American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

February 16, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Equity of Emergency Care Capacity and Quality (ECCQ) Electronic Clinical Quality Measure (eCQM)

Dear Administrator Brooks-LaSure:

On behalf of our nearly 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the Yale Center for Outcomes Research and Evaluation (CORE)-developed Equity of Emergency Care Capacity and Quality (ECCQ) Electronic Clinical Quality Measure (eCQM) for the Hospital Outpatient Quality Reporting (HOQR) program. This measure 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 emergency department (ED) visits that meet at least one of four outcomes:

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.

ACEP commends Yale CORE for developing a measure that addresses boarding in the ED. 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

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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 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.

In November 2022, ACEP and 34 other organizations sent a letter to the White House asking the President to convene a summit or task force on this issue with all affected stakeholders so that we could together collaborate on near- and longer-term solutions. Since we had not yet received a formal response to the letter, ACEP convened our own summit in September 2023 to analyze the causes of boarding, discuss barriers to overcoming these causes, and identify priority areas to pursue in creating systemwide solutions. We were pleased see the recent announcement that the Agency for Healthcare Research and Quality (AHRQ) will work with partners from across the Department of Health and Human Services (HHS) to convene a multistakeholder Director's Roundtable within the next six months.

Measurement is essential to identifying, diagnosing, and solving the complex boarding problem. Unfortunately, our ability to measure this problem is now severely 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 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.

With that context in mind, we offer the following comments addressing the specific topics requested.

Alternative Outcomes for the Measure

Yale CORE seeks comment on inclusion of four outcomes as the numerator. It also seeks comment on any additional outcomes for consideration.

Outcome 1: The patient waited longer than 1 hour to be placed in a treatment space in the ED.

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, ACEP seeks clarification on the definition of "treatment space" within the context of this measure. We recommend "treatment space" be revised as "treatment room or a dedicated treatment area that allows for audiovisual privacy during history-

[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.

taking and physical examination." Hallway beds and public waiting rooms should be explicitly excluded from the definition of treatment space/room.

Outcome 2: The encounter ended without the patient undergoing a completed medical screening examination (MSE) by qualified medical personnel (QMP).

ACEP requests clarification on the definition of "medical screening exam" (MSE) in the context of this outcome due to ambiguity and variation. While this is a legal concept, Yale CORE proposes to use electronic health records (EHRs) as the means of reporting this measure. We are concerned that there may be inconsistencies between sites and institutions with respect to what constitutes an MSE, despite the legal definition.

ACEP seeks clarification on if Outcome 2 refers to patients who leave the ED without being seen (LWBS) before being evaluated by a clinician or leave without treatment (LBT), including patients who have been seen by a triage nurse but have not been examined by qualified medical personnel. We believe this is an important distinction, as LWBS rates have risen sharply in recent years,[3] just as boarding rates have. In addition, research indicates that boarding reduces the throughput of non-boarded patients at a ratio of approximately 4:1, thereby directly affecting LWBS rates.[4] Thus, it is essential to measure both elements of this immense problem. Numerous studies have shown that ED overcrowding, which longer LWBS rates signify, negatively affects patient outcomes.[5,6,7,8] We therefore recommend that this outcome include, at minimum, LWBS.

We also seek clarification if patients leaving the ED against medical advice (AMA) are included in this outcome. Our recommendation is to exclude patients who leave AMA in this outcome. It would be more appropriate for patients who leave AMA to be included in Outcomes 3 and 4, to capture if these patients left AMA *because* they were being boarded.

Outcome 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.

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 note that patients who are admitted to intensive care units (ICUs) and older adults aged 65 and older are disproportionately adversely affected by ED boarding.[9,10] Boarding times should be kept as short as possible for these high-risk groups.

Outcome 3 as written only applies to admitted patients, including patients who are transferred in from other facilities and admitted at the receiving facility. ED visits with a disposition status of transfer to another acute care facility (transfer out) should be excluded. Emergency physicians are bound by the Emergency Medical Treatment and Labor Act (EMTALA), which requires hospitals to provide an MSE to every individual who "comes to the emergency

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[3] Janke AT, Melnick ER, Venkatesh AK. Monthly Rates of Patients Who Left Before Accessing Care in US Emergency Departments, 2017-2021. JAMA Netw Open. 2022;5(9):e2233708. doi:10.1001/jamanetworkopen.2022.33708

[4] Napoli, Anthony & Ali, Shihab & Baird, Janette & Jouriles, Nick. (2022). A Quantitative Assessment of Emergency Department Boarding and its Association with Decreases in Operational Efficiency: A Multicenter Nationwide Study. Academic Emergency Medicine. 29. 10.1111/acem.14560.

[5] Richardson DB. Increase in patient mortality at 10 days associated with emergency department overcrowding. Med J Aust. 2006;184:213-216.

[6] Verelst S, Wouters P, Gillet J-B, Van den Berghe G. Emergency Department Crowding in Relation to In-hospital Adverse Medical Events: A Large Prospective Observational Cohort Study. JEM. 2015;49(6):949-961. doi:10.1016/j.jemermed.2015.05.034.

[7] Sprivulis PC, Da Silva JA, Jacobs IG, et al. The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments. Med J Aust. 2006;184:208-212.

[8] Bernstein SL, Aronsky D, Duseja R, et al. The effect of emergency department crowding on clinically oriented outcomes. Acad Emerg Med. 2008;16:1-10.

[9] 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.

[10] 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.

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 develop appropriate mechanisms to meet increased patient needs. Patients should not receive a lower quality of care because of inefficient hospital flow systems, staff shortages, insufficient beds, ineffective triage systems, or any other failure of planning that results in ED boarding.

Outcome 4: The patient had an ED length of stay (LOS) (time from ED arrival to ED departure) of longer than 8 hours.

ACEP is concerned that the measure may inaccurately capture the true prevalence of boarding in hospitals. Since observation patients are excluded from Outcomes 3 and 4, hospitals could decide to make some inpatient admissions an observation admission first until a bed becomes available. Because observation patients and admitted patients are reimbursed differently, we are concerned that patients will unfairly bear the cost of observation. In fact, this phenomenon is already happening. Some hospitals are leaving patient admissions with low or no reimbursement (such as an admission for nursing home placement for a frail older adult) in the ED so they do not take up a "paying" bed. CMS should consider requiring hospitals to report this measure by aggregate and by insurance type to reveal disparities in care, and to carefully monitor this outcome to ensure that the use of observation does not increase as a replacement for hospitalization. We also recommend that ED visits with a disposition status of transfer to another acute care facility (transfer out) be excluded from Outcome 4. ED visits who arrive as transfers from another acute care facility (transfer in) should be included regardless of final disposition status at the receiving facility as this reflects quality at the receiving facility.

Additional Comments

ACEP is concerned that the numerator groups together too many different concepts which may dilute the effectiveness of properly measuring the boarding problem. We seek clarity on the decision to classify this as an intermediate outcome measure. In its current iteration, this measure would capture a percentage of each ED visit depending on how many of the outcomes were experienced. Another way to structure this measure would be to capture four data points from each ED visit representing the four outcomes. Based on data collection from this measure, CMS could set a benchmark median percentage (i.e., did over 50 percent of ED visits have an ED length of stay of longer than 8 hours?) for hospital quality reporting. Structuring the measure in this fashion 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.

Component Numerator Thresholds

Outcomes 1, 3, and 4 require decision-making about which threshold cut-offs should be used in the final measure. The measure developers seek comment on considerations on these thresholds.

Outcome 3 has a threshold of 4 hours. While ACEP has suggested a threshold of 4 hours in the past, we reiterate that 4 hours is the maximum amount of time that patients should be boarded. We feel strongly that future performance targets should move towards shorter time periods as the quality gap closes.

Weighing of Outcomes

The four numerator components are currently proposed to be weighted equally in calculation of the measure score. The measure developers seek feedback on the weighing of each outcome in measure calculation.

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, we suggest that Outcome 3 be weighed 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.

Inclusion of Equity

Yale CORE recognizes that there are larger access gaps for vulnerable populations that seek care in the ED setting, and as such, all of the proposed outcome components are influenced by social risk factors. Yale CORE also plans to capture and complete analyses with variables such as payer type during alpha and beta testing, in addition to evaluating disparities in access that may be impacted by race, ethnicity, or primary language. Hospitals with a higher proportion of patients with social risk factors that do not have mitigation strategies in place will perform poorly on this measure compared with their peers who do have these strategies. Therefore, Yale CORE proposes not adjusting the measure for social risk factors because adjusting for those factors could potentially hide disparities that are important to consider. Yale CORE seeks feedback on this topic.

ACEP has long supported accounting for social risk factors in Medicare payment programs. ED patients in rural parts of the country, as well as those in medically underserved urban areas, often have many more social risk factors than those in geographic areas that are better served, with less access to the many resources and community services needed to ensure better health outcomes. Inadequate risk adjustments that do not account for these factors could result in unfair penalties for providers that care for the highest acuity low-income patients, creating a perverse incentive that could result in these patients over the long term being further underserved and having their access to care threatened. Therefore, we support Yale CORE's proposal to not adjust for social risk factors as they could hide pertinent information related to social risk factor disparities.

Pediatrics

Yale CORE welcomes feedback on how to address the pediatric population while developing this measure.

Unfortunately, the pediatric population is not immune to the serious ED boarding issue we are facing—particularly those with mental health conditions. During the last decade, pediatric ED visits for mental health conditions have risen dramatically. The COVID-19 pandemic led to a substantial acceleration of these visits, causing several pediatric health organizations to issue a national emergency for children's mental health in 2021 and the U.S. Surgeon General to release an advisory on mental health among youth. According to the Centers for Disease Control and Prevention (CDC), during March–October 2020, among all ED visits, the proportion of mental health-related visits increased by 24 percent among U.S. children aged 5–11 years and 31 percent among adolescents aged 12–17 years, compared with 2019.[11] Further, a metanalysis conducted in 2020 illustrates the detrimental effects of boarding among the pediatric population. Multiple studies show that pediatric patients with mental health conditions who are boarded are more likely to leave without being treated and less likely to receive counseling or psychiatric medications. Beyond mental health, children with other health care conditions are experiencing similar ED wait times as adults.

Thus, we commend Yale CORE for their consideration of the unique challenges associated with pediatric patient boarding within the broader context of the boarding problem. We strongly recommend separating pediatric visits within EDs that see all ages to measure the gravity of the boarding problem for the pediatric population. Whenever possible, pediatric EDs should also be reported separately from adult EDs at the facility level.

ED Observation Stays

Yale CORE proposes only measuring ED observation stays for the applicable outcomes: Outcome 1: waited longer than 1 hour to be placed in a treatment space in the ED; and Outcome 2, did not receive evaluation or treatment. Due to widespread variation in the use of observation between facilities, we believe observation should currently be excluded for Outcomes 3 and 4 in order to not penalize facilities appropriate using ED observation for patients whose anticipate length-of-stay is less than 24 hours.

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[11] Radhakrishnan L, Leeb R, et. al. (2022). Pediatric Emergency Department Visits Associated with Mental Health Conditions Before and During the COVID-19 Pandemic — United States, January 2019–January 2022. MMWR Morb Mortal Wkly Rep 2022; 71(8);319-324. https://www.cdc.gov/mmwr/volumes/71/wr/mm7108e2.htm.

For observations that result in inpatient hospitalization (instead of discharge home), ACEP seeks clarity regarding whether the outcome is measured from the time of observation order or from the time of the inpatient admission order. In some cases, observations resulting in inpatient hospitalization may be considered for inclusion in Outcomes 3 and 4. However, due to variation in the use of observation between facilities, we believe the most cautious approach would be to exclude these altogether at this time.

Behavioral Health Stratification

The measure is currently proposed to have two cohorts: one for patients with behavioral health disorders (psychiatric and substance use disorders) and one for patients without behavioral health disorders. ACEP supports this stratification 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.

Patients with behavioral health needs are disproportionately affected by ED boarding, waiting on average three times longer than medical patients because of significant gaps in our health care system. While the ED is the critical frontline safety net, it is not ideal for long-term treatment of mental and behavioral health needs. Research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location – away from the active and disruptive ED setting – have their symptoms resolve to the point they can be discharged in less than 24 hours.[12] However, far too many Americans have limited options for accessing outpatient mental health care. This can exacerbate ED boarding from two directions: on one end, as patients who can't access outpatient treatment may then enter into a crisis that requires an ED visit; and from the other end, a lack of available outpatient follow-up care prevents patients from being discharged from inpatient psychiatric care and freeing up a bed for the next admission waiting in the ED.

Measure Score Calculation

Yale CORE is proposing that the measure score be first calculated at the individual ED level as the proportion of ED visits where any one of the four outcomes occurred. Scores will be standardized z-scores by ED case volume strata (defined in ED visit volume bands of 20,000 visits). For CCNs with more than one ED, volume-adjusted z-scores are then combined as a weighted average for that CCN. The measure score for the individual ED is reportable, but the z-scores are intended for use in payment programs. A z-score of greater than zero means worse performance and less than zero means better performance, compared to like EDs.

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. It is well demonstrated that EDs that have higher volumes and adult patient mix will have longer patient processing times.[13,14,15] Like to like hospital comparison (in the volume cohorts that were proposed) is appropriate for Outcomes 1, 2 and 4.

Additional Comments

Yale CORE proposes no exclusions applied to the denominator (thus, the denominator would be all ED visits). It is important to ensure that these can be auto-extracted from an EHR in almost all EDs in order to avoid too much administrative burden from any potential manual chart abstraction.

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[12] Zeller, S. High-Acuity Psychiatric Emergency Care and EmPATH Units: Effective, Humane Alternatives to Psychiatric Patient Boarding. 2020.

[13] Jeanmonod, D., & Jeanmonod, R. (2018). Overcrowding in the Emergency Department and Patient Safety. InTech. doi: 10.5772/intechopen.69243

[14] Cha WC, Shin SD, Cho JS, Song KJ, Singer AJ, Kwak YH. The association between crowding and mortality in admitted pediatric patients from mixed adult-pediatric emergency departments in Korea. Pediatric Emergency Care. 2011;27(12):1136–1141

[15] National Hospital Ambulatory Medical Care Survey: 2015 Emergency Department Summary Tables. Hyattsville, Md. :U.S. Dept. of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Health Statistics.

ACEP applauds CMS for developing a measure to address such an immense and overwhelming issue for emergency physicians and patients everywhere. We appreciate the opportunity to provide comments in order to strengthen the measure and improve care for patients. If you have any questions, please contact Erin Grossmann, ACEP's Manager of Regulatory and External Affairs, at egrossmann@acep.org.

Sincerely,

Aisha T. Terry, MD, MPH, FACEP
ACEP President