StratisHealth Rural Quality Improvement Technical Assistance

Emergency Department Transfer Communication (EDTC) Measure (NQF #291) 2018 Technical Expert Panel

Summary Brief: Background, Process, and Recommendations

NOTE: Recommend revisions to the EDTC Measure are currently under review for endorsement by the National Quality Forum.

Hospitals should continue to use the current EDTC specifications for data collection and submission for the MBQIP program.

- EDTC Data Specifications Manual
- EDTC Data Collection Resources

The revised measure will be utilized as part of the Medicare Beneficiary Quality Improvement Program (MBQIP) starting with Q1 2020 data collection.

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Background

The Emergency Department Transfer Communication (EDTC) quality measure is National Quality Forum (NQF) endorsed (NQF #291), and relevant to small rural hospitals. This measure is being collected and reported by critical access hospitals (CAHs) as part of the Medicare Beneficiary Quality Improvement Project (MBQIP) because small rural hospitals frequently transfer a higher proportion of emergency department (ED) patients than larger urban facilities. It is an essential goal of MBQIP to help hospitals improve care transitions, including ED transfers, to reduce preventable hospital readmissions and adverse events in hospitals.

The EDTC measure was originally developed and field tested by Stratis Health and the University of Minnesota Rural Health Research Center in 2003-2005 and was initially endorsed by the NQF in 2007. The EDTC measure was further pilot tested in a handful of states starting in 2005. In 2014, more than 100 CAHs across eight states participated in a one-year special innovation project funded by the Centers for Medicare & Medicaid Services (CMS) and led by Stratis Health. A case study discussing implementation of EDTC in Minnesota was also done by the Flex Monitoring Team (FMT), a Federal Office of Rural Health Policy (FORHP) funded consortium of research centers, in 2014. EDTC became a required MBQIP measure in 2015, and reporting rates among CAHs nationwide have risen dramatically since that time. Currently, 88.8% of the 1,335 CAHs participating in MBQIP are reporting EDTC-All.

The measure is composed of seven sub-measures compiled into one all-or-none composite measure (EDTC-All), calculated from 27 data elements abstracted from patient transfer charts. The seven sub-measures include administrative communication, patient information, vital signs, medication information, physician/practitioner-generated information, nurse-generated information, and procedures and tests. For EDTC-All, every one of the 27 data elements must be met.

In 2018, given the more widespread use and rapidly changing environment of how health care information is transferred between facilities, a thorough review and re-evaluation of the measure by a technical expert panel (TEP) was initiated. This review was deemed timely and important for the measure to remain relevant and meet the needs of hospitals, as well as federal and state agencies which use it in reporting programs.

Stratis Health convened the TEP as part of its role as the Rural Quality Improvement Technical Assistance Center (RQITA) for the Federal Office of Rural Health Policy (FORHP). The University of Minnesota Rural Health Research Center is the NQF measure “owner and steward” and was a key partner in the 2018 TEP process.

2018 EDTC TEP Process

A group of nine national experts was identified to serve on the TEP, including those representing critical access hospitals, clinicians, measurement experts, care transitions experts, and EHR (electronic health record) experts. (See TEP membership listed below).

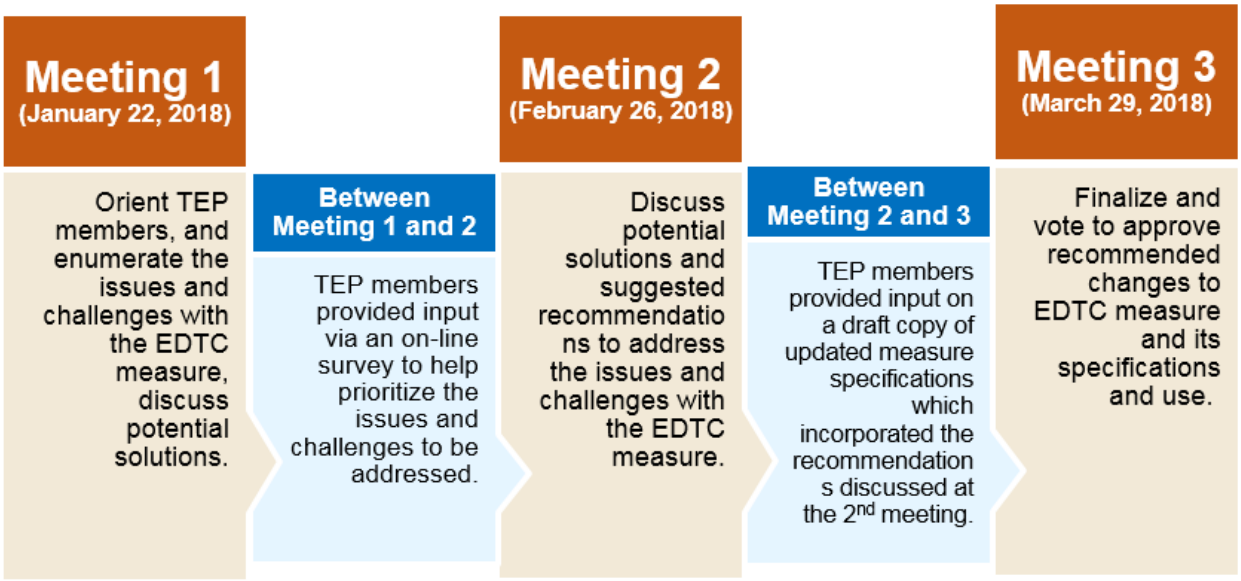
The goal of the TEP was to gather input from experts regarding the EDTC measure to recommend updates, which will be submitted to the NQF as part of the ongoing measure endorsement process. The work of the TEP was accomplished through three virtual meetings in January through March of 2018, supplemented by an online survey and review of draft recommendations by TEP members between meetings. Honorariums to participate in the TEP were not provided.

To frame the TEP discussions, Stratis Health compiled data and feedback from a variety of sources for input prior to the launch of the TEP, including experience of Stratis Health and U of MN in fielding technical assistance questions and other discussions with users and stakeholders, review of data from pilot tests, and current utilization data. A formal feedback request to Flex programs and CAHs was also distributed in December 2017. Eighty-three responses were received from 18 geographically diverse states. Responses primarily came directly from CAHs.

From this background work, issues and challenges were organized into three themes that were brought to the TEP for discussion:

- EDTC in a "wired world": The measure was originally developed when paper charts were the norm. There has been a significant increase in the adoption of EHRs and electronic transfer of information since 2005.
- Population for transfers: The measure currently includes transfers to acute care hospitals as well as 'other' health care facilities such as long-term care. Needs emerged to clarify the scope of transfer destinations appropriate to include.
- Clinical relevance and specific data elements: The measure needed a review to ensure the clinical relevance and provide clarity regarding the specific data elements included in the measure.

Before the first meeting, a variety of background material was provided to the TEP, including the EDTC Data Specifications Manual, and EDTC Brief. An outline of the process and focus of each of the three TEP meetings is below:



TEP Recommendations

The TEP recommended significant streamlining and updating to modernize the EDTC measure. A summary of changes is listed below:

Changes to measure and measure elements:

- Reduced the overall number of measure elements to reflect highest priority items, and eliminated the sub-measure structure

    - Total number of data elements reduced from 27 to eight (16 elements removed, two were combined)
- Revised names, descriptions, and specifications for the remaining data elements to improve clarity and specificity

Changes to population and definition of 'sent'

- Confirmed the inclusion of long-term care and nursing home transfers
- Removed patients under Observation status
- Updated and clarified language regarding communication via EHR or health information exchange (HIE) to focus on immediacy of data availability

Additional detail regarding the TEP recommendations can be found in the attached summary from the Minnesota Rural Health Research Center.

Next Steps

The University of Minnesota Rural Health Research Center is submitting the recommended revisions to the measure to the National Quality Forum to update endorsement of the measure. After NQF endorsement, tools and resources for data collection and reporting of the EDTC measure will be rolled out to CAHs for continued use of the measure as part of the MBQIP measure, and the measure will be submitted to CMS for consideration as part of CMS quality reporting programs. Anticipated timeline for release of the updated EDTC measure is late-2019.

2018 EDTC TEP Members

- Billie Bell, RN; Medina Healthcare System, Texas
- Tim Boyd, MS, RN; New England QIN-QIO, New Hampshire
- Dale W. Bratzler, DO, MPH; Oklahoma University Physicians, Oklahoma
- Justa Clark, RN; CPSI, Texas
- Melanie Hoover, RN, BSN, CNOR; Magruder Hospital, Ohio
- Denis J, Kuhlmann, MD, FACEP, FAAEM; Emergency Practice Associates, Iowa
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EDTC Modifications Approved by Expert Panel, Spring 2018

Overview

Recommended modifications would reduce total measure elements from 27 to 8. The rationale for these recommendations is to streamline data collection and include measures / elements that are essential for continuity of care and care coordination.

The names, titles, and definitions of the data elements have been updated for clarity, particularly for some of the broad areas.

Measures / Elements Retained

	Elements to keep	Rationale for retention
1	Medications administered in ED	Key aspect of coordination-of-care.
2	Allergies	Key aspect of coordination-of-care.
3	Home medications	Key aspect of coordination-of-care.
4	Provider note	Key aspect of coordination-of-care.
5	Mental status / orientation	Functional/cognitive status changes are recognized as best/ earliest indicators of deterioration and are key aspects of assessment and coordination of care. This measure is a combination of two former measures: Neurological status and Sensory status ("impairments").
6	Reason for transfer and/or plan of care	Key aspect of assessment and coordination-of-care.
7	Tests and procedures done	Key aspect of assessment and coordination of care.
8	Tests and procedures sent	Key aspect of assessment and coordination of care.

(List of Approved Modifications: next page)

Measures / Elements Removed

Measure code	Elements to remove	Rationale for removal
EDTC-SUB 1 Administrative communication (2 elements removed)	Nurse-to-nurse communication Physician-to-physician communication	Evidence that this pre-transfer communication is occurring on a regular basis. Added to data collection burden. Documentation of this process step does not add value.
EDTC-SUB 2 Patient information (6 elements removed)	Name Address Age Gender Significant other's contact information Insurance	Evidence that this communication is occurring on a regular basis. Added to data collection burden. Documentation of this process step does not add value.
EDTC-SUB 3 Vital signs (5 elements removed, 1 element modified)	Pulse Respiratory rate Blood pressure Temperature Oxygen saturation	Evidence that vital signs are being communicated on a regular basis. They added to data collection burden. Documentation of this process step does not add value.
	Neurological status	Modified and kept (part of "Mental status/orientation")
EDTC-SUB 6 Nurse-generated information (4 elements removed, 1 element modified)	Catheters Immobilizations Respiratory support Oral limitations	Evidence that most of this communication is occurring on a regular basis. Catheters, oral limitations and immobilizations discontinued because this is now included in assessments interventions and response.
	Sensory status (formerly Impairments)	Modified and kept (part of "Mental status/orientation")