American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

December 12, 2024

The Leapfrog Group
1775 K St NW #400
Washington, DC 20006

RE: PROPOSED CHANGES TO THE 2025 LEAPFROG HOSPITAL SURVEY

Dear Leapfrog Group:

On behalf of our nearly 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the proposed changes to the 2025 Leapfrog Hospital Survey, including the addition of two measures associated with emergency department (ED) boarding under Section 6E. ACEP appreciates the Leapfrog Group's acknowledgement of the patient safety risks associated with ED boarding of admitted patients and commends the Group for proposing collection of this information. We offer comments on the measure specifications, optionality of measure reporting, and potential enhancements of data collection and reporting.

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Systemic Nature of ED Boarding

Boarding has become its own public health emergency. However, we want to make abundantly clear that boarding is a systemic problem that hinders patients' access to care caused by health system dysfunction related to inpatient capacity constraints rather than ED operational issues or ED inefficiency. Any emergency patient can find themselves boarded for prolonged periods of time, regardless of their acuity, age, insurance coverage, income, or geographic area. Patients in need of intensive care may board for hours even days in ED spaces that cannot accommodate intensity of monitoring they need. Those in mental health crisis, especially 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.

A major driver of long wait times in the emergency department is the boarding of admitted patients in the ED waiting for an available inpatient bed; that is, the mismatch between available bed capacity and demand for those beds. Prolonged boarding leads to negative patient outcomes, as a substantial body of evidence has shown that ED boarding and the resultant crowding lead to increased cases of preventable mortality related to downstream delays of treatment for both high and low acuity patients. 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. Whilst the COVID-19 pandemic undeniably exacerbated boarding prevalence and increased wait times, as mentioned on Page 17 in the proposed changes document, boarding has been identified as a problem for decades.

Because of the relationship between the lack of inpatient hospital capacity (high census)

and ED overcrowding/boarding, we suggest that the Leapfrog Group consider systemic capacity limitations and other factors outside of the ED's control, like licensed bed availability, regulatory neglect, unmanageable hospital census, and risk adjustments for patient complexity and social determinant of health differences, in order to avoid unnecessary penalization or misleading conclusions about ED efficiency. The Leapfrog Group should consider measuring hospital capacity for comparison to ED boarding times to draw attention to the inverse linkages between inpatient bed capacity and ED boarding and overcrowding.

Necessity of Measurement

Measurement is essential to identifying, diagnosing, and solving the complex boarding problem. However, our ability to measure this problem is currently 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. CMS is now considering a new measure, the Emergency Care Capacity and Quality (ECCQ) Electronic Clinical Quality Measure (eCQM), for implementation in the Hospital Outpatient Quality Reporting Program and Rural Emergency Hospital Quality Reporting Program. However, it is unknown yet whether that measure will be recommended for adoption and/or fully implemented in these programs.

Thus, we appreciate that the Leapfrog Group is proposing collection of the following measures, and encourage their adoption into the 2025 Leapfrog Hospital Survey:

- The percentage of ED patients admitted to the hospital that had an ED Boarding time of 4 hours or less (where lower percentages are desirable)
- The average length of stay in the ED for patients admitted to the hospital (where lower averages are desirable)

These measures will be calculated based on the following specific questions:

1) *12-month reporting period used (01/01/2024 – 12/31/2024 or 07/01/2024 – 06/30/2025);*
2) *Did your hospital operate a dedicated emergency department (ED)* during the reporting period? (Yes, No, or Yes, but ED is now closed or wasn't open for the entire reporting period)*
3) *Total number of emergency department (ED) visits (of patients of any age) during the reporting period that were admitted to the hospital's inpatient setting, with Excluded Populations** removed;*
4) *Total number of ED visits indicated in question #3 that had a boarding time*** that was longer than 4 hours;*
5) *Total number of hours spent**** in the ED for ED visits indicated in question #3*

***Patients with an ED visit that are admitted to observation status, but not the inpatient setting, are excluded from the denominator (question #3).*

Note: A patient can have multiple ED visits with a hospital admission during the performance period so each patient ED visit with an inpatient admission is included in the denominator (question #3).

****Boarding time is defined as the difference between the "time from the admission order" to "patient departure from the ED for admitted patients."*

*****Hours spent in the ED is defined as the difference between the "patient arrival time at the ED" to "patient departure from the ED for admitted patients."*

Measure Specifications

4-Hour Threshold

While ACEP appreciates the inclusion of question #4, suggesting a target maximum timeframe of 4 hours that all

admitted patients should remain in the ED between admission order and patient departure referred to in this proposed measure, we emphasize that this 4-hour threshold should reflect the time between decision/intent to admit and patient departure. Thus, this should not be treated as a mean or median target but as an absolute maximum limit, as is supported by the Joint Commission's recommendations. Total time in the ED, as referenced in question #5, should never exceed 8 hours.

We also feel strongly that future performance targets should move towards shorter time periods as the quality gap closes; for example, a target of 6 hours of total time in the ED and a target of 2 hours from decision/intent to admit to departure. For patients who are admitted to intensive care units (ICUs) and older adults aged 65 and older, who are disproportionately adversely affected by ED boarding, boarding times should be kept as short as possible for these high-risk groups.

Observation Stay Exclusion

The Leapfrog Group is proposing to exclude patients that are admitted to ED observation status, but not the inpatient setting, from reporting. There is widespread variation in the use of observation status from hospital to hospital, and we are concerned that fully excluding observation status patients could create a system where hospitals are incentivized to inappropriately convert patients to observation status until an inpatient bed becomes available to avoid poor scores. Careful monitoring and consideration should be given to ensure that the use of observation does not increase as a replacement for hospitalization.

Measure Stratification

We acknowledge that this is the first year of proposed data collection of these measures. However, as the Leapfrog Group continues to collect this data, ACEP suggests that it be parsed into stratified groups based on patient type: age group (pediatric, adult, or geriatric), psychiatric, and medical/surgical. This will help to discern the level of dysfunction (if any) within a particular hospital as compared to external factors outside of that hospital's control that contribute to patient boarding, such as regional specialized bed availability and community resources.

Completeness of Data

ACEP believes that the proposed measures represent a valuable starting point to collect and report ED boarding data. As the Leapfrog Group continues to collect this data, ACEP suggests that the Leapfrog Group consider adding additional measures to fully measure and define the practice of in patient boarding in the ED. One example would be to include the time from arrival to placement in a dedicated ED treatment area. Another consideration would be the proportion of ED encounters that ended without the patient being evaluated by a medically licensed clinician (e.g., physician, advanced practice nurse, or /physician's assistant), as are reflected in the proposed ECCQ eCQM.

Optionality of Measure Reporting

The Leapfrog Group proposes asking hospitals to report on two measures which will be used for fact-finding only in 2025. In the future, ACEP encourages reporting on these measures to be mandatory for all acute care hospitals. We are concerned that because reporting of these data is optional, only those hospitals who will score well on these measures will report, especially if this information is publicly available, therefore skewing the data and underplaying the severity of the nation's boarding crisis.

Thank you for providing the opportunity to comment on the proposed changes to the 2025 Leapfrog Hospital Survey. If you have any questions, please contact Erin Grossmann, ACEP's Manager of Regulatory and External Affairs, at egrossmann@acep.org.

Sincerely,

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