American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

June 30, 2023

Micky Tripathi, Ph.D., M.P.P.
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
Department of Health and Human Services
330 C St SW
Floor 7
Washington, DC 20201

Dear Coordinator Tripathi:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the draft data element list for the United States Core Data for Interoperability (USCDI+) Quality. ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education, and advocacy, ACEP advances emergency care on behalf of its members and the more than 150 million patients they treat on an annual basis.

The Office of the National Coordinator for Health Information Technology (ONC) developed the USCDI+ Quality initiative to align electronic clinical quality measures (eCQMs) across federal partners, health care providers, the health IT community, and other industry partners to inform and support health IT advancement for data element lists, standards, implementation specifications and potential certification criteria. They are seeking feedback on the USCDI+ Quality draft data element list in an effort to harmonize quality data elements into a common list of data elements to streamline the development and reporting of quality measures.

ACEP believes that it is important to establish a foundation of standards to build interoperable electronic health information that supports patient care across health systems and supports the idea of a common data framework specifically for quality measurement by centering the data elements that are critical for measure development. Increased interoperability and ease of quality measurement will reduce administrative burden on emergency physicians and other health care professionals, allowing delivery of the highest quality of patient care to remain our focus. However, ACEP believes that the draft element list for USCDI+ Quality is insufficient for quality reporting needs and, if finalized, would break measure logic that has been established in emergency medicine, reduce the capacity of measures that could be reported on as a specialty, and diminish the ability to provide data rationale.

Our comments below address the specific feedback sought by the Office of the National Coordinator of Health Information Technology (ONC) on the draft data element list.

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Level of Completeness

The current USCDI+ Quality draft data element list includes data mapped for eCQMs as well as additional data points for use cases related to public health and quality, safety and quality, long-term and post-acute care quality measurement, cancer-related quality measurement, and maternal and child health quality measures. However, **the list has completely overlooked emergency care.** This would restrict participation of the over 1,000 emergency departments (EDs) in ACEP's Qualified Clinical Data Registry, CEDR, a process these EDs rely on to improve quality and provide cutting edge, evidence-based care. Interoperability with EDs paves the way for a more streamlined continuum of care, potentially transforming the post-ED outcomes and long-term health trajectories of some the country's most vulnerable populations.

Level of Specificity

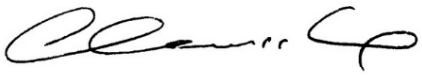
Several data elements have been altered in the USCDI version 3 (v3) by which USCDI+ Quality is proposed to be implemented. Specifically, the data elements represented in the USCDI v3 standard emphasize the collection of patient demographic information, with multiple data elements capturing the patient's gender identity and sexual orientation and extensive capture of the patient's social determinants of health assessment. Whilst ACEP supports enhanced data collection of social determinants of health to expand health equity, the inclusion of these data elements comes at the expense of elimination or reduction of other data elements. For example, in USCDI v3, data elements capturing Clinical Tests have been constrained to three measures, lacking the granularity necessary to fully analyze the results and impact of the clinical tests. Therefore, we request an expanded level of data capture for the Encounter Information, Medication (e.g., segregation of medications by home medications, administered or prescribed), Clinical Tests, and Procedures (individual sections for orders and results) sections. Precise and accurate measure calculation, physician attribution, and research of emergent clinical quality care gaps will be severely limited if USCDI v3 is the new baseline of measurement. Expanded data capture of clinical encounters will allow for more comprehensive analysis of how social determinants of health and other patient demographic information interact with the health care system, potentially enhancing health equity by more adequately identifying gaps in care.

Frequency of Updates

USCDI+ Quality limits requests for new standardized data elements to once a year. This restriction will significantly reduce data adoption, measure logic, and data rationale, and disproportionately do so for emergency medicine. The proposed data element list has approximately 100 data elements, whereas ACEP's CEDR alone has 250 elements that are required to accurately calculate our approved measure library (the registry contains 800 unique elements in total). In the rapidly changing health care landscape, it is imperative that measures are being continuously refined to ensure the most accurate data capture to best inform care. However, the annual updates to the standardized data element list as proposed would severely diminish the capability for interoperability and standardization between emergency medicine datasets and those of other specialties. If an annual update is finalized, it would reduce the viability and longevity of current data, making data two years removed from the update obsolete. A robust dataset is necessary for analyzing data and measuring results over time. Therefore, elimination of historical data diminishes reasonable rationale in analyzing emergency medicine data trends, which will potentially result in negative impacts on patient outcomes.

In sum, ACEP believes that a quality and performance infrastructure that is interoperable and robust is critical to ensure measurement of what is meaningful to patients and physicians in a way that does not burden clinicians and health care organizations. We appreciate the opportunity to share our comments. If you have any questions, please contact Erin Grossmann, ACEP's Regulatory and External Affairs Manager, at egrossmann@acep.org.

Sincerely,



Christopher S. Kang, MD, FACEP

ACEP President