February 16, 2024

Yale New Haven Health Services Corporation
Center for Outcomes Research and Evaluation (CORE)

Submitted electronically to https://yalesurvey.ca1.qualtrics.com

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

Dear CORE reviewers:

The American Nurses Association (ANA) thanks CORE and the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on Equity of Emergency Care Capacity and Quality (ECCQ) Electronic Clinical Quality Measure (eCQM). ANA is the premier organization representing the interests of the nation's over 5 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. ANA members also include the four advanced practice registered nurse roles (APRNs): nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs). RNs serve in multiple direct care, care coordination, and administration leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members.

ANA firmly supports the integration of health equity throughout CMS programs. Providing equitable care to patients has long been an ethical imperative for the nursing profession. Nurses embrace diversity and engage in equity focused care, while working to remove unconscious biases to effectively promote meaningful patient outcomes. Ultimately, nurses are key in designing, directing, and delivering care that appropriately meets the needs of patients, improves access to needed care, promotes positive outcomes, and reduces disparities. Nurses, in addition to providing quality care to patients, often serve as advocates for their patients and are best positioned to identify factors that could result in inequitable health outcomes.

APRNs play an important role in ensuring equitable access to care across the care spectrum and especially in emergency care. ANA has long advocated for policy improvements to expand access to care provided by APRNs, including removal of unnecessary federal barriers to APRN practice. Such policy improvements have been indicated by the National Academy of Medicine (NAM) at least since its 2011 Future of Nursing report; and again in NAM's 2021 report. Federal experts are unequivocal that APRNs

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should be able to practice to the full extent of their education and training. By removing these unnecessary barriers more highly qualified APRNs can fill provider gaps in emergency departments and be critical partners for obtaining the objectives of the ECCQ eCQM.

ANA supports this measure and its goal of achieving more equitable emergency department (ED) care for all patients. The measure will only be as useful as the data collected. ANA asks that CMS include screening tools and pilot timeline for implementation that ensures the data collected under the measure is high quality and useful for solving disparate outcomes. Additionally, care coordination and discharge planning are important factors for consideration. Nurses drive these pieces of the treatment plan and are necessary for successful patient care and satisfaction. CMS should consider where and how these factors can be captured to ensure quality equitable care.

Questions

1. Alternative outcomes for the measure

An additional metric that should be included is a patient satisfaction score. An important part of delivering equitable health care is establishing a provider-patient relationship that leaves the patient feeling truly heard. Whether trust is built impacts a patient's adherence to treatment plans. Patient satisfaction is impacted by the other factors measured in these criteria. The correlation between success of the other criteria and patient's satisfaction will give more pinpointed information for equity of care.

Another factor that impacts the length of ED stays is the provider turnover. Not only are there less providers seeing patients causing longer waits, but this can also reduce the overall years of experience of current providers. Less overall experience can cause delays in care as higher-level workups are ordered or decisions are delayed.

2. Component numerator thresholds

For criteria one, adding triage level is important data as practically only emergencies are bedded in less than one hour. Counting the severity of condition and co-morbidity as well as whether this is a vulnerable population such as geriatric or pediatric will be important to know here because these populations have very different needs. For example, geriatric populations have a completely separate set of emergency care guidelines.[1] Additionally, defining "treatment space" is necessary as the use of hallways, closets, and more is now the regular process in EDs rather than the exception. Finally, with more reliance on technologies to mitigate ED flow, will "tele-triage" be included in this numerator and how will that impact this data?

For criteria three, specifying the difference between boarding time and time when inpatient treatment actually begins is critical. This is the heart of delays in care leading to disparate outcomes. "Prolonged

[1] Shih, R. D., et al. *Balancing vision with pragmatism: the geriatric emergency department Guidelines – realistic expectations from emergency medicine and geriatric medicine*, Journal of the American Geriatrics Society, May 2022, available at: https://pubmed.ncbi.nlm.nih.gov/35181186/.

boarding in the emergency department has been associated with longer duration of mechanical ventilation, longer ICU and hospital length of stay, and higher mortality."[2] We suggest separating out bed availability, insufficient staffing, and lack of specialty unit for actionable data results. As above, determining the age and whether this is a behavioral health patient is important to know.

For criteria four, the overall question should be why. Was it an MRI that could have been done as an outpatient that delayed to this level? Was it the impact of staffing? We suggest considering staffing models in their impact on this threshold.

3. Weighting of outcomes

Based upon the feedback CORE receives in comments on this measure, we suggest when weighting outcomes there should be separation into subcategories for each numerator. Solutions to this complex problem, especially with boarding, require more in-depth data. Boarding times in the ED is a problem beyond the ED, including nursing facility shortages and staffing challenges.[3] It is important to utilize this measure data while looking holistically at all CMS programs from an equity perspective as well as impact on EDs.

4. Inclusion of equity

ANA strongly agrees that not adjusting for social risk factors is critical for this measure. While adjusting for social risk factors in other contexts is correct practice, for identifying necessary data in this specific measure we believe adjustments could hide key details. Evidence continues to show that patients of color more often leave without being seen and are boarded longer in the ED. It will also be important to include the factors of lack of access to high quality primary care and specialists. Communities of color consistently report more barriers to these essential health services causing escalation of their conditions and reliance on ED care for ongoing conditions.[4] It will also be important to include all social determinants of health that identify the impact on LGBTQ+ communities – especially gender-expansive populations, people with disabilities, and all vulnerable populations.

5. Pediatrics

The impact on pediatric patients, especially those with behavioral health conditions, when boarded for extended times is severe. This measure should include analysis for social determinants of health in pediatric populations as well. As EDs are main intervention points for human trafficking and sexual abuse victims, especially among young patients, sub-analysis is critical in this metric and screening for these interventions means these populations have longer stays.

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[2] Nicholas M Mohr, et al., *Boarding of Critically Ill Patients in the Emergency Department*, Crit Care Med, August 2020, available at: https://pubmed.ncbi.nlm.nih.gov/32697489/.

[3] Mariah Taylor, *ED Capacity Issues Nearing Boiling Point*, Beckers Hospital Review, February 9, 2024, available at: https://www.beckershospitalreview.com/care-coordination/ed-capacity-issues-nearing-boiling-point.html.

[4] Layla Parast, PhD, et al., *Racial/Ethnic Differences in Emergency Department Utilization and Experience*, J Gen Intern Med., January 2022, available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8021298/

6. ED observation stays

ANA agrees on including ED observation stays in measure testing. When collecting data on patients admitted for ED observation status, we suggest including whether the patient was adult or pediatric. Additionally, including outcomes of stays due to lack of bed availability and actual 23-hour holds could be more productive than the suggested criteria alone. Additionally, it is no longer regular practice that each ED has ED observation stays. How will this measure impact EDs that do not have them? CMS must clarify if there is a separation of ED observation stays from inpatient hospital observation stays. In EDs without observation stays once the patient is categorized as observation they are then outside ED care. We want to reiterate that the measure should overall open solutions and more detailed data is required to help mitigate the essential problem of excessive boarding.

7. Behavioral health stratification

ANA recommends changing this part of the measure to "diagnoses" or "no diagnoses." It will be important to know if behavioral health patients have diagnoses or fall into other behavioral health categories as these all have different root causes and impact on the ED.

8. Measure score calculation

When calculating the score, ANA suggests not averaging by CMS Certification Number (CCN) as this would hide individual site data and prevent each site from addressing their specific issues. This measure cannot be productive, and solutions focused, if it prevents this kind of identification.

9. Measurement period

As mentioned above, data can only be as good as the process for collecting it. ANA suggests a 6-month pilot for implementing a collection process with assistance from CMS collection tools. Then follow this with a one-year collection period to ensure quality data.

Conclusion

ANA appreciates the goal of this measure and opportunity to provide detailed feedback. If CORE would like any additional information or follow up questions, please contact Tim Nanof, Vice President, Policy and Government Affairs at (301) 628-5166 or tim.nanof@ana.org.

Sincerely,

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cc: Jennifer Mensik Kennedy PhD, MBA, RN, NEA-BC, FAAN, ANA President
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