

December 19, 2023

Partnership for Quality Measurement  
505 King Avenue  
Columbus, OH 43201

## RE: 2023 Measures Under Consideration

Dear Members of the 2023-2024 Pre-Rulemaking Measure Review (PRMR) Committee Hospital Workgroup:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the 2023 Measures Under Consideration list. Our comments are limited to the measures specifically pertinent to emergency medicine.

### Age Friendly Hospital Measure

The Age Friendly Hospital measure is under consideration for the Centers for Medicare and Medicaid Services (CMS) Hospital Inpatient Quality Reporting (IQR) Program. Developed in partnership with the American College of Surgeons (ACS), the Institute for Healthcare Improvement (IHI), and ACEP, this measure is meant to help build a better, safer environment for older adults and will help patients and caregivers know where to find good care.

The U.S. population is rapidly aging, and the U.S. health care system struggles to care for older adults. Based on 2019 U.S. Census data, the 65-and-older population grew by over a third since 2010, and by 2030 this population is estimated to grow to 72 million (20 percent of the total population).<sup>1,2</sup> Over one third of all inpatient surgeries are performed on individuals over the age of 65, and frailty is associated with poor post-operative outcomes and increased surgical cost of care.<sup>3,4,5,6</sup> One study showed that only 25 percent of patients undergoing high risk surgery had advance care plans documented.<sup>7</sup>

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<sup>1</sup> United States Census Bureau. 65 and Older Population Grows Rapidly as Baby Boomers Age. 2020. CB20-99. Accessed December 1, 2023. <https://www.census.gov/newsroom/press-releases/2020/65-older-population-grows.html>.

<sup>2</sup> ProximityOne. Demographic Characteristics of the Population Age 65 & Over. Accessed December 1, 2023. <https://proximityone.com/demographics65up.htm>.

<sup>3</sup> Deiner S, Westlake B, Dutton RP. Patterns of Surgical Care and Complications in the Elderly. *J Am Geriatric Soc*. 2014;62(5):829-835. doi: 10.1111/jgs.12794

<sup>4</sup> Collard RM, Boter H, Schoevers RA, Oude Voshaar RC. Prevalence of frailty in community-dwelling older persons: a systematic review. *J Am Geriatr Soc*. 2012;60(8):1487-1492. doi: 10.1111/j.1532-5415.2012.04054.x

<sup>5</sup> Nidadavolu LS, Ehrlich AL, Sieber FE, Oh ES. Preoperative Evaluation of the Frail Patient. *Anesth Analg*. 2020;130(6):1493-1503. doi: 10.1213/ANE.0000000000004735

<sup>6</sup> Wilkes JG, Evans JL, Prato BS, Hess SA, MacGillivray DC, Fitzgerald TL. Frailty Cost: Economic Impact of Frailty in the Elective Surgical Patient. *J Am Coll Surg*. 2019;288(6):861-870. doi: 10.1016/j.jamcollsurg.2019.01.015

<sup>7</sup> Tang VL, Dillon EC, Yang Y, et al. Advance Care Planning in Older Adults with Multiple Chronic Conditions Undergoing High-Risk Surgery. *JAMA Surg*. 2019;154(3):261-264. doi:10.1001/jamasurg.2018.4647

This is even more profound for patients of low socioeconomic status.<sup>8</sup> Hospitals are increasingly faced with older patients who have complex medical, physiological, and psychosocial needs that are often inadequately addressed by the current healthcare infrastructure. In response to this gap in care, the Age Friendly measure was created and built on evidence-based best practices to provider-centered, clinically effective care for older patients.

The Age Friendly Hospital measure is an updated measure that combines two measures previously reviewed by the National Quality Forum's Measures Application Partnership (MAP) in 2022: the Geriatrics Hospital Measure (MUC-2022-112) and the Geriatrics Surgical Measure (MUC-2022-032). While the MAP Hospital Workgroups were very supportive of both measures, they conditionally supported the Geriatric Surgical Measure with mitigating factors: 1) combining the two geriatric measures into a single measure that is less burdensome, or 2) focusing on only one measure. In the 2024 IPPS proposed rule, CMS highlights the need for a comprehensive measure that addresses the aging population during hospital stays and solicited comments on the measure concept. The measure concept has support across organizations who care for older adults and was recently highlighted in Health Affairs.<sup>9</sup>

Based on this feedback, ACS submitted a new single combined measure, the Age Friendly Hospital Measure. The new streamlined measure now includes domains which target high-yield points of intervention for older adults-- Eliciting Patient Healthcare Goal, Responsible Medication Management, Frailty Screening and Intervention (i.e., Mobility, Mentation, and Malnutrition, Social Vulnerability (social isolation, economic insecurity, ageism, limited access to health care, caregiver stress, elder abuse), Age Friendly Care Leadership. The new measure encourages hospital systems to reconceptualize the way they approach care for older patients with multiple medical, psychological, and social needs at highest risk for adverse events. It also puts an emphasis on the importance of defining patient (and caregiver) goals not only from the immediate treatment decision, but also for long-term health and aligning care with what the patient values.

The concept behind the programmatic measure is based on several decades of history implementing programs that demonstrably improve patient care provided by the clinical team along with the facility. The Age Friendly Hospital Measure incorporates elements of the Institute of Healthcare Improvement's (IHI) Age Friendly Health Systems program known as the 4Ms (What Matters, Medications, Mentation, Mobility), standards from the Geriatric Emergency Department Accreditation (GEDA) framework developed by the American College of Emergency Physicians (ACEP), and ACS Geriatric Surgical Verification (GSV) standards. The programmatic approach is modeled after ACS quality programs, which lead to demonstrable improvements in patient outcomes across a broad range of populations.

### Geriatric Emergency Department Accreditation (GEDA)

GEDA was developed by leaders in emergency medicine to ensure that our older patients receive well-coordinated, quality care at the appropriate level at every emergency department (ED) encounter. Geriatric emergency departments (GEDs) incorporate specially trained staff, assess older patients in a more comprehensive way, and take steps to make sure the patient experience is more comfortable and less intimidating for older adults. All of this allows for a better care experience for older adults while in the ED and safer transitions to a community setting for those who do not need medical admission. An accredited GED has four key areas of differentiation from a traditional ED. First, physicians and nurses receive additional education in geriatric emergency medicine that provides added expertise in the emergency care of older adults. Additional education focuses on:

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<sup>8</sup> Waite KR, Federman AD, McCarthy DM, et al. Literacy and Race as Risk Factors to Low Rates of Advance Directives Among Older Adults. *J Am Geriatric Soc.* 2013; 61(3):403-406. doi: 10.1111/jgs.12134

<sup>9</sup> Snyder RE, Fulmer T. The Need for Geriatrics Measures. *Health Affairs.* April 14, 2023. Accessed December 1, 2023. <https://www.healthaffairs.org/content/forefront/need-geriatrics-measures>.

- Geriatric specific syndromes and concepts (e.g., atypical presentation of disease, changes with age, transitions of care) relevant to emergency medicine,
- Clinical issues nearly exclusive to geriatric patients (e.g., end of life care, dementia, delirium, systems of care for older adults), and
- Issues common to all ED patients but focused on the unique factors found in older adults (e.g., trauma in older adults, cardiac arrest care for the geriatric patient)

Second, GEDs have enhanced screening processes. Patients receive additional screenings that can quickly uncover physical or mental health risks that are more common in older adults. For example, screening tools uncover geriatric syndromes (like falls, polypharmacy, delirium, dementia) as well as social vulnerabilities (like food scarcity or elder mistreatment).

Third, GEDs are often supported by interdisciplinary team members that help provide enhanced community connections for the most vulnerable older adults, as well as focus on transitions of care. Team members can reach out to the local agency on aging, services like Meals on Wheels, physical therapy providers and home health agencies, or help facilitate direct to skilled nursing facility (SNF) transfers when an in-patient admission is not required.

Finally, a GED is usually not a separate space or standalone ED, but rather has structural enhancements to the physical environment that make the experience more conducive to older adults. Oftentimes this includes a designated, quieter, cordoned-off space within an ED, light dimmers, non-stick flooring to minimize falls, comfortable space for caregivers in the ED, or the inclusion of handrails.

There are accredited GEDs all across the country in a wide range of settings. Of GEDA’s 473 accredited sites, 111 (23.5%) are classified as rural. Rural geriatric patients deserve the same quality level of health care as patients in more urban areas, and it is possible to advance towards greater health equity for rural geriatric patients through the use of GEDs.

### ED Boarding

In our comments on the 2024 IPSS proposed rule, ACEP was supportive of the potential inclusion of the Geriatric Hospital measure in the IQR program. However, we expressed concern about the omission of “boarding” in the ED. Boarding is a situation where patients are kept waiting in the ED for hours, days, or longer due to the lack of available inpatient beds or space in other facilities where the patient could be transferred. Boarding has hit crisis levels, and in November 2022, ACEP and 34 other organizations wrote a [letter to President Biden](#) asking his Administration to convene a summit on this issue with all impacted stakeholders so that we can together collaborate on near- and longer-term solutions. In September 2023, without action from the federal government, ACEP convened our [own summit of stakeholders](#) across health care to discuss the factors contributing to the boarding crisis and strategies to pursue collaborative solutions.

Even with the worst of the COVID-19 pandemic now behind us, EDs all over the country are at, or even past, the breaking point, with no relief in sight. It led to a [nurse in Washington calling 911](#) as her ED became completely overwhelmed with waiting patients and boarders. Her story is not unique – it is happening right now in EDs across the country, every day. To paint a broader picture of the distressing scope of the ED boarding problem, ACEP collected hundreds of firsthand accounts from emergency physicians who have [shared their stories](#) from the front lines.

Boarding affects patients of all kinds, regardless of their condition, age, insurance coverage, income, or geographic location. These excessive waits for needed care directly harm patients through worse outcomes, increased risk of medical errors, and even avoidable deaths.<sup>10,11</sup> One emergency physician account noted that in addition to average boarding times of more than 70 hours at their hospital, “...we have patients who unfortunately have died in our waiting room while awaiting treatment. These deaths were entirely due to boarding.”

Boarding in the ED also disproportionately affects more vulnerable and historically disadvantaged populations. One study found that Black patients wait for about one hour longer than non-Black patients before they are transferred to an inpatient bed.<sup>12</sup> Another found that cognitive stressors, specifically overcrowding and patient load, are associated with increased implicit bias that may affect patient care.<sup>13</sup> Those with acute psychiatric conditions, especially children and adolescents, are particularly hard hit by boarding and may board for months at a time in noisy, chaotic EDs as they wait for an available psychiatric inpatient bed to open up somewhere. A November 2023 JAMA article found that older patients (aged 75 years and older) who spent a night in the ED, particularly those with limited autonomy during that stay, had a higher in-hospital mortality rate, increased risk of adverse effects, and increased median length of stay than their counterparts who were admitted to a hospital ward before midnight.<sup>14</sup> In other words, older patients who had to wait in the ED for a hospital bed died waiting.

All the above-described long wait times are entirely outside of the control of the ED; rather, they are the product of a multitude of factors, including decades’ worth of misaligned economic incentives and systemic faults. These stressful working conditions only serve to accelerate the record levels of physician and nurse burnout as these professionals simply do not have the resources to keep up with the volume of patients coming in. As one emergency physician describes, “These kinds of working conditions are NOT sustainable, yet similar conditions continue all over the country. It’s like a warzone everyday. No wonder doctors and nurses are leaving healthcare in droves and rates of depression and suicide are so high- working in those conditions day in and day out, not being able to provide the care and treatments we know patients need.” The alarming health care workforce shortages that continue to worsen have been a major driver to the growing boarding crisis, which itself leads to more burnout, causing more to leave health care altogether and sending the nation’s emergency care system further into its spiral towards collapse.

Thus, we are appreciative of the inclusion of Domain 3, attestation 6: “*Protocols exist to reduce the risk of emergency department delirium by reducing length of emergency department stay with a goal of transferring a targeted percentage of older patients out of the emergency department within 8 hours of arrival and/ or within 3 hours of the decision to admit.*” However, we acknowledge that the inclusion of this attestation represents a minimum starting point for measuring boarding in the ED. We implore CMS to consider the boarding crisis in future considerations of measure reporting programs.

### Attestation-Based Measurement

A hospital’s score on the Age Friendly Hospital measure is based on the hospital’s attestation of each domain. Though the inclusion of this measure in the IQR program would not require quantitative metrics, we believe that implementation of the measure would still support evidence-based best practices to improve emergency care for older

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<sup>10</sup> Morley C, Unwin M, Peterson GM, Stankovich J, Kinsman L. Emergency department crowding: A systematic review of causes, consequences and solutions. *PLoS One*. 2018;13(8):e0203316. <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0203316>.

<sup>11</sup> Berg LM, Ehrenberg A, Florin J, Ostergren J, Discacciati A, Goransson KE. Associations between crowding and ten-day mortality among patients allocated lower triage acuity levels without need of acute hospital care on departure from the emergency department. *Ann Emerg Med*. 2019 Sep;74(3):345-356. <https://www.sciencedirect.com/science/article/pii/S0196064419303312?via%3Dihub>.

<sup>12</sup> <https://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2009.00381.x>

<sup>13</sup> <https://onlinelibrary.wiley.com/doi/10.1111/acem.12901>

<sup>14</sup> Roussel M, Teissandier D, Yordanov Y, et al. Overnight Stay in the Emergency Department and Mortality in Older Patients. *JAMA Intern Med*. 2023;183(12):1378–1385. doi:10.1001/jamainternmed.2023.5961

patients. GEDA operates as attestation-based; that is, GEDA accreditation is awarded to EDs based on written applications detailing applicants' care processes. However, there is a growing body of literature that supports the outcomes of GEDs to lower cost, improve quality, and improve the patient experience:

- Up to 16.5 percent reduced risk of hospital admission<sup>15</sup> and 17.3 percent of readmission<sup>16</sup>
- Up to \$3,202 savings per Medicare beneficiary after 60 days<sup>17</sup>
- Decreased odds of 30- and 60-day fall-related ED revisit with PT services<sup>18</sup>
- 3 percent increase with the clarity of discharge information and perceived wellbeing<sup>19</sup>
- Multiple studies showcasing improved experience across a variety of interventions<sup>20</sup>

The measure is a critical piece in the optimization of care for older patients by using a holistic approach to create a quality program that better serves the needs of this unique population. We believe the domains included in this measure will help build a better, safer environment for the geriatric patient and when the information is shared publicly will help patients and caregivers know where to get good care that is in line with their values. A hospital designation that displays that the hospital has taken steps to prioritize care for older adults will help geriatric patients and their families confidently search for care that meets their needs.

### **Screening for Social Drivers of Health (SDOH) and Screen Positive Rate for Social Drivers of Health (SDOH)**

Two measures that assess social risk, Screening for Social Drivers of Health (SDOH) (MUC2023-156) and Screen Positive Rate for Social Drivers of Health (SDOH) (MUC2023-171), are under consideration for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program, Hospital Outpatient Quality Reporting (OQR) Program, and Rural Emergency Hospital Quality Reporting (REHQR) Program.

When developing new measures that assess social risk, a critical consideration is measure attribution, or the process of selecting a patient population for which a group or entity will be held accountable for providing appropriate health services and achieving adequate health outcomes. ACEP encourages evaluation at the *clinician group level* in order to ensure that gaps are fairly attributed to entities with adequate agency to be responsible and accountable for outcomes.

There should also be sensitivity, and perhaps an actual formulaic coefficient applied, when evaluating under-resourced facilities to ensure some congruency between their quality performance relative to facilities with more resources. CMS should consider adjusting programmatic requirements to ensure that reporting on quality measures is feasible for all facilities and that under-resourced facilities do not face undue difficulty or burdensome penalties that could affect access to care for vulnerable populations.

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<sup>15</sup> Hwang, U., Dresden, S.M., Rosenberg, M.S., Garrido, M.M., Loo, G., Sze, J., Gravenor, S., Courtney, D.M., Kang, R., Zhu, C.W., Vargas-Torres, C., Grudzen, C.R., Richardson, L.D. and (2018), Geriatric Emergency Department Innovations: Transitional Care Nurses and Hospital Use. *J Am Geriatr Soc*, 66: 459-466. <https://doi.org/10.1111/jgs.15235>

<sup>16</sup> Dresden SM, Hwang U, Garrido MM, Sze J, Kang R, Vargas-Torres C, Courtney DM, Loo G, Rosenberg M, Richardson L. Geriatric Emergency Department Innovations: The Impact of Transitional Care Nurses on 30-day Readmissions for Older Adults. *Acad Emerg Med*. 2020 Jan;27(1):43-53. doi: 10.1111/acem.13880. Epub 2019 Dec 1. PMID: 31663245.

<sup>17</sup> Hwang U, Dresden SM, Vargas-Torres C, et al. Association of a Geriatric Emergency Department Innovation Program With Cost Outcomes Among Medicare Beneficiaries. *JAMA Netw Open*. 2021;4(3):e2037334. doi:10.1001/jamanetworkopen.2020.37334

<sup>18</sup> Lesser A, Israni J, Kent T, Ko KJ. Association Between Physical Therapy in the Emergency Department and Emergency Department Revisits for Older Adult Fallers: A Nationally Representative Analysis. *J Am Geriatr Soc*. 2018 Nov;66(11):2205-2212. doi: 10.1111/jgs.15469. Epub 2018 Aug 21. PMID: 30132800.

<sup>19</sup> Guttman A, Afilalo M, Guttman R, Colacone A, Robitaille C, Lang E, Rosenthal S. An emergency department-based nurse discharge coordinator for elder patients: does it make a difference? *Acad Emerg Med*. 2004 Dec;11(12):1318-27. doi: 10.1197/j.aem.2004.07.006. Erratum in: *Acad Emerg Med*. 2005 Jan;12(1):12. PMID: 15576523.

<sup>20</sup> Berning MJ, Oliveira J E Silva L, Suarez NE, Walker LE, Erwin P, Carpenter CR, Belloio F. Interventions to improve older adults' Emergency Department patient experience: A systematic review. *Am J Emerg Med*. 2020 Jun;38(6):1257-1269. doi:10.1016/j.ajem.2020.03.012. Epub 2020 Mar 12. PMID: 3222314.

We appreciate the opportunity to provide comments. If you have any questions, please contact Erin Grossmann, ACEP's Manager of Regulatory and External Affairs, at [egrossmann@acep.org](mailto:egrossmann@acep.org).

Sincerely,

A handwritten signature in black ink, appearing to read 'A Terry'.

Aisha T. Terry, MD, MPH, FACEP  
ACEP President