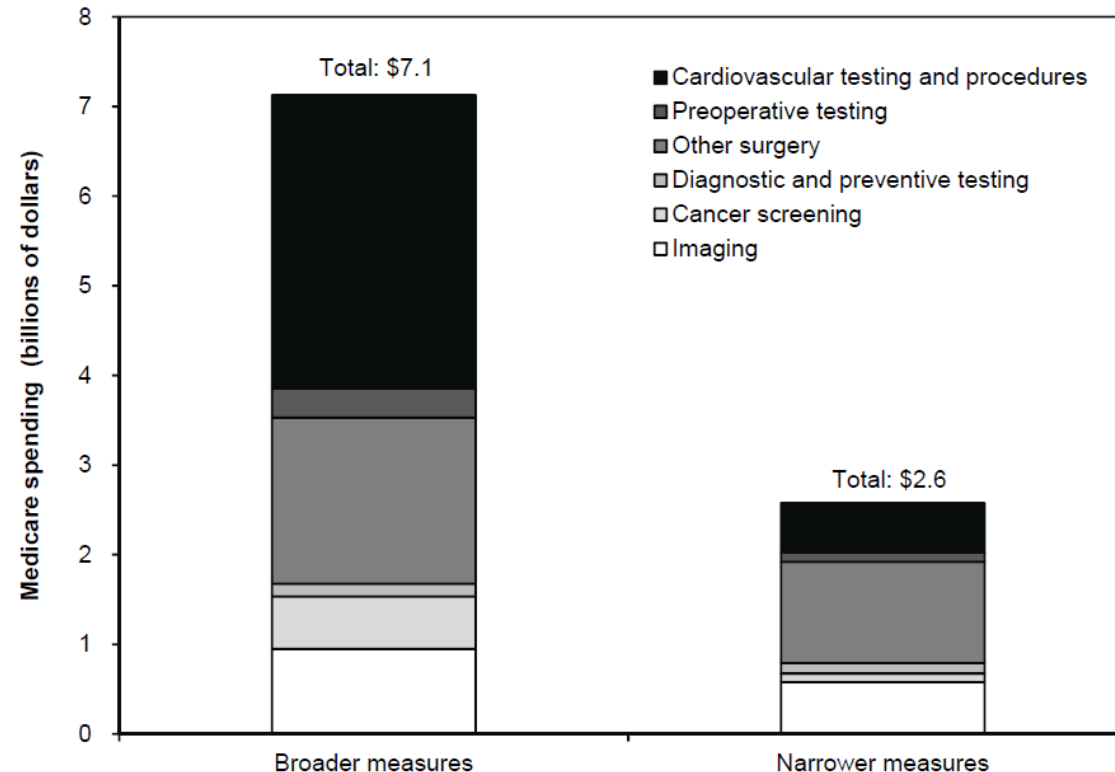
Note: CT (computed tomography), MRI (magnetic resonance imaging), FFS (fee-for-service). Data include imaging services paid under the fee schedule for physicians and other health professionals that were provided in all settings but exclude technical component-only services. The number of echocardiography and nuclear cardiology services excludes add-on services.

Source: MedPAC analysis of the 100 percent physician/supplier procedure summary files from CMS 2000, 2013, and 2014.

# Why do policymakers care about imaging use?

- Cost → Waste (low-value care)

Chart 5-8. Spending on services detected by selected measures of low-value care, by category, 2013



Note: Spending includes Medicare Part A and Part B program spending and beneficiary cost sharing for services detected by measures of low-value care. To estimate spending, we used standardized prices to adjust for regional differences in payment rates. The standardized price is the median payment amount per service in 2009, adjusted for the increase in payment rates between 2009 and 2012. This method was developed by Schwartz et al. (2014).

# What tools do policymakers have to reduce imaging costs?

- Reduce payment per procedure
  - MedPAC has done this
  - Unpopular
- Encourage clinicians to reduce utilization
  - Quality measures
  - Increase use of clinical evidence

# E•QUAL

EMERGENCY  
QUALITY  
NETWORK

## TCPi

Transforming Clinical  
Practices Initiative



American College of  
Emergency Physicians®

ADVANCING EMERGENCY CARE



## Choosing Wisely

An initiative of the ABIM Foundation

American College of Emergency Physicians

American College of  
Emergency Physicians®  
ADVANCING EMERGENCY CARE

### Five Things Physicians and Patients Should Question

1

#### Avoid computed tomography (CT) scans of the head in emergency department patients with minor head injury who are at low risk based on validated decision rules.

Minor head injury is a common reason for visiting an emergency department. The majority of minor head injuries do not lead to injuries such as skull fractures or bleeding in the brain that need to be diagnosed by a CT scan. As CT scans expose patients to ionizing radiation, increasing patients' lifetime risk of cancer, they should only be performed on patients at risk for significant injuries. Physicians can safely identify patients with minor head injury in whom it is safe to not perform an immediate head CT by performing a thorough history and physical examination following evidence-based guidelines. This approach has been proven safe and effective at reducing the use of CT scans in large clinical trials. In children, clinical observation in the emergency department is recommended for some patients with minor head injury prior to deciding whether to perform a CT scan.

2

#### Avoid placing indwelling urinary catheters in the emergency department for either urine output monitoring in stable patients who can void, or for patient or staff convenience.

Indwelling urinary catheters are placed in patients in the emergency department to assist when patients cannot urinate, to monitor urine output or for patient comfort. Catheter-associated urinary tract infection (CAUTI) is the most common hospital-acquired infection in the U.S., and can be prevented by reducing the use of indwelling urinary catheters. Emergency physicians and nurses should discuss the need for a urinary catheter with a patient and/or their caregivers, as sometimes such catheters can be avoided. Emergency physicians can reduce the use of indwelling urinary catheters by following the Centers for Disease Control and Prevention's evidence-based guidelines for the use of urinary catheters. Indications for a catheter may include: output monitoring for critically ill patients, relief of urinary obstruction, at the time of surgery and end-of-life care. When possible, alternatives to indwelling urinary catheters should be used.

3

#### Don't delay engaging available palliative and hospice care services in the emergency department for patients likely to benefit.

Palliative care is medical care that provides comfort and relief of symptoms for patients who have chronic and/or incurable diseases. Hospice care is palliative care for those patients in the final few months of life. Emergency physicians should engage patients who present to the emergency department with chronic or terminal illnesses, and their families, in conversations about palliative care and hospice services. Early referral from the emergency department to hospice and palliative care services can benefit select patients resulting in both improved quality and quantity of life.

4

#### Avoid antibiotics and wound cultures in emergency department patients with uncomplicated skin and soft tissue abscesses after successful incision and drainage and with adequate medical follow-up.

Skin and soft tissue infections are a frequent reason for visiting an emergency department. Some infections, called abscesses, become walled off and form pus under the skin. Opening and draining an abscess is the appropriate treatment; antibiotics offer no benefit. Even in abscesses caused by Methicillin-resistant *Staphylococcus aureus* (MRSA), appropriately selected antibiotics offer no benefit if the abscess has been adequately drained and the patient has a well-functioning immune system. Additionally, culture of the drainage is not needed as the result will not routinely change treatment.

5

#### Avoid instituting intravenous (IV) fluids before doing a trial of oral rehydration therapy in uncomplicated emergency department cases of mild to moderate dehydration in children.

Many children who come to the emergency department with dehydration require fluid replacement. To avoid the pain and potential complications of an IV catheter, it is preferable to give these fluids by mouth. Giving a medication for nausea may allow patients with nausea and vomiting to accept fluid replenishment orally. This strategy can eliminate the need for an IV. It is best to give these medications early during the ED visit, rather than later, in order to allow time for them to work optimally.

# Clinical Decision Support (CDS)

IMAGING FOR THE CLINICIAN SPECIAL SECTION  
CLINICAL RESEARCH STUDY

Robert G. Stern, MD, Section Editor

THE AMERICAN  
JOURNAL of  
MEDICINE®

## Does Clinical Decision Support Reduce Unwarranted Variation in Yield of CT Pulmonary Angiogram?

Luciano M. Prevedello, MD, MPH,<sup>a,b,e</sup> Ali S. Raja, MD, MBA, MPH,<sup>a,c,e</sup> Ivan K. Ip, MD, MPH,<sup>a,b,d,e</sup>  
Aaron Sodickson, MD, PhD,<sup>a,b,e</sup> Ramin Khorasani, MD, MPH<sup>a,b,e</sup>

<sup>a</sup>Center for Evidence-Based Imaging and <sup>b</sup>Department of Radiology, <sup>c</sup>Department of Emergency Medicine, and  
<sup>d</sup>Department of Medicine, Brigham and Women's Hospital, Boston, Mass; <sup>e</sup>Harvard Medical School, Boston, Mass.



Contents lists available at ScienceDirect

American Journal of Emergency Medicine

journal homepage: [www.elsevier.com/locate/ajem](http://www.elsevier.com/locate/ajem)



Original Contribution

Impact of clinical decision support on head computed tomography use in patients with mild traumatic brain injury in the ED

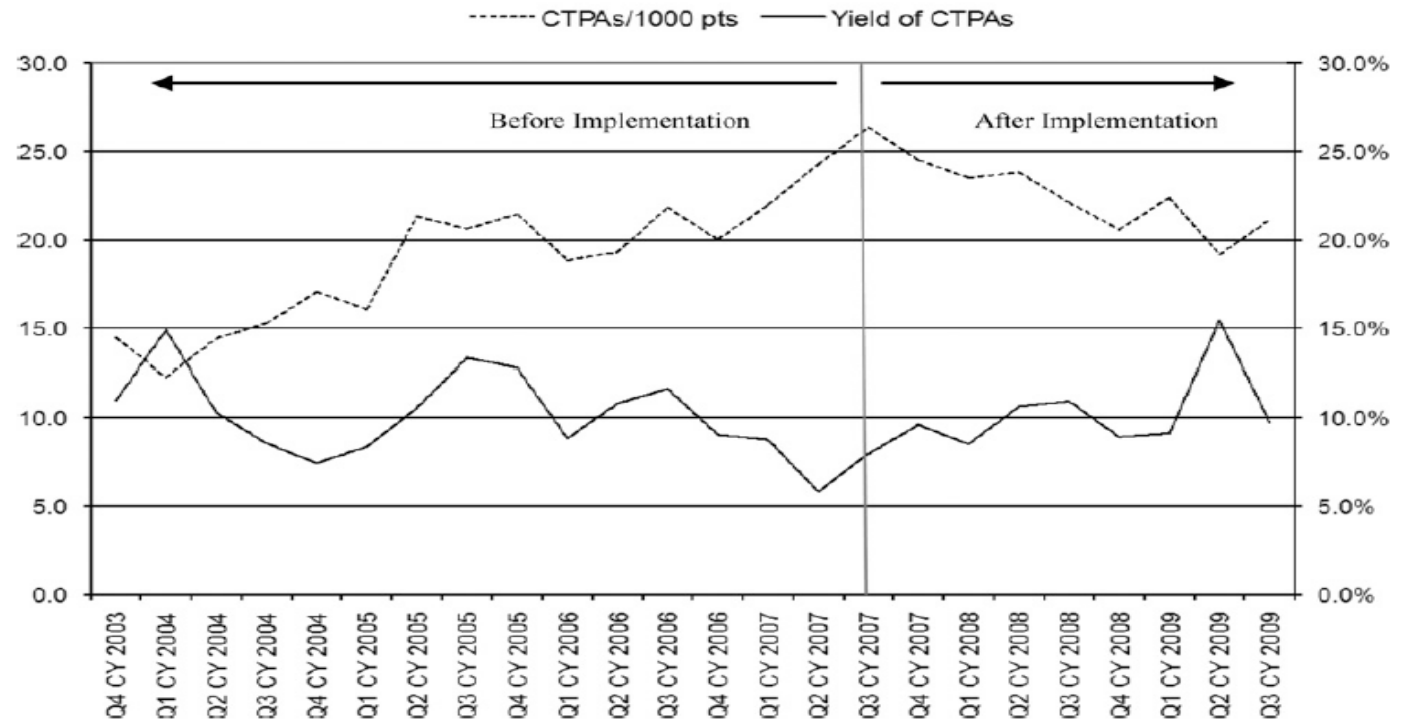


Ivan K. Ip, MD, MPH<sup>a,b,c,e,\*</sup>, Ali S. Raja, MD, MPH, MBA<sup>a,b,d,e</sup>, Anurag Gupta, MD, MBA, MMSc<sup>a,b,d,e</sup>,  
James Andruchow, MD<sup>a,b,d,e</sup>, Aaron Sodickson, MD, PhD<sup>a,b,e</sup>, Ramin Khorasani, MD, MPH<sup>a,b,e</sup>

## Effect of Computerized Clinical Decision Support on the Use and Yield of CT Pulmonary Angiography in the Emergency Department<sup>1</sup>

Ali S. Raja, MD, MBA, MPH  
Ivan K. Ip, MD, MPH  
Luciano M. Prevedello, MD  
Aaron D. Sodickson, MD, PhD  
Cameron Farkas  
Richard D. Zane, MD  
Richard Hanson  
Samuel Z. Goldhaber, MD  
Ritu R. Gill, MBBS  
Ramin Khorasani, MD, MPH

**Figure 3**

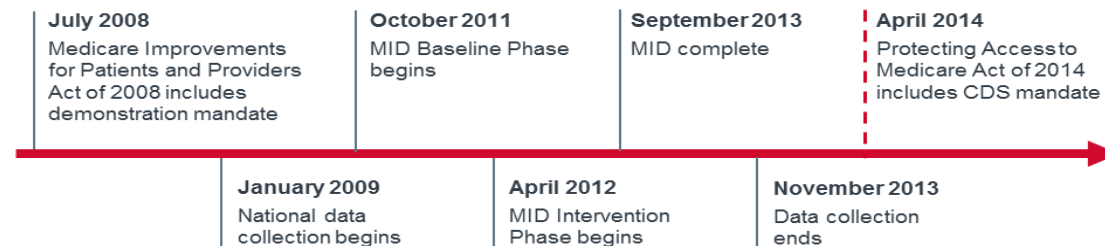


**Figure 3:** Graph shows CT pulmonary angiography (CTPA) use and yield before and after CDS implementation. CY = calendar year, Q1 = first quarter, Q2 = second quarter, Q3 = third quarter, Q4 = fourth quarter.

# Medicare Imaging Demonstration Project

- **Who:** 5 institutions chosen as “conveners“, 4,000 providers
  - National Imaging Associates, Brigham and Women’s, Henry Ford Health System, University of Wisconsin, and Maine Medical Center.
- **What:** CDS & feedback
  - Providers used CDS software for 2 years, for 11 specific advanced imaging procedures within 3 modalities, for Medicare FFS beneficiaries.
  - Baseline Phase (6 months): providers used CDS to order exams, no feedback.
  - Intervention Phase (18 months): CDS delivered real-time feedback about adherence to appropriate use criteria.

Medicare Imaging Demonstration Timeline



# MIDS Evaluation: Conclusion

“In summary, we found no evidence that the intervention led to anything beyond a small reduction—if any reduction at all—in advanced imaging volume. Furthermore, since more than half of the ordered advanced images did not link with guidelines, in these instances, appropriateness feedback was not available to share with ordering clinicians.”

-Medicare Imaging Demonstration Evaluation Report for the Report to Congress, RAND Health



# Rating of Orders for Appropriateness

- Many imaging studies weren't rated for appropriateness, and this did not improve in all sites
  - varied by site from 20% reduction to 25% increase

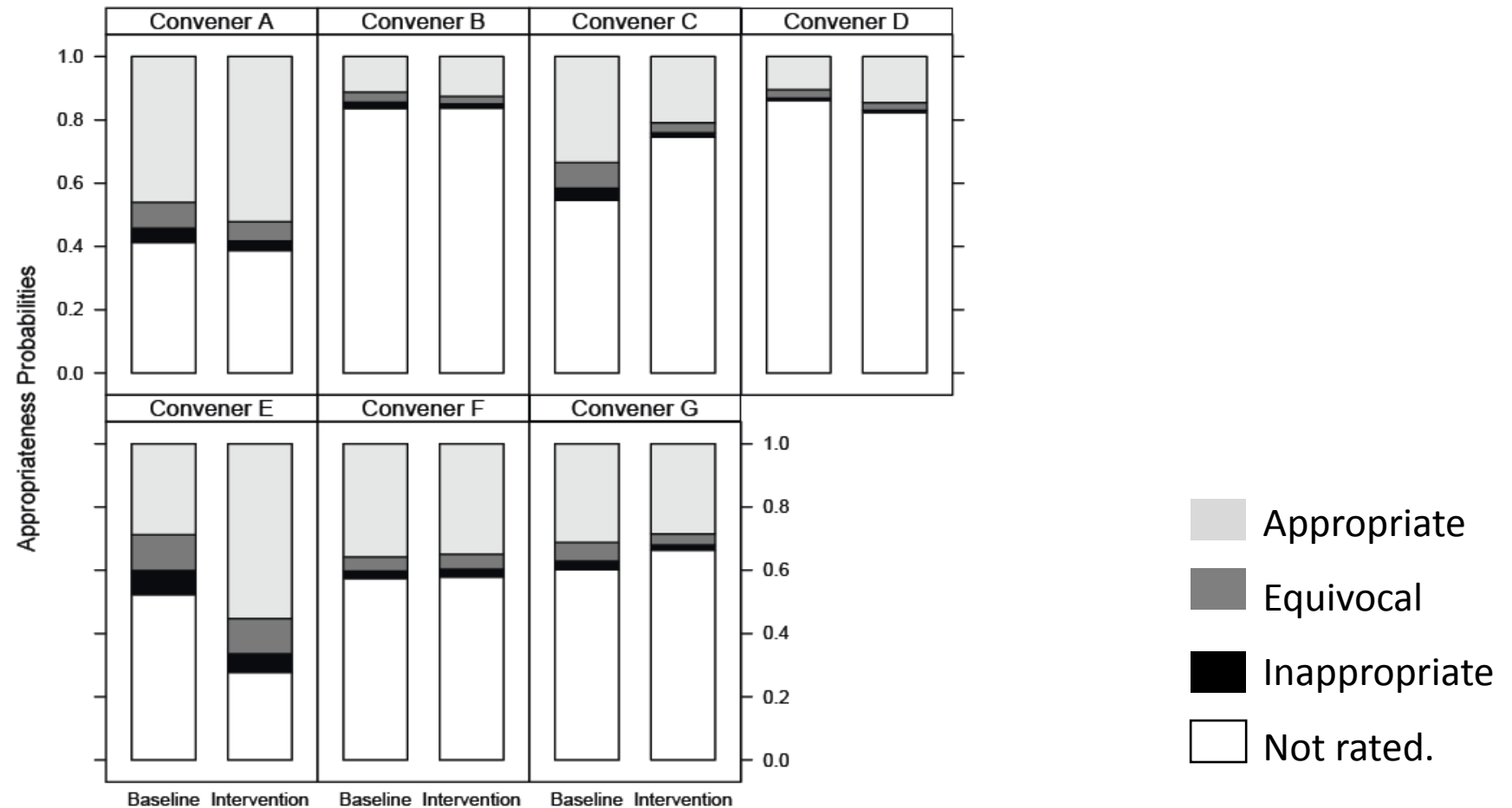
**Table 3.2. Calculated Probability of Rated Images for the Typical Provider, Averaged Across Specialty, in the Baseline and the Intervention Periods and the Change Between These Probabilities, by Convener**

Convener	Baseline	Intervention	Change
A	0.587	0.612	0.025*
B	0.164	0.162	-0.001
C	0.454	0.254	-0.201*
D	0.139	0.177	0.038*
E	0.477	0.722	0.246*
F	0.426	0.421	-0.005
G	0.399	0.336	-0.063*

\* Significance with  $P < 0.05$ .

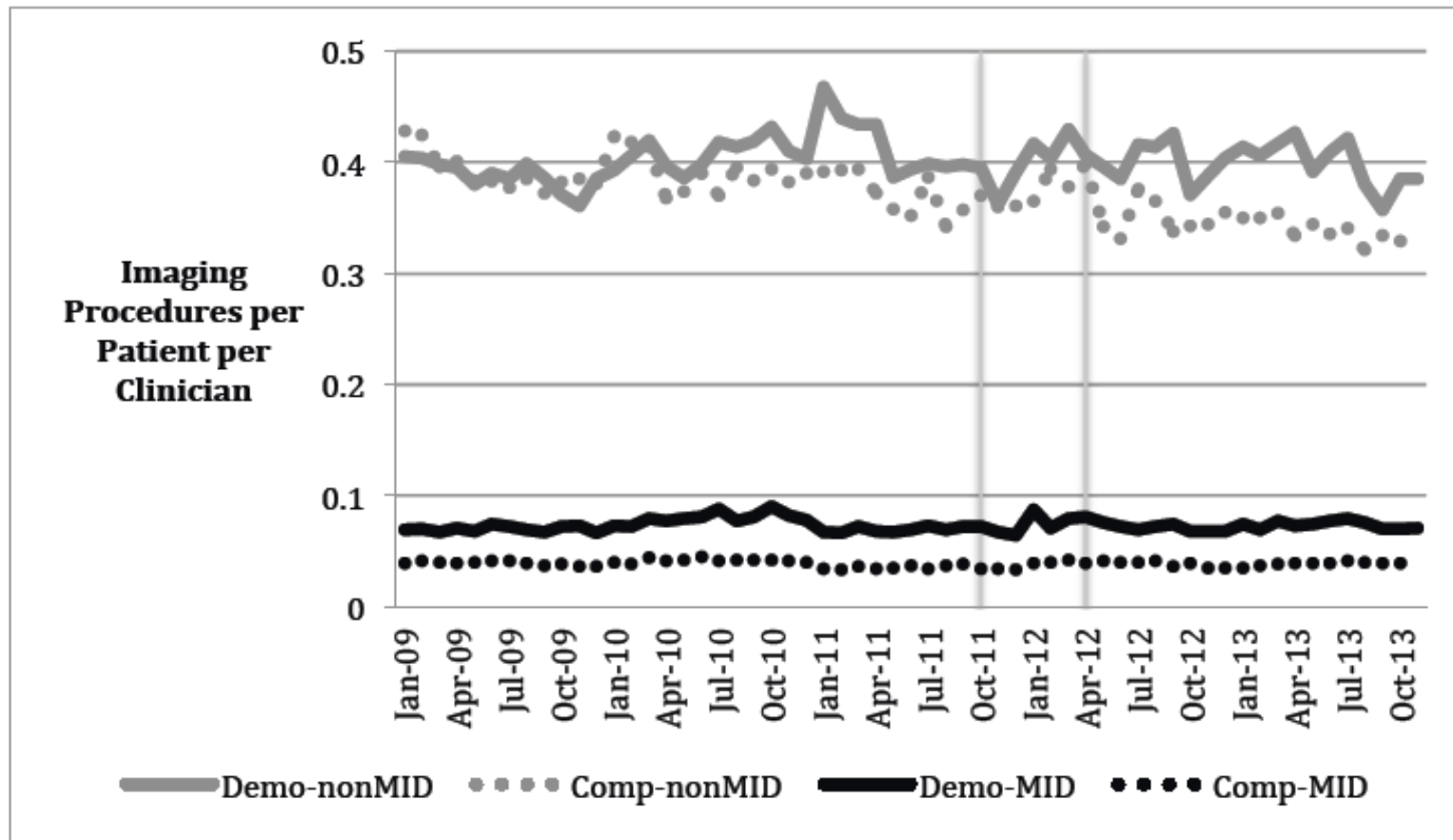
# No significant reduction in “inappropriate images” across all studies

Figure 3.2. Probabilities for Typical Providers of Combined Rated/Not Rated and Appropriateness Categories, Averaged Across Specialty



## Were any national or regional patterns or trends evident in utilization of advanced imaging procedures?

Figure 5.1. MID and Non-MID Imaging Procedure Rates per Patient per Clinician, January 2009–November 2013



NOTE: Demo = demonstration group. Comp = comparison group. The vertical gray lines indicate the beginning of the baseline and intervention periods.

## How satisfied were physicians in the demonstration with being exposed to advanced imaging appropriateness criteria?

- Only two of 97 focus group participants stated that guidelines were useful or helpful.

**Table 6.1 Distribution of Survey Respondent Ratings About Guidelines Used with MID Decision Support Systems, by Specialty Type**

Statement	% distribution for generalists (n=27)		% distribution for medical specialists (n=22)		% distribution for surgical specialists (n=12)	
	Agree	Disagree	Agree	Disagree	Agree	Disagree
A. The DSS clinical guidelines are useful to my practice	48	52	42	58	22	78

# Advisory Board Review of MID

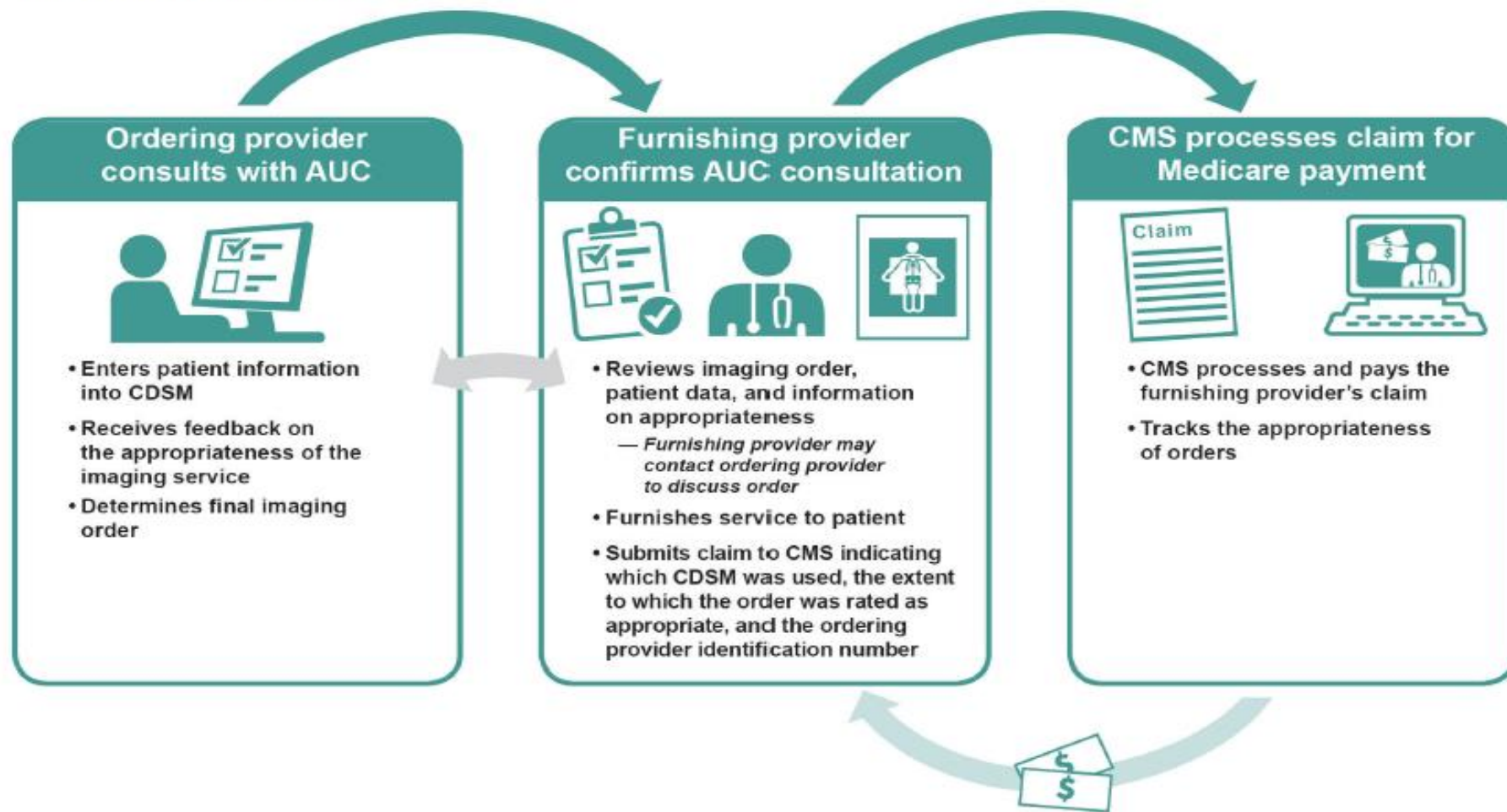
- 3 major flaws
  - **Limited, static guidelines**
    - The appropriate use criteria imbedded into decision support during the demonstration were taken directly from national medical specialty societies with no option to modify criteria or add local guidelines.
  - **Poor software integration**
  - **Unreliable appropriateness scoring**
    - For the demonstration, each imaging order was designated into one of four categories: appropriate, inappropriate, uncertain, and not covered by guidelines.
    - more than 60% of orders fell into the unrated category.
- **“Bottom line: let the MID act as guidance for how not to implement CDS, rather than proof CDS will not work.”**

# Protecting Access to Medicare Act of 2014 (PAMA)

- Assumptions:
  - There is wasteful low-value imaging
  - Clinicians are not familiar with or applying the evidence for imaging appropriateness
  - Appropriate use criteria (AUC) can help clinicians apply evidence and reduce low-value imaging
  - Radiologists are important gatekeepers in the imaging ordering process and should be incentivized to have ordering providers use AUC

# PAMA

Figure 1: Use of Clinical Decision Support Mechanisms (CDSM) and Payment of Claims under the Medicare Imaging Appropriate Use Criteria (AUC) Program



# PAMA

- Requires CMS to provide implementation details around 4 key components of the program:
- **Approval process for AUC:** The clinical guidelines that providers consult to comply with the mandate
- **Approval process for CDS mechanisms:** The electronic tools that allow providers to consult AUC during ordering
- **Provider requirements:** How ordering providers will demonstrate that they consulted AUC through an approved mechanism, how furnishing providers will submit that information to CMS, and how CMS will penalize those providers who do not comply
- **Identification of outlier providers:** How CMS will identify up to 5% of ordering providers as outliers and require them to obtain preauthorization when ordering imaging for Medicare patients



# PAMA: Who decides what's appropriate?

- **Qualified provider-led entities**

Qualified provider-led entities as of July 2016
American College of Radiology
Brigham and Women's Physician Organization
CDI Quality Institute
Intermountain Healthcare
Massachusetts General Hospital, Radiology
National Comprehensive Care Network
Society for Nuclear Medicine and Molecular Imaging
University of California Medical Campuses
University of Washington Physicians
Weill Cornell Medical Physicians Organization

# PAMA: Highlights

- Ordering providers must consult CDS for all outpatient advanced imaging exams → radiologists' reimbursement depends on documenting ordering providers' use
  - Claims must include
    1. CDS mechanism consulted
    2. Whether the order adherence to AUC, does not adhere to AUC, or no criterion are applicable
    3. NPI
- Outlier status for ordering providers will be determined by adherence to eight priority clinical areas

## Finalized Priority Clinical Areas

- |  |                                |
|--|--------------------------------|
| <b>1</b> Coronary artery disease*      | <b>5</b> Low back pain         |
| <b>2</b> Suspected pulmonary embolism* | <b>6</b> Shoulder pain*        |
| <b>3</b> Headache                      | <b>7</b> Cancer of the lung    |
| <b>4</b> Hip pain*                     | <b>8</b> Cervical or neck pain |

\*Priority clinical areas not included in proposed rule

# PAMA: Timeline

## April 2014

PAMA<sup>1</sup> signed into law, requiring provider use of AUC via CDS for advanced imaging

## November 2016

MPFS CY 2017 final rule established CDS mechanism requirements and approval process, clinical priority areas

## January 1, 2020

Ordering providers identified as **outliers**, may be required to obtain **preauthorization**

## November 2015

MPFS<sup>2</sup> CY 2016 final rule established appropriate use criteria approval process

## January 1, 2018

**Ordering providers must consult AUC through qualified CDS; to receive payment, furnishing must submit claims-based documentation**

# Does PAMA cover EM? CMS vs. ACEP

## CMS

- PAMA requires CDS of all hospital based providers
- PAMA exempts emergency medical conditions
- Not all ED visits are EMCs
- So PAMA should apply to all ED visits except conditions clearly exempted, e.g. unstable trauma

## ACEP

- PAMA exempts emergency medical conditions
- Radiology is used to determine if a patient has an EMC
- So CDS shouldn't be required in ED visits

**2016 Final Rule: Emergency Medical Conditions are exempt– but not all ED visits are EMCs**

# Summary

- Clinical decision support is an effective tool to increase imaging appropriateness, reduce utilization, and reduce variation\*
  - Context specific design: applicable evidence & workflow
  - Local champions
- PAMA requires CDS for high cost radiology ordering
  - EDs will be pulled in by hospital HER
- It is unclear how exactly this will affect you...
  - Worst case: more useless clicking before ordering radiology tests
  - Best case: targeted evidence based decision support that supports best practice
- What should you do?
  - Have EM representation on hospital CDS / HER group
  - Advocate for context specific CDS and feedback

# Questions ?



**@JSchuurMD**

# Does PAMA cover EM? 2016 Final Rule → YES

- f. Exceptions to Consulting and Reporting Requirements Section 1834(q)(4)(C) of the Act provides for certain exceptions to the AUC consultation and reporting requirements under section 1834(q)(4)(B) of the Act. First, the statute provides for an exception under section 1834(q)(4)(C)(i) of the Act where an applicable imaging service is ordered for an individual with an emergency medical condition as defined in section 1867(e)(1) of the Act. We believe this exception is warranted because there can be situations in which a delay in action would jeopardize the health or safety of individuals. Though we believe they occur primarily in the emergency department, these emergent situations could potentially arise in other settings. Furthermore, we recognize that most encounters in an emergency department are not for an emergency medical condition as defined in section 1867(e)(1) of the Act. We proposed to provide for an exception to the AUC consultation and reporting requirements under §414.94(i)(1) for an applicable imaging service ordered for an individual with an emergency medical condition as defined in section 1867(e)(1) of the Act. For example, if a patient, originally determined by the clinician to have an emergency medical condition prior to ordering an applicable imaging service, is later determined not to have had an emergency medical condition at that time, the relevant claims for applicable imaging services would still qualify for an exception. To meet the exception for an emergency medical condition as defined in section 1867(e)(1) of the Act, the clinician only needs to determine that the medical condition manifests itself by CMS-1654-F 874 acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual (or a woman's unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Orders for advanced imaging services for beneficiaries with an emergency medical condition as defined under section 1867(e)(1) of the Act are excepted from the requirement to consult AUC. We intend through the CY 2018 PFS proposed rule to propose more details around how this exception will be identified on the Medicare claim.

**E•QUAL**

EMERGENCY  
QUALITY  
NETWORK

**TCPi**

Transforming Clinical  
Practices Initiative

 American College of  
Emergency Physicians®

ADVANCING EMERGENCY CARE 





# Avoidable Imaging Wave II

# E-QUAL and MIPS Credit



**2019**  
(2017 Performance Data)

**2021 and Beyond**  
(2019 Performance Data)



**E-QUAL is considered a high value activity for CPIA**

# Avoidable Imaging Wave II

**Launching March 2017**

## 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

## 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 (CEDR)
- Re-enrollment

\*Time Commitment  
1.5hours per month

# What do I need to do NOW?

- **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

**Deadline to enroll into the  
Avoidable Imaging Wave II  
February 22<sup>nd</sup>**

# For More Information

E-QUAL Website: [www.acep.org/equal](http://www.acep.org/equal)

E-QUAL Email: [equal@acep.org](mailto:equal@acep.org)

## Contacts:

- Nalani Tarrant: (Project manager) [ntarrant@acep.org](mailto:ntarrant@acep.org)
- Jay Schuur: (co-PI) [jschuur@partners.org](mailto:jschuur@partners.org)
- Arjun Venkatesh: (co-PI) [arjun.venkatesh@yale.edu](mailto:arjun.venkatesh@yale.edu)

**E•QUAL**

EMERGENCY  
QUALITY  
NETWORK

**TCPi**

Transforming Clinical  
Practices Initiative



American College of  
Emergency Physicians®

ADVANCING EMERGENCY CARE 

