February 15, 2024

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

To our colleagues at The Centers for Medicare & Medicaid Services (CMS) and Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE):

Thank you for the opportunity to review and provide feedback regarding the proposed measures of emergency care capacity and quality. As the organization representing over 26,000 Nurse Practitioners providing emergency care, the American Academy of Emergency Nurse Practitioners (AAENP) appreciates the attention of CMS and Yale CORE to invite conversations which are aimed at ensuring accurate reporting of key components of emergency department (ED) care.

While some routine data collection within EDs can be used for exploration of social determinants of health (SDOH)[1], there is no validated and standardized screening tool targeting collection of SDOH variables widely used within ED settings. Encouraging the adoption of evidence-based practices and innovative approaches to measuring and addressing social risk factors can drive meaningful improvements in healthcare outcomes for all patients[2]. The suggested metrics and outcome measures provide opportunities for robust sub-analyses which may further describe the variation in equity of emergency care and measuring the capacity and quality of emergency care.

Comments and considerations for the following specific measures are included below.

1. **Alternative outcomes for the measure.** The identified four outcomes are inclusive and appropriate for circumstances to capture all patients presenting for ED care.

2. **Component numerator thresholds.**

   Criterion #1: Waited longer than 1 hour to be placed in a treatment space in the ED.
   - "Treatment space" needs to be defined with broad and inclusive awareness to physical space limitations in some EDs.
   - Is this measured only based on admitted patients?
   - How would "teletriage" be included?
   - Why one hour? Would appreciate understanding why this timing threshold was selected.
   - **Severity of Condition** - It's essential to consider the severity of patients' conditions when assessing wait times. Patients with more severe conditions requiring urgent attention should ideally be prioritized to minimize the risk of adverse outcomes. Therefore, stratifying wait time data based on triage categories (e.g., emergent, urgent, non-urgent) **could provide a clearer understanding of how wait times impact patients' health outcomes and equity**.

   Criterion #3: Boarded in the ED for longer than 4 hours. Agree this is an appropriate measure, but need to simultaneously consider the following:
   - Was boarding due to no bed availability (i.e., hospital at capacity)?
   - Was boarding due to insufficient staffing?

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- Was boarding due to lack of specialty unit type (ICU, behavioral health, e.g.) or bed type (e.g., isolation, obstetrics, pediatrics)?
- Was boarding due to delays in transfer to another facility?
- Clarification of timelines – time to bed assignment vs. physical transfer to in-patient bed area

Criterion #4: Had an ED length of stay longer (LOS) than 8 hours. Similarly, we agree this is an appropriate measure, but this requires definition of start and stop for LOS (does the clock stop when disposition determined or when the patient physically leaves the ED?).

3. **Weighting of outcomes.** While unadjusted data may be most representative, some nuances in unique care settings and delivery must be recognized as inherent factors. These are listed below at the conclusion of our response. Additionally, with consideration of the disparities in healthcare access and outcomes experienced by historically marginalized and vulnerable populations, weighting of outcomes based on their potential to exacerbate health inequities can be beneficial.

4. **Inclusion of equity.** It is important to recognize that while there are many contributors to SDOH, the current ED landscape and traditional data collected in this setting is limited. For this reason, AAENP supports non-weighted outcomes for social risk factors.

   However, SDOH must be considered during data interpretation as the **populations serviced by different EDs will vary (e.g., EDs equipped to care for specific populations such as pediatrics, psychiatric, obstetrics, and older adults[3])**. The importance of considering both socioeconomically deprived areas and an individual's SDOH cannot be over-emphasized [Powell]. We have concerns regarding developing measures which may ultimately result in penalties for failing to satisfy measures with thresholds that do not account for the impact of SDOH.

   The following considerations may provide additional valuable insights:

   - **Care Coordination and Discharge Planning** – Lengthy ED stays may indicate challenges in care coordination and discharge planning, particularly for patients with complex medical needs or limited social support. Evaluating the effectiveness of discharge planning processes, including communication with primary care providers, arranging follow-up appointments, and facilitating access to community resources, can help identify opportunities for improving transitions of care and reducing ED LOS disparities.
   - **Effect on Patient Experience and Satisfaction** – Prolonged ED stays can negatively impact patients' experience and satisfaction with care, potentially exacerbating disparities in healthcare access and quality. Collecting patient feedback and incorporating their perspectives into quality improvement initiatives can provide valuable insights into the lived experiences of patients during extended ED stays and inform strategies for enhancing patient-centered care delivery.

   Acknowledging that social risk factors extend beyond race and ethnicity is crucial for ensuring a comprehensive approach to equity in healthcare. Factors such as socioeconomic status, geographic location, educational attainment, housing stability, access to healthcare, transportation, and social support networks can significantly impact individuals' ability to access and navigate healthcare services which also places a burden on ED care delivery. By considering a

broad range of SDOH, measures can more effectively identify and address disparities in ED care quality.

5. **Pediatrics.** As with the inclusion of equity, pediatric patients must be considered in the context of SDOH. Paying special attention to at-risk and vulnerable pediatric populations is essential for addressing health disparities and promoting equity in pediatric emergency care. Vulnerable groups, such as children from low-income families, children with disabilities and certain medical conditions, those experiencing homelessness and abuse (including human trafficking) may face unique barriers to accessing and receiving quality healthcare services.

6. **ED observation stays. AAENP advocates for exclusion of this population from the numerator.** Current staffing models frequently utilize different staff, reporting and documentation for patients in an ED observation status[4]. Patients in ED observation stays often have time limits imposed by regulatory or clinical guidelines, and their care experience is influenced by various factors such as consults, staffing levels, and the need for diagnostic testing and procedures. In fact, distinct metrics for care delivery during ED observation stays currently exist[5]. For each of these reasons, **the ability to capture accurate data for this subset of ED patients is compromised and should therefore be addressed as a separate entity**.

7. **Behavioral health stratification.** This measure is less clear as described, and we caution that there are additional considerations which may impact this metric. **We recommend that behavioral health stratification be defined as presenting & pre-existing diagnoses**.

8. **Measure score calculation:** We support the proposed methodology for calculating and standardizing z-scores by ED case volume strata is robust and aligns with best practices in quality measurement and benchmarking. However, this approach limits the ability to distinguish facility-level data, removing the option for future sub-analyses which may be helpful in exploring SDOH. By providing a standardized framework for comparing performance across EDs, this approach supports equitable evaluation of care quality and incentivizes continuous improvement efforts to optimize patient outcomes in emergency care settings.

9. **Measurement period –** Given the complexity of these measures and multiple influencers on both data collection and reporting, we do not feel that one year is enough time. We advocate for a 6-month pilot for incorporation of appropriate screening tools and baseline data collection, followed by a one-year data collection period.

As an organization, we believe that the suggested measures are aligned with the project aims. The proposed outcomes for assessing ED care align with the goal of promoting health equity by addressing variations in access, quality, and timeliness of emergency care. Monitoring and addressing these outcomes are crucial steps toward ensuring equitable healthcare delivery for all patients.

In summary, **additional clarification is needed regarding conceptual and operational definition of measures** (e.g., length of stay) which ultimately determine the accuracy of measures. **We are concerned that additional unique situations influencing ED capacity and quality are not clearly identified.** The following questions remain after thorough review of the proposal:

- Will smaller EDs such as critical access and frontier designated facilities be included and held to the same standards?

- Will staffing of providers (NP or PA only versus physician plus NP or PA) be considered in the metrics?
- Will nursing shortages be considered?

Encouraging the adoption of evidence-based practices and innovative approaches to measuring and addressing social risk factors can drive meaningful improvements in healthcare outcomes for all patients[2,6]. The suggested metrics and outcome measures provide opportunities for robust sub-analyses which may further describe the variation in equity of emergency care and measuring the capacity and quality of emergency care.

AAENP welcomes the opportunity for continued dialogue and collaboration. Thank you for your consideration of this feedback.

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References:

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