Equity of Emergency Care Capacity and Quality (ECCQ) Electronic Clinical Quality Measure (eCQM) Public Comment Document

Hospital Outpatient Quality Reporting (HOQR) Program

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Executive Summary

Background

This measure aims to reduce patient harm and improve outcomes for patients requiring emergency care in an emergency department (ED) by addressing the variation in equity of emergency care and measuring the capacity and quality of emergency care. There are long-standing concerns about parameters that impact the quality and timeliness of care in the ED. Currently, there are no national metrics to assess the proportion of patients impacted by the quality of timely ED care.

The purpose of this request for public comment is for the Yale Center for Outcomes Research and Evaluation (CORE) to gain feedback from a broad range of stakeholders (including technical experts, providers, patients, purchasers, and the public at large) on the development of this electronic clinical quality measure (eCQM).

This measure, Equity of Emergency Care Capacity and Quality (ECCQ) eCQM, is being developed under contract with CMS for the Hospital Outpatient Quality Reporting (HOQR) program. The contract name is Development, Reevaluation, and Implementation of Outpatient Outcome/Efficiency Measures, Option Period 4. The contract number is 75FCMC18D0042, Task Order 75FCMC19F0002. The measure is currently under development (anticipated completion is spring 2024), and the specifications are subject to revision based on stakeholder input and further conversations with CMS.

Request for Public Comment

Comments received will inform potential refinements to the measure which is planned for pilot testing this upcoming winter in the hospital outpatient department (HOPD) setting. Yale CORE seeks comment on the measure specifications within this document with specific attention to:

1. Alternative outcomes for the measure
2. Component numerator thresholds
3. Weighting of outcomes
4. Inclusion of equity
5. Pediatrics
6. ED observation stays
7. Behavioral health stratification
8. Measure score calculation
9. Measurement period

Please refer to page 6 for further details on the areas where feedback is requested.

To be considered, comments must be received by 11:59 PM EST on February 16, 2024 by filling out the survey found at https://yalesurvey.ca1.qualtrics.com/jfe/form/SV_bI9ZRmWhCuh4kse. Comments submitted via email to cmsemergencycarecapacity@yale.edu will also be accepted but survey response is strongly preferred.

For questions or concerns please contact cmsemergencycarecapacity@yale.edu.

Title

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

Measurement Period

January 1 – December 31, one calendar year

Measure Type

Intermediate outcome

Measure Description

The primary objectives of this measure are to capture variation in equity of emergency care, and measure capacity and quality of emergency care to support hospital quality improvement. The measure aims to reduce patient harm and improve outcomes for patients requiring emergency care in an emergency department (ED). Emergency care capacity is inclusive of several concepts pertaining to boarding and crowding in an ED. This measure will be designed to align with incentives to promote improved care both in EDs and the broader health system.

The measure intends to capture established outcome metrics that quantify capacity and access of care in an ED. The target population includes patients of all ages and all visits that occur at an ED. There are two separate cohorts for this measure: one for patients without behavioral health disorders, and one for patients with behavioral health disorders.

Definitions

Behavioral Health: Behavioral health generally refers to mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. Behavioral health care refers to the prevention, diagnosis, and treatment of those conditions.[1]

Boarding: The practice of holding patients in the emergency department after they have been admitted to the hospital, because no inpatient beds are available.[2]

Measure Specifications

Data Sources

This measure will be calculated using data from electronic health records (EHRs) from individual EDs, including standalone EDs and those associated with a hospital and/or health system.

Denominator Population:

All ED visits associated with patients of all ages, for all-payers, during the performance period. Patients can have multiple visits during a performance period; each visit is eligible to contribute to the outcome.

Exclusion Criteria:

This measure has no denominator exclusions.

Numerator:

The numerator is comprised of any ED visit in the denominator with a quality gap in access; if the patient experiences any of the following during a visit, the visit is included in the numerator:

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

Numerator Exclusion:

Patients who are admitted to ED observation status will be included in this measure but outcomes for boarding and ED length of stay will not be included as part of the measure score calculation for those patients. These patients will be included in relevant components of the numerator, specifically criteria # 1 and # 2. These patients will be excluded from criteria # 3 and # 4

Stratification:

This measure could be calculated across multiple strata, including pediatric/adult and behavioral health/non-behavioral health categories. Two versions of the measure will be calculated: one for behavioral health visits, and one for non-behavioral health visits. Stratification by age will also be considered for patients less than 18 years of age and patients 18 years of age and older.

Risk Adjustment

The measure 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. Large volume EDs will always be compared to large volume EDs, while smaller volume EDs will always be compared to EDs of similar size. We will collect other demographic data to explore score variation by various social and demographic risk factors.

Measure Score Calculation

The measure score is 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 CCN’s 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 ED’s.

Request for Public Comment Feedback

In this public comment request, CORE seeks feedback on the following topics related to the development of this ECCQ eCQM and its future use. These comments will inform measure development including decisions pertaining to the measure cohort, numerator outcome, risk adjustment, stratification, measure calculation, and intended future use.

Below is a summary of the topics for which feedback is specifically being requested, however CORE welcomes any comments or feedback beyond the topics described below.

1. Alternative outcomes for the measure: We seek comment on inclusion of these four outcomes as the numerator, as well any additional outcomes for consideration. Based on current literature and stakeholder engagement, we propose using the above well-established measures of access to ED care that best capture the entirety of an ED visit.

2. Component numerator thresholds: Three of the four proposed outcomes require decision-making about which threshold cut-offs should be used in the final measure. Thresholds for outcomes #1, #3, and #4 will be explored with measure testing, stakeholder input, and from this public comment.
    a. For criteria #1, waited longer than 1 hour to be placed in a treatment space in the ED. We welcome additional considerations for this criterion.
    b. For criteria #3, boarded in the ED for longer than 4 hours. We welcome additional considerations for this criterion.
    c. For criteria #4, had an ED length of stay longer than 8 hours. We welcome additional considerations for this criterion.

3. Weighting of Outcomes: The four numerator components are currently proposed to be weighted equally in calculation of the measure score. We welcome feedback on alternate approaches to weighting the four outcomes.

4. Inclusion of Equity: Addressing equity is vital to this measure, as heard distinctly from stakeholders, in particular patients and caregivers. As evidenced in literature, 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. We plan 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, CORE proposes not adjusting the measure for social risk factors because adjusting for those factors could potentially hide disparities that are important to consider. We welcome feedback on this topic.

5. Pediatrics: Measure testing will include patients of all ages, and these measure testing results will be further explored through stakeholder engagement. We welcome feedback on how to address the pediatric population while developing this measure.

6. ED Observation Stays: ED observation stays are proposed to be included in the numerator, and we welcome feedback on this decision for inclusion or exclusion. However, we propose only measuring ED observation stays for the applicable outcomes: criteria #1, waited longer than 1 hour to be placed in a treatment space in the ED and criteria #2, did not receive evaluation or treatment.

7. Behavioral health stratification: The measure is currently proposed to have two cohorts: one for patients with behavioral health disorders and one for patients without behavioral health disorders. Further testing will help inform methods of identifying behavioral health diagnoses. We welcome feedback on this stratification approach.

8. Measure score calculation: Described above is the proposed measure score calculation, and we welcome feedback on this approach and consideration for other approaches to calculation.
    a. Volume standardization: It is proposed that the measure scores will be weighted by ED volume, as described in the measure score calculation, and with this the measure will not be risk adjusted.

9. Measurement Period: We welcome feedback on the length of the measurement period for this measure.

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References

1. What is behavioral health? American Medical Association. August 22. https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health.
2. Definition of Boarding. ACEP. https://www.acep.org/patient-care/policy-statements/definition-of-boarded-patient#:~:text=The%20primary%20cause%20of%20overcrowding,no%20inpatient%20beds%20are%20available.