American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

December 23, 2024

Partnership for Quality Measurement
505 King Avenue
Columbus, OH 43201

**RE: 2024 Measures Under Consideration (MUC) List**

Dear Members of the 2023-2024 Pre-Rulemaking Measure Review (PRMR) Committee:

On behalf of our nearly 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the 2024 Measures Under Consideration list. Our comments are limited to the measures specifically pertinent to emergency medicine: the Emergency Care Capacity and Quality electronic clinical quality measure and the Addressing Social Needs Assessment and Intervention measure.

**Emergency Care Capacity and Quality (ECCQ) Electronic Clinical Quality Measure (eCQM)**

ACEP commends the Partnership for Quality Measurement for including a measure that addresses boarding in the emergency department (ED) for recommendatio consideration. The issue of patients "boarding" in the ED, a scenario where patients are placed in a holding pattern for extended periods of time while waiting for an inpatient bed after admission to the hospital or transfer to another facility, is overwhelming emergency physicians, non-physician clinicians, nurses, and other staff who are doing all they can to treat or stabilize every patient that needs care.

Boarding has become its own public health emergency. Our nation's safety net is on the verge of breaking beyond repair; EDs are gridlocked and overwhelmed. And this breaking point is entirely outside the control of the highly skilled emergency physicians, nurses, and other ED staff doing their best to provide equitable, high quality and safe care.

Boarding is a systemic problem that hinders patients' access to care. Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Patients in need of intensive care may board for hours in ED beds not set up for the extra monitoring they need. Those in mental health crisis, often children or adolescents, can board for months in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. Patients may delay or avoid emergency care and risk their physical and mental health because of these systemic bottlenecks.

ED boarding and crowding are not caused by ED operational issues or inefficiency; rather, they stem from broader health system dysfunction. This dysfunction also leads to negative patient outcomes, as a substantial body of evidence has shown that ED boarding and crowding lead to increased cases of mortality related to downstream delays

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of treatment for both high and low acuity patients.[1, 2] Boarding can also lead to ambulance diversion, increased adverse events, preventable medical errors, lower patient satisfaction, violent episodes in the ED, emergency physician and staff burnout, and higher overall health care costs.

Measurement is essential to identifying, diagnosing, and solving the complex boarding problem. Unfortunately, our ability to measure this problem has recently become limited, as the Centers for Medicare & Medicaid Services (CMS) eliminated an important measure regarding ED overcrowding, wait times, and boarding. In the Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS) final rule, CMS decided to sunset ED-2, the Admit Decision Time to ED Departure Time for Admitted Patients measure, starting in 2024. ACEP strongly opposed the removal of this measure as it was not only a specific measure capturing ED boarding, but also one of the only measures available to track this statistic and provide incentives and enforcement to help reduce wait times and boarding.

In the Calendar Year (CY) 2024 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment system proposed rule, CMS again proposed to eliminate another boarding and crowding-related measure, the Left Without Being Seen (LWBS) Measure, due to indications that (1) limited evidence linked the measure to improved patient outcomes; (2) the assertion that increased LWBS rates may reflect poor access to timely clinic-based care rather than intrinsic systemic issues within the ED; and (3) unintended effects on LWBS rates caused by other policies, programs, and initiatives may lead to skewed measure performance. ACEP strongly opposed the removal of this measure as well, and we were pleased that CMS reversed its position in the final OPPS rule by retaining the measure. Since we strongly believe that it is important to track the ongoing issue of ED boarding, and there is a paucity of measures that CMS currently uses to do so, ACEP supports the Partnership for Quality Measurement's recommendation of this measure for inclusion in the Hospital Outpatient Quality Reporting (OQR) Program.

The ECCQ eCQM seeks to capture variation in equity of emergency care and measure capacity and quality of emergency care to support hospital quality improvement by measuring the proportion of ED visits that meet at least one of four outcomes:

1. The patient waited longer than **1 hour** to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination; or
2. The patient left the ED without being evaluated by a physician/advanced practice nurse/physician's assistant, or
3. The patient boarded (time from Decision to Admit (order) to ED departure for admitted patients) in the ED for longer than **4 hours**, or
4. The patient had an ED length of stay (LOS) (time from ED arrival to ED physical departure as defined by the ED depart timestamp) of longer than **8 hours**.

<u>History of the Measure</u>

In January 2024, the Yale Center for Outcomes Research and Evaluation (CORE), being contracted by CMS to develop a measure of emergency care capacity and quality for the Hospital OQR Program, issued a request for public comment on an earlier iteration of this measure, with the outcomes differing slightly:

1. *The patient waited longer than 1 hour to be placed in a treatment space in the ED.*
2. *The encounter ended without the patient undergoing a completed medical screening examination (MSE) by qualified medical personnel (QMP).*
3. *The patient boarded (time from admission order to patient departure from the ED for admitted patients) in the ED for longer than 4 hours.*
4. *The patient had an ED length of stay (LOS) (time from ED arrival to ED departure) of longer than 8 hours.*

[1] Hsuan C, Segel JE, Hsia RY, Wang Y, Rogowski J. Association of emergency department crowding with inpatient outcomes. Health Serv Res. 2023 Aug;58(4):828-843. doi: 10.1111/1475-6773.14076. Epub 2022 Oct 12. PMID: 36156243; PMCID: PMC10315392.
[2] do Nascimento Rocha HM, da Costa Farre AGM, de Santana Filho VJ. Adverse Events in Emergency Department Boarding: A Systematic Review. J Nurs Scholarsh. 2021 Jul;53(4):458-467. doi: 10.1111/jnu.12653. Epub 2021 Mar 31. PMID: 33792131.

ACEP made extensive comments on these outcomes, and we appreciate that Yale CORE incorporated some of our suggestions into the final version now up for recommendation consideration. Our suggestions and Yale's responses included the following:

*Outcome 1: The patient waited longer than **1 hour** to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination*

Due to the boarding crisis, emergency physicians administer care in any available physical space they can find, including hallway stretchers, hallway chairs, overflow tents, and even chairs in the waiting room. Thus, we had recommended that "treatment space" as written in the initial outcome be revised as "treatment room or a dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination," and that hallway beds and public waiting rooms should be explicitly excluded from the definition of treatment space/room. We appreciate that our suggestion was accepted by Yale CORE.

*Outcome 2: The patient left the ED without being evaluated by a physician/advanced practice nurse/physician's assistant*

Outcome 2 previously used the terminology "medical screening exam" (MSE), and ACEP expressed concern due to ambiguity and variation of possible definitions of this term. While an MSE is a legal concept in the context of the Emergency Medical Treatment and Labor Act (EMTALA), Yale CORE proposed to use electronic health records (EHRs) as the means of reporting this measure. We expressed concern that there may be inconsistencies between sites and institutions with respect to what constitutes an MSE, despite the legal definition. Thus, we appreciate the new wording offered in this outcome.

We further asked for clarity on the inclusion of patients who leave the ED without being seen (LWBS) and patients leaving the ED against medical advice (AMA) in this measure, with recommendation for inclusion of the former, and exclusion of the latter. We appreciate the clarification and acceptance of our suggestions in the revised version of this outcome's specifications.

*Outcome 3: The patient boarded (time from Decision to Admit (order) to ED departure for admitted patients) in the ED for longer than **4 hours***

ACEP supports the 4-hour maximum timeframe that all admitted patients should remain in the ED between admission order and patient departure referred to in this outcome. We emphasize that this 4-hour threshold should not be treated as a mean or median target but as an absolute maximum limit. Total time in the ED should never exceed 8 hours.

We also feel strongly that future performance targets should move towards shorter time periods as the quality gap closes; for example, a target of 6 hours of total time in the ED and a target of 2 hours from decision/intent to admit to departure. For patients who are admitted to intensive care units (ICUs) and older adults aged 65 and older, who are disproportionately adversely affected by ED boarding, [3,4] boarding times should be kept as short as possible for these high-risk groups.

Outcome 3, as previously written, only applied to admitted patients, including patients who are transferred in from other facilities and admitted at the receiving facility. We requested that ED visits with a disposition status of transfer to another acute care facility (transfer out) should be excluded. Emergency physicians are bound by EMTALA, which requires hospitals to provide a to every individual who "comes to the emergency department." To meet the obligations under EMTALA, larger hospitals in urban areas usually accept rural ED transfers. Rural hospitals often experience difficulty finding destination hospitals to accept patients with needs that extend beyond the capabilities of their rural hospital. Hospitals bear the responsibility of ensuring the prompt care coordination of interfacility transfer patients and should

[3] Mohr NM, Wessman BT, Bassin B, Elie-Turenne MC, Ellender T, Emlet LL, Ginsberg Z, Gunnerson K, Jones KM, Kram B, Marcolini E, Rudy S. Boarding of Critically Ill Patients in the Emergency Department. Crit Care Med. 2020 Aug;48(8):1180-1187. doi: 10.1097/CCM.0000000000004385. PMID: 32697489; PMCID: PMC7365671.

[4] Roussel M, Teissandier D, Yordanov Y, Balen F, Noizet M, Tazarourte K, Bloom B, Catoire P, Berard L, Cachanado M, Simon T, Laribi S, Freund Y; FHU IMPEC-IRU SFMU Collaborators; FHU IMPEC−IRU SFMU Collaborators. Overnight Stay in the Emergency Department and Mortality in Older Patients. JAMA Intern Med. 2023 Dec 1;183(12):1378-1385. doi: 10.1001/jamainternmed.2023.5961. PMID: 37930696; PMCID: PMC10628833.

develop appropriate mechanisms to meet increased patient needs. Thus, we appreciate the updated wording of Outcome 3 and believe that it appropriately addresses our prior concerns.

Measure Stratification

The ECCQ eCQM is stratified into four groups: age (18+/<18) and mental health diagnoses (with, and without). We appreciate the stratification proposed in the measure, as it will help to ensure hospitals address boarding appropriately while remaining fair to external barriers that tend to affect patients with behavioral health needs more than non-behavioral. Additionally, we had previously recommended separating pediatric visits within EDs that see all ages to measure the gravity of the boarding problem for the pediatric population and that whenever possible, pediatric EDs be reported separately from adult EDs at the facility level. Thus, we support the proposed stratification. We additionally see value in further stratifying the age 18+ population group into two groups, patients aged 18-65 and 65+, as geriatric patients are more acutely negatively affected by ED boarding as referenced above.

Measure Calculation

*Standardization*

As written, the ECCQ eCQM will utilize volume standardization to address differences in patient population between hospitals. Volume-standardization is harmonized with other existing measures and accommodates a "like to like" comparison among hospitals. While we agree with this approach for Outcomes 1, 2, and 4, "like to like" comparison is not appropriate for Outcome 3. All hospitals, regardless of ED volume, have an equal opportunity and responsibility to manage the hospital so that boarding times are kept at a minimum. Therefore, while we acknowledge Outcome 3 may vary by hospital size, we recommend reporting without standardization by volume.

*Measure Type*

The ECCQ eCQM is currently formatted as an intermediate outcome measure; a patient encounter that meets one of the outcomes is weighted the same as a patient encounter that meets multiple outcomes. Therefore, from a quality assessment standpoint, it is extremely difficult to discern which of the four outcomes needs the most improvement and impossible to identify any correlations between outcomes. Structuring the measure as a composite measure instead would allow for more granular analysis of specific deficiencies rather than capturing the universe of deficiency as a whole and may allow for analysis of patterns in overlapping negative ED encounter outcomes.

ACEP recognizes that all four outcomes proposed reflect quality gaps in patient experience in the ED. However, we feel that boarding is the number one priority that needs to be measured and rectified. Thus, if the ECCQ eCQM is structured as a composite measure, Outcome 3 should be weighted more heavily than Outcomes 1, 2, and 4 (40% to 20%). While Outcomes 1 and 2 are influenced by boarding, they may also be influenced by other factors (such as ED staffing) that are related to, but not always, downstream effects of boarding.

Applicability to Quality Reporting Programs

The ECCQ eCQM is being considered for the Hospital OQR Program and the Rural Emergency Hospital Quality Reporting (REHRQ) Program, with slightly differing specifications for each program. We strongly encourage inclusion in the Hospital OQR Program but recommend against inclusion in the REHRQ Program.

Facilities designated as REHs have 50 or fewer beds, are required to provide 24-hour emergency and observation services, and can elect to furnish other outpatient services. An REH cannot have inpatient beds, except those furnished in a distinct part unit licensed as a skilled nursing facility. Despite ACEP's prior recommendations, a physician with experience in emergency medicine (either a board-certified emergency physician or a family physician with significant expertise in emergency medicine) is not required to provide the care or oversee the care delivered by non-physician practitioners in an REH; rather, a doctor of medicine (MD) or doctor of osteopathy (DO), a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or expertise in emergency care must always be onsite or on-call and available onsite within 30 minutes, or within 60 minutes if certain frontier or remote area criteria are met.

As such, REHs have constraints that may skew data or have external factors that contribute to extended wait times or boarding outside of the REH's control. For example, as previously mentioned, rural hospitals often experience difficulty finding destination hospitals to accept patients with needs that extend beyond the capabilities of their rural hospital. Thus, the receiving facility should be evaluated for the time from patient admission to patient transfer, rather than the facility that lacks the capabilities necessary to treat the patient.

**Addressing Social Needs Assessment & Intervention**

CORE developed the Addressing Social Needs (ASN) eCQM to measure screening of patients for social needs within four domains – food insecurity, housing insecurity, utility insecurity, and transportation insecurity – as well as if an intervention activity is performed. The ASN eCQM aims to build upon existing measurement by:

- Enhancing the accuracy of measurement by refining social need domain definitions and requiring technical standards for endorsed screening tools;
- Promoting efficiency and alignment across the ecosystem through use of all-payer eCQMs;
- Improving alignment with national health information technology interoperability standards (USCDI); and
- Encouraging follow-up when screening is positive.

The measure is being considered for the Inpatient Hospital Reporting (IQR) Program, the Medicare Promoting Interoperability Program, and the Merit-based Incentive Payment System (MIPS).

It is well documented that racial and ethnic minorities represent a disproportionate share of patients in the ED and are more likely to rely on emergency care for both time-sensitive and non-urgent care needs.[5] We also recognize that much more work needs to be done to address these disparities. Thus, we appreciate CMS' ongoing effort to assess how best to measure health care disparities and report those results to health care providers.

As emergency physicians, we see patients from all social statuses, and both by law and by oath, we treat all patients that come through our doors. EDs serve as the safety net in many communities, providing a place where those who are most vulnerable and those in need of the most immediate attention can receive care. The unique role of emergency medicine positions EDs as potential drivers of health equity given our compulsory commitment to treating every patient.

However, despite the disproportionate representation of social vulnerability in so many ED patients, most EDs do not currently have the necessary resources to screen for and initiate interventions on social determinants of health (SDoH) in their patients. The integration of screening for social needs, including food insecurity, housing insecurity, transportation insecurity, and utility insecurity, could facilitate the allocation of critical resources, such as social workers, case managers, and community health workers into emergency care model, addressing health inequities directly from the ED setting. This additional screening would pave the way for a more streamlined continuum of care, potentially transforming the post-ED outcomes and long-term health trajectories of some the country's most vulnerable populations, as well as reduce costs for low-acuity ED care use for visits in which patients delayed care because they did not have access to a primary care physician or specialist.

However, the current lack of necessary resources to screen for and initiate interventions renders this measure inappropriate for emergency physicians through the MIPS program. Clinicians should not be penalized for their inability to connect patients to necessary interventions due to factors outside of their control. Further, institutions that have the resources to evaluate social drivers of health will perform well on this measure, and therefore choose to report it, which may skew a small subset to high performance. This may cause CMS to judge this measure to be prematurely "topped out" when in fact the majority of clinicians are not reporting on those measures due to the continuing need for improvement. It is in CMS' interest for the health of patients to encourage physicians to continue to improve in

[5] Richardson LD, Norris M. Access to Health and Health Care: How Race and Ethnicity Matter: ACCESS TO HEALTH AND HEALTH CARE. *Mt Sinai J Med.* 2010;77(2):166-177. doi:10.1002/msj.20174.

those areas, rather than drop the measure for reporting. The current topped out process leads to high administrative costs and burden because of the need to frequently implement new processes in order to report new measures and the continuous need for new measures to be developed to replace those topped out measures. In addition, it penalizes clinicians who focus on improving their performance on certain quality measures over time and, in some cases, forces them to switch to new measures that may be less meaningful to their clinical practice.

Further, the institutions that have the necessary resources to effectively implement screening processes for social drivers of health often treat patients that do not experience food insecurity, housing instability, transportation challenges, utility difficulties, interpersonal safety issues, and other negative social determinants of health. Thus, the actual reported data may not accurately capture the measurement intent.

However, collection of this data is still valuable to assessing the social needs of patient populations. Thus, we request that the ASN eCQM be included in the Hospital OQR Program or another data collection program that does not penalize individual clinicians or unfairly penalize institutions that have higher proportions of populations that screen positive. Thus, the measure would serve to identify patterns in SDoH, screening rates, and intervention resource availability, rather than putting the onus on an individual provider.

Thank you for providing the opportunity to comment on this proposed rule. If you have any questions, please contact Erin Grossmann, ACEP's Manager of Regulatory and External Affairs, at egrossmann@acep.org.

Sincerely,

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