# Summary of Technical Expert Panel (TEP) Evaluation of Measure
# Equity of Emergency Care Capacity and Quality Electronic Clinical Quality Measure (eCQM)

April 2024

**Prepared by:**

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## Background

The Centers for Medicare & Medicaid Services (CMS) contracted with Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (Yale CORE) to develop a measure of equity of emergency care capacity and quality. The measure will be an electronic clinical quality measure (eCQM), titled "Equity of Emergency Care Capacity and Quality Electronic Clinical Quality Measure" (ECCQ eCQM). This project's primary objective is to develop an equity of emergency care capacity and quality that supports hospital quality improvement to reduce harm and improve outcomes for patients needing emergency care. The contract name is Measure & Instrument Development and Support (MIDS): Development, Reevaluation, and Implementation of Outcome/Efficiency Measures for Hospital and Eligible Clinicians, Option Period 4. The contract number is HHSM-75FCMC18D0042.

As part of this project, CORE assembled a national Technical Expert Panel (TEP) of stakeholders, experts, and consumer advocates who contributed their input through the measure design process. This TEP was convened to assemble a group with diverse perspectives and expertise to advise on conceptual, technical, and implementation considerations of the measure under development.

This report summarizes the feedback and recommendations received during the project's second TEP meeting held on April 15, 2024. During the second meeting, CORE presented the results of public comment on the measure specifications, solicited measure importance votes, and requested TEP input on a variety of questions including use of the measure for rural emergency hospitals, logic for inclusion and exclusion for patients transferred in and out of emergency departments, the definition of treatment space, and other stratification options and equity considerations.

## The TEP

In alignment with the CMS Measures Management System (MMS), Yale CORE held a 30-day public call for nominations and convened a TEP for the development of a measure of equity of emergency care capacity and quality. CORE solicited nominations for TEP members via a posting on CMS's website, emails to individuals and organizations identified by the CORE Measure Development Team, and email notifications sent to CMS physician and hospital email listservs. After reviewing the TEP nominations, CORE confirmed a TEP of 23 members (see Table 1 for members). The appointment term for the TEP is from August 2023 to August 2024.

CORE hosted the second meeting for the project on April 15, 2024, via webinar/teleconference. 20 TEP members attended the meeting on April 15, 2024. TEP meetings follow a structured format consisting of the presentation of key issues to discuss for measure development, followed by an open discussion of topics with TEP members.

## Specific Responsibilities of the TEP Members

The role of the TEP is to provide feedback and recommendations on key methodological

and clinical decisions. TEP members are required to:

- Complete and submit all nomination materials, including the TEP Nomination Form, statement of interest, and curriculum vitae;
- Review background materials provided by CORE prior to each TEP meeting;
- Attend and actively participate in TEP conference calls;
- Provide input on key clinical, methodological, and other decisions;
- Provide feedback on key policy or other non-technical issues;
- Review the TEP summary report prior to public release;
- Be available to discuss recommendations and perspectives following TEP meetings and public release of the TEP Summary Report to CMS.

## Second TEP Meeting

TEP Meeting Overview

Prior to the TEP meeting, CORE provided TEP members with a packet of information, including the meeting agenda, updated measure specifications, considerations for rural emergency hospitals, and a description of the proposed discussion items.

During the TEP meeting, CORE solicited feedback from the panel on use of the measure for rural emergency hospitals, logic for inclusion and exclusion for patients transferred in and out of emergency departments, the definition of treatment space, and other stratification options and equity considerations. The CORE staff who presented at the TEP meeting were Dr. Clarissa Myers, Ms. Leianna Dolce, Dr. Arjun Venkatesh, and Dr. Rebekah Heckmann. Following the meeting, TEP members who were unable to join the primary meeting were provided with the meeting recording and the opportunity to provide written feedback.

Below we provide a high-level summary of what was presented and discussed during the TEP meeting, including the written responses of the TEP members unable to join.

*Administrative*

- Ms. Leianna Dolce opened the meeting and reviewed general housekeeping items including a confidentiality reminder, the project funding source, discussion decorum, the meeting agenda, and re-introductions of the CORE team and TEP members. She concluded the administrative section with a review of the TEP role and went over the goals for the meeting.

*Public Comment*

- Dr. Clarissa Myers presented an overview of the public comment period held for the ECCQ measure specifications. She reviewed the sources of the 677 comments and their breakdown into 2,462 independent comments. Next Dr. Myers reviewed the feedback received in various focus areas including general measure, alternative outcomes, the numerator criteria, mental health stratification, pediatrics, scoring, and other categories including ED observation stays, equity and risk adjustment, and the measurement period. Dr. Myers concluded by reviewing the changes made to the measure based

on public comments received.

*Considerations for Rural Emergency Hospitals*

- Dr. Arjun Venkatesh noted that CMS has prioritized consideration of the ECCQ eCQM for use in the REHQR program and gave a high-level overview of REH facilities. He concluded by reviewing a table with considerations for each component of the numerator in this setting.

*Discussion #1: ECCQ in the REHQR Program*

- Dr. Rebekah Heckmann introduced the questions regarding the use of the measure for REH facilities including whether the concept of "transfer boarding" (i.e., time from decision to transfer to ED departure) should be used as a substitute numerator component for criteria #3 (boarding time) for REHs and if ED observation stays should be excluded for REHs as they are in the HOQR measure?
    - TEP members essentially unanimously supported excluding transfer boarding from the REHQR measure, with many TEP members reaffirming the significance of collecting this data for surveillance purposes, and to inform future quality measurement decisions. They stated that accountability for long delays in transfers resided primarily with receiving facilities and mentioned that emergency medical services (EMS) availability may also play a role.
    - TEP members agreed this is a gap in measurement, impacting timeliness and quality of care for patients being transferred between facilities, particularly in rural areas.
    - Several TEP members suggested capturing the process of requesting transfers, detailed through timestamps (decision to transfer, time to transport or ED departure) for testing and future consideration.
    - Ultimately, this discussion highlighted that transfers between EDs is important to measure but that it does not fit well within this specific measure.

*Discussion #2: Transfer Patients*

- Dr. Rebekah Heckmann reviewed the logic table proposed for the inclusion of patients transferred into and out of a facility for each numerator component and solicited TEP input.
    - One TEP member stated that there is an important concept being missed: direct and indirect transfers. Direct transfers occur through the health system, whereas indirect transfers are patients discharged and told to go to a different facility on their own. Capturing the same or next-day visit to another hospital (bounce-back visits) could help capture those transfer patients.
    - TEP members agreed that including transfers in the HOQR measure would disproportionately affect the sending facility, with similar

reasons cited as in the first discussion. They agree with, and recommend, excluding transfers from the LOS criteria. Collecting transfer data for surveillance is of the utmost importance, to raise the issue for future decisions.

*Discussion #3: Definition of a Treatment Space*

- Reviewing the proposed definition of a treatment space recommended by the American College of Emergency Physicians via Public comment on 2/16/2024 and supported by CMS, Dr. Rebekah Heckmann asked TEP members how treatment space should be defined using elements from the EHR based on the recommendation from ACEP above and similar concepts and how patients placed in a room who then go back to an internal waiting area for the remainder of the ED visit should be handled.
    - TEP members gave feedback on major concerns of gaming this criterion and questioned the feasibility of redefining and capturing treatment space as specified. It opens an opportunity for a subjective interpretation of private treatment spaces, and for their use throughout the course of an ED visit. Several TEP members stated that EDs are crowded and simply do not have enough space, so their providers treat patients in all spaces available; they cautioned against the measure penalizing EDs and providers from optimizing their workflow and treating patients sooner, even if in a less optimal treatment space. TEP members reinforced 'vertical flow' models of ED treatment: triaging patients, evaluating them in private rooms, then if stable, returning them to wait for aspects of care in a waiting room, allowing EDs to maximize their space for treatment.
    - TEP members agreed that on an aspirational level, it is the goal and the intent to improve quality of care; however, they were concerned about a potential need for a new data element in electronic health records (EHRs) to capture this new definition of private treatment space;
    - TEP members also discussed licensed beds and regulatory considerations for this numerator criterion, sharing that there is significant variation in definitions and processes by region. They expressed concern regarding burden and that gaming that will occur; hospitals may report that all treatment spaces comply with this definition.
    - Another TEP member mentioned an unintended consequence may be restrictions on seeing patients because there are no compliant treatment spaces available.

*Discussion #4: Measure Stratification and Equity Considerations*

- Dr. Rebekah Heckmann reviewed the related concepts of measure

stratification and equity. She asked TEP members what kind of variables could be used to stratify the measure beyond mental health and how the measure can specifically address equity.

- TEP members provided feedback that it may be beneficial to explore differences between hospitals and patient-level variables. Such options presented included exploring acuity level; safety-net hospitals based on percentage of social security disability insurance (SSDI); race and ethnicity; gender; zip code; and primary language. The TEP members agree on these other elements to capture and explore to inform if any further stratification of the measure should be considered in the future. Measuring and understanding these differences between populations is of great value.
- One TEP member also reiterated support for a non-risk adjusted measure.
- TEP members generally agreed that this measure is a good step towards assessing equality and equity of emergency care, but it does not accomplish that on its own. This is one part of the puzzle towards improving health equity for patients seeking ED care. Hospitals and health systems, and their capacity, is a large driver of this measure's outcome and as such, needs to be considered in that context.

*Measure Importance*

- Ms. Leianna Dolce introduced the significance of the TEP role in assessing measure importance throughout measure development. She reviewed that two statements would be reviewed via survey and two questions would be asked in discussion format as time allowed.
- Members present were invited to complete the poll questions with provided time during the meeting or wait and complete it at a later time the following week. Members not present were invited to participate in the survey after reviewing the meeting materials via email.
- The poll results are as follows for the first statement: The Equity of Emergency Care Capacity and Quality Electronic Clinical Quality Measure is easy to understand and useful for decision making.
  - 4 (26.7%) members voted for “strongly agree”
  - 9 (60%) members voted for “agree”
  - 1 (6.7%) member voted for “neutral”
  - 1 (6.7%) member voted for “disagree”
  - 0 (0%) members voted for “strongly disagree”
  - Members commented that the measure has face validity, can be used to drive quality improvement, and appears to be easy to understand and useful for decision making. It is generally concise and clear, but perhaps may appear to be complex for the public to understand.
  - Members commented that the four components tied together makes the

measure less understandable and more complex, and there are concerns that certain items need further clarification, such as the first criteria's definition.

- The poll results are as follows for the second question: The Equity of Emergency Care Capacity and Quality Electronic Clinical Quality Measure could differentiate good from poor quality care among providers (or accountable entities).
    - 2 (13.3%) members voted for "strongly agree"
    - 9 (60%) members voted for "agree"
    - 3 (20%) members voted for "neutral"
    - 1(6.7%) member voted for "disagree"
    - 0 (0%) members voted for "strongly disagree"
    - Members said there are still gaming opportunities that may limit the measure's ability to differentiate quality of care, but testing, implementation, and improvement can attend to these concerns. A TEP member was concerned that many facilities will have a high percentage of patients waiting longer than one hour to be placed in an appropriate treatment space.
    - Members commented that this is one part of quality and there are essential components of ED care not captured in this measure (case mix, patient outcome) and should be considered in future steps.
    - Members also believed this is a good start, an improvement from existing or prior quality measurement in this space, and it has the potential to be extremely powerful and useful to compare facilities.
- Dr. Rebekah Heckmann introduced the first discussion question asking if the measure addresses health equity, defined as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes".
    - TEP members provided feedback that this measure does not directly address health equity, and perhaps this measure addresses equality more than it addresses equity, which is a limitation of our healthcare system. Furthermore, to the extent that it does address health equity through capturing social determinants of health, it is not necessarily something a hospital can fix given their resources and geography.
- Moving to the final question regarding measure importance, Dr. Rebekah Heckmann asked TEP members if the measure addresses emergency care capacity and emergency care quality.
    - TEP members provided feedback that the ED is one part of the hospital and health system's capacity issues, namely where those issues are most highly visible. It is beyond the ability of one hospital department to solve a system wide issue. This is merely one important step in addressing ED capacity and quality.

*Final Discussion*

- Ms. Dolce revisited the updated numerator language after the public comment period,

as requested by a TEP member.

- The one TEP member noted that they recommend modifying the second criteria (left without being seen) to "left without completion of an evaluation", citing that having a provider in triage is an easy way to game this criterion as currently written.
- TEP members discussed the two options and the cohorts of patients captured by these differing definitions and ultimately decided that the current definition should be maintained in the specifications, as it is consistent with data captured reliably and feasibly from an EHR, routinely tracked by hospitals, and is perhaps clearer as to why patients leave without being seen versus those that leave without completion of treatment.

Conclusion

The TEP provided valuable feedback based upon the guided discussion topics: consideration of applicability in the REHQR program; definition of treatment space; consideration around transfers; stratification and equity considerations; and definition of the left without being evaluated criterion. The TEP was agreeable to applicability of the ECCQ measure in the REHQR program. The TEP was essentially unanimous in their recommendation to exclude transfers from both REHQR and HOQR versions of the measure, citing that sending facilities should not be held accountable for long delays in transfer of patients to another facility. They strongly recommend surveillance on emergency department transfers, as it is an important gap in measurement that relates to quality of care. The TEP provided suggestions and discussed redefining the first and second criteria, particularly around gaming considerations and future implementation considerations, but it did not result in any suggested language changes to the specifications. Lastly, the TEP encouraged consideration of various social risk factors, to explore differences in facilities' patient populations and better understand the social risk these patients experience. The TEP voted on measure importance, and discussed how the measure does not directly address equity, but capturing and reporting the data has value. Lastly, the TEP reiterated caution that this measure may lay responsibility on a single department, the emergency department, when in fact the outcomes to be measured are impacted by drivers of the larger hospital or health system.

## Next Steps

CORE will continue to solicit feedback from TEP members and other relevant stakeholders during the measure development process and will meet again with the TEP to discuss testing results over the summer of 2024.

## Appendix A. List of all TEP Members and Information

*Table 1: TEP Member Name, Affiliation and Location*

| Name | Organization (title); clinical specialty, if applicable | Location |
|---|---|---|
| JohnMarc Alban, MS, RN, CPHIMS | The Joint Commission (Associate Director, Quality Measurement & Informatics) | Oakbrook Terrace, IL |
| David Andrews | Patient/Caregiver Representative | Aiken, SC |
| Kelly Bookman, MD | University of Colorado School of Medicine, UC Health (Professor and Vice Chair of Operations, Senior Medical Director of Informatics) | Denver, CO |
| Joey Braggs | Patient/Caregiver Representative | Detroit, MI |
| Howard Bregman, MD, MS, FAAP | Epic Systems Corporation (Director, Clinical Informatics) | Verona, WI |
| Teresa M. Breslin DeLellis, PharmD, BCPS, BCGP | American Geriatrics Society (Pharmacist) | Fort Wayne, IN |
| Isbelia Briceno, CSPO | Oracle Cerner (Senior Product Manager, EHR Vendor) | Kansas City, MO |
| Lynn Ferguson | Patient/Caregiver Representative | Nashville, TN |
| Mustafa Mark Hamed, MD, MBA, FAAFP, FAEMS | American Academy of Family Physicians (AAFP) (Board Certified Family Physician and Emergency Medical Services Physician) | Novi, MI |
| Jennifer Hoffmann, MD, MS | Northwestern University and Lurie Children's Hospital of Chicago (Assistant Professor of Pediatrics) | Chicago, IL |
| Charleen Hsuan, JD, PhD | Pennsylvania State University (Assistant Professor) | University Park, PA |
| David Levine, MD, FACEP | Vizient, Inc. (Senior Vice President and Chief Medical Officer) | Chicago, IL |
| Kelly McGuire, MD, MPA | EmblemHealth (Medical Director, Behavioral Health) | Katonah, NY |
| Sofie Morgan | University of Arkansas for Medical Sciences (Patient Experience Professional, Emergency Physician) | Little Rock, AR |
| Deepti Pandita, MD, FACP, FAMIA | University of California, Irvine (Associate Professor of Medicine, Chief Medical Information Officer) | Laguna Niguel, CA |
| Anne-Marie Podgorski Dunn, MBA, BSN, RN | Independent (EHR Expert) | West Chester, PA |
| Rupinder K Sandhu, BSN, MBA, MSHSA | UC Davis Medical Center (Executive Director, Emergency Services) | Sacramento, CA |
| Nathaniel Schlicher, MD, JD, MBA, FACEP | Physician and Administrative Leader | Gig Harbor, WA |

| Name | Organization (title); clinical specialty, if applicable | Location |
|---|---|---|
| Jodi A. Schmidt, MBA | University of Kansas Health System (Executive Director, UKHS Care Collaborative Patient Safety Organization) | Westwood, KS |
| Jeremiah Schuur, MD, MHS | St. Elizabeths Medical Center, Chief of Emergency Medicine | Brighton, MA |
| David P Sklar | Arizona State University College of Health Solutions (Physician) | Phoenix AZ |
| Anne Sugrue | Patient/Caregiver Representative | Gaithersburg, MD |
| Benjamin Sun, MD, MPP, FACEP, FACHE | University of Pennsylvania (Perelman Professor and Chair, Department of Emergency Medicine) | Philadelphia, PA |