



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0291

Corresponding Measures:

De.2. Measure Title: EMERGENCY TRANSFER COMMUNICATION MEASURE

Co.1.1. Measure Steward: University of Minnesota Rural Health Research Center

De.3. Brief Description of Measure: Percentage of all patients transferred from an Emergency Department to another healthcare facility whose medical record documentation indicated that all required information was communicated (sent) to the receiving facility within 60 minutes of transfer For all data elements, the definition of 'sent' includes the following:

- Hard copy sent directly with the patient, or
- Sent via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared Electronic health record (EHR) or Health Information Exchange (HIE) (see definition below)

For purposes of this measure, a shared electronic health record (EHR) is defined as one where data entered into the system is immediately available at the receiving site. Facilities using the same EHR vendor or a Health Information Exchange (HIE) cannot assume immediate access by the receiving facility to the transferred patient's record.

1b.1. Developer Rationale: Improved timely communication of data elements will facilitate a better understanding of the patients' condition prior to arrival at the receiving facility and reduce duplication of tests and procedures.

Improved timely communication of data elements will facilitate a better understanding of the patients' condition prior to arrival at the receiving facility and reduce duplication of tests and procedures. This is true for the previous specifications and the current specifications.

S.4. Numerator Statement: Numerator Statement: Number of patients transferred from an ED to another healthcare facility whose medical record documentation indicated that all of the following relevant elements were documented and communicated to the receiving hospital in a timely manner:

- Home Medications
- Allergies and Reactions
- Medications Administered in ED
- ED Provider Note
- Mental Status and Orientation Assessment
- Reason for Transfer and Plan of Care
- Tests and/or Procedures Performed
- Tests and/or Procedures Results

S.6. Denominator Statement: Denominator Statement: Transfers from an ED to another healthcare facility

Included Population: All transfers from an ED to another healthcare facility

Excluded Populations: Patients observation status.

S.8. Denominator Exclusions: All emergency department patients not discharged to another healthcare facility. Those admitted, sent home, left AMA, those on observations status, etc.

De.1. Measure Type: Process

S.17. Data Source: Claims, Electronic Health Data, Electronic Health Records, Management Data, Paper Medical Records

S.20. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Nov 15, 2007 **Most Recent Endorsement Date:** Sep 18, 2014

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? These Eight Data elements should be communicated for continuity of care and cost containment.

- Home Medications
- Allergies and Reactions
- Medications Administered in ED
- ED Provider Note
- Mental Status and Orientation Assessment
- Reason for Transfer and Plan of Care
- Tests and/or Procedures Performed
- Tests and/or Procedures Results

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[NQF_evidence_attachment_1.12.2020.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

Yes

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Improved timely communication of data elements will facilitate a better understanding of the patients' condition prior to arrival at the receiving facility and reduce duplication of tests and procedures.

Improved timely communication of data elements will facilitate a better understanding of the patients' condition prior to arrival at the receiving facility and reduce duplication of tests and procedures. This is true for the previous specifications and the current specifications.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

The validity and reliability testing reflect data on the new specifications. The new specifications are a subset of the old specifications, the analysis for validity and reliability contains only the 8 current elements.

Data from the MBQIP submission site from 2017 from over 1000 CAH hospitals is summarized here. It provides the descriptive stats for 2 quarters in 2017 from the previous specifications. Data from the new specifications will be available after Oct 2020. The overall mean for all reported increased from 75% to 78 %, the standard error narrowed from .8% to .7%; both of these are statistically

significant with over 1100 observations. Scores by decile show a swing to higher scores. In the approximate top decile, (top 9 %), there were 38% in Q1 and 42% in Q 4. Improvements in completion are being made over a short amount of time.

Descriptive stats

q1 2017		q4 2017	
Mean	0.750450484	Mean	0.786365037
Standard Error	0.008025333	Standard Error	0.007349871
Median	0.845299145	Median	0.87755102
Mode	1	Mode	1
Standard Deviation	0.273568515	Standard Deviation	0.253010691
Sample Variance	0.074839732	Sample Variance	0.06401441
Range	1	Range	1
Minimum	0	Minimum	0
Maximum	1	Maximum	1
Sum	872.0234623	Sum	931.8425689
Count	1162	Count	1185

Decile approximations 2017 MBQIP

q1	Cumulative %	q4	Cumulative %
0.00	2.84%	0.00	2.70%
0.41	13.43%	0.41	10.21%
0.65	26.85%	0.65	21.43%
0.76	39.67%	0.76	33.25%
0.82	47.33%	0.82	41.27%
0.88	55.77%	0.88	50.38%
0.91	62.82%	0.91	58.82%
0.94	68.33%	0.94	64.89%
0.97	74.53%	0.97	71.81%
More	100.00%	More	100.00%

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.)* For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

There is not disparity data this time.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across

organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Non-Condition Specific(check all the areas that apply):

Care Coordination, Care Coordination : Readmissions, Care Coordination : Transitions of Care, Safety, Safety : Medication

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

The new specifications are only available to hospitals participating in the pilot in June 2019. Here is the link to the new specifications. <http://www.stratishealth.org/documents/EDTC-Data-Specs-Manual-2019.pdf>

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment:

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

Yes

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

The Denominator has been clarified to include transfers to non-acute facilities such as nursing homes and to exclude patients in observation status. Continuity of care as derived from these data elements can prevent errors. The measure has been redesigned under the direction of a technical expert panel to include 8 of the original data elements.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Numerator Statement: Number of patients transferred from an ED to another healthcare facility whose medical record documentation indicated that all of the following relevant elements were documented and communicated to the receiving hospital in a timely manner:

- Home Medications
- Allergies and Reactions

- Medications Administered in ED
- ED Provider Note
- Mental Status and Orientation Assessment
- Reason for Transfer and Plan of Care
- Tests and/or Procedures Performed
- Tests and/or Procedures Results

S.5. Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Numerator Statement: Number of patients transferred from an ED to another healthcare facility whose medical record documentation indicated that all of the following relevant elements were documented and communicated to the receiving hospital in a timely manner:

- Home Medications
- Allergies and Reactions
- Medications Administered in ED
- ED Provider Note
- Mental Status and Orientation Assessment
- Reason for Transfer and Plan of Care
- Tests and/or Procedures Performed
- Tests and/or Procedures Results

For ALL data elements, the definition of ‘sent’ includes the following documentation:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared Electronic Health Record (EHR) or Health Information Exchange (HIE) (see definition below)

For purposes of this measure, a shared electronic health record (EHR) is defined as one where data entered into the system is immediately available at the receiving site. Facilities using the same EHR vendor or a Health Information Exchange (HIE) cannot assume immediate access by the receiving facility to the transferred patient’s records.

ED Transfer Communication (EDTC) Initial Patient Population

The population of the EDTC measure is defined by identifying those patients admitted to the emergency department who were then discharged, transferred, or returned to these facilities:

Inclusions:

- Acute Care Facility – Cancer Hospital or Children’s Hospital – Including emergency department
- Acute Care Facility – Critical Access Hospital – Including emergency department
- Acute Care Facility – Department of Defense or Veteran’s Administration – Including emergency department
- Acute Care Facility- General Inpatient Care – Including emergency department
- Hospice – healthcare facility
- Other health care facility*, including discharge, transfer or return to:
 - o Extended or Intermediate Care Facility (ECF/ICF)
 - o Long Term Acute Care Hospital (LTACH)
 - o Long Term Care Facility
 - o Nursing Home or Facility, including Veteran’s Administration Nursing Facility
 - o Psychiatric Hospital or Psychiatric Unit of a Hospital
 - o Rehabilitation Facility, including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
 - o Skilled Nursing Facility (SNF), Sub-Acute Care, or Swing Bed
 - o Transitional Care Unit (TCU)

*Other health care facilities MUST be included in the population.

S.6. Denominator Statement *(Brief, narrative description of the target population being measured)*

Denominator Statement: Transfers from an ED to another healthcare facility

Included Population: All transfers from an ED to another healthcare facility

Excluded Populations: Patients observation status.

S.7. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

ED Transfer Communication (EDTC) Initial Patient Population

The population of the EDTC measure is defined by identifying those patients admitted to the emergency department who were then discharged, transferred, or returned to these facilities:

Inclusions:

- Acute Care Facility – Cancer Hospital or Children’s Hospital – Including emergency department
- Acute Care Facility – Critical Access Hospital – Including emergency department
- Acute Care Facility – Department of Defense or Veteran’s Administration – Including emergency department
- Acute Care Facility- General Inpatient Care – Including emergency department
- Hospice – healthcare facility
- Other health care facility*, including discharge, transfer or return to:
 - o Extended or Intermediate Care Facility (ECF/ICF)
 - o Long Term Acute Care Hospital (LTACH)
 - o Long Term Care Facility
 - o Nursing Home or Facility, including Veteran’s Administration Nursing Facility
 - o Psychiatric Hospital or Psychiatric Unit of a Hospital
 - o Rehabilitation Facility, including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
 - o Skilled Nursing Facility (SNF), Sub-Acute Care, or Swing Bed
 - o Transitional Care Unit (TCU)

*Other health care facilities MUST be included in the population.

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

All emergency department patients not discharged to another healthcare facility.

Those admitted, sent home, left AMA, those on observations status, etc.

S.9. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

Exclusions:

- AMA (left against medical advice)
- Expired
- Home, including:
 - o Assisted Living Facilities
 - o Board and care, foster or residential care, group or personal care homes, and homeless shelters
 - o Court/Law Enforcement – includes detention facilities, jails, and prison
 - o Home with Home Health Services
 - o Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs, and Partial Hospitalization
- Hospice-home
- Not documented/unable to determine
- Observation Status

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and*

coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

Stratification by discharge destination is suggested to target groups where improvement is needed specifically separating acute care vs long term care transfers.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Continuous variable, e.g. average

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

The measure is reported as an average of the patient observations scores from the facility. The individual patient's score is the sum of the elements scores which use an all-or-none approach. If an individual patient's record is missing one element then the patient's score is zero. Reporting of element level scores may be useful for improvement or reporting. Data elements are identified for the measure. If the data element is not appropriate for the patient, items scored as NA (not applicable or not available) are counted in the element as a positive, or 'yes,' response and the patient will meet the element criteria. The patient will either need to meet the criteria for all of the data elements (or have an NA) to pass the element. Measurement stratification by discharge destination may help identify areas for targeted improvement activities.

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

Hospitals need to submit a minimum of 45 cases per quarter from the required population.

A hospital may choose to sample and submit more than 45 cases. Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. Hospitals whose initial patient population size is less than the minimum number of 45 cases per quarter for the measure cannot sample and should submit all cases for the quarter.

Hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data.

Sample cases should be randomly selected in such a way that the individual cases in the population have an equal chance of being selected.

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

n/a

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims, Electronic Health Data, Electronic Health Records, Management Data, Paper Medical Records

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

Hospitals submit information to their State Flex Coordinators and the State Flex Coordinators submit info to the MBQIP data bank.

Hospitals use a variety of tools to collect information from their ED records including paper records, electronic records and external vendors.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at

A.1)

Available in attached appendix at A.1

S.20. Level of Analysis (Check *ONLY* the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility

S.21. Care Setting (Check *ONLY* the settings for which the measure is SPECIFIED AND TESTED)

Emergency Department and Services, Inpatient/Hospital, Outpatient Services

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2. Validity – See attached Measure Testing Submission Form

[NQF_testing_attachment_11.6.19-637087248040991410__1.10.2020.docx](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for maintenance of endorsement.

ALL data elements are in defined fields in electronic health records (EHRs)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

Hospitals with electronic medical records shared with the patient's destination can capture these elements easily. Hospitals who do not share electronic medical records with the destination hospital require additional paper trails for capture of necessary process elements.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

The measure was originally tested in 2003. Since that time we have expanded the application to include transfers to non-acute settings. We continue to clarify the specifications.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

none.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
Payment Program	Public Reporting
Regulatory and Accreditation Programs	Program Name: Minnesota Statewide Quality Reporting and Measurement System. http://www.mnhealthscores.org/hospital-quality-patient-experience-ratings

	Quality Improvement (external benchmarking to organizations) MN statewide forms http://www.health.state.mn.us/healthreform/measurement/index.html Medicare Beneficiary Quality Improvement Project (MBQIP) https://www.ruralcenter.org/tasc/mbqip Quality Improvement (Internal to the specific organization) Medicare Beneficiary Quality Improvement Project (MBQIP) https://www.ruralcenter.org/tasc/mbqip
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4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

MBQIP:

- Name of program and sponsor: The Medicare Beneficiary Quality Improvement Project (MBQIP) is a quality improvement activity under the Medicare Rural Hospital Flexibility (Flex) grant program of the Health Resources and Services Administration's Federal Office of Rural Health Policy (FORHP).
- Purpose: The goal of MBQIP is to improve the quality of care provided in critical access hospitals (CAHs), by increasing quality data reporting by CAHs and then driving quality improvement activities based on the data. This project provides an opportunity for individual hospitals to look at their own data, measure their outcomes against other CAHs and partner with other hospitals in the state around quality improvement initiatives to improve outcomes and provide the highest quality care to each and every one of their patients.

In order to access the full scope of Flex resources available to them, CAHs must be reporting a minimum threshold of quality measures. Reporting of EDTC is one of the measures that is included in that criteria. The reporting threshold is updated annually, information on the Fiscal Year 2017 criteria can be found here: <https://www.ruralcenter.org/resource-library/flex-eligibility-criteria-for-mbqip-participation-and-waiver-template>

- Geographic area and number and percentage of accountable entities and patients included:
More than 1100 of the 1341 CAHs in the country currently report the EDTC measure through MBQIP. There are reporting CAHs in each of the 45 states that have CAHs (5 states do not have any CAHs). CAHs report at least 45 eligible cases each quarter. If they have more than 45 eligible cases they are allowed to use a sampling process, if they have less than 45 cases they report on all eligible cases.
- Level of measurement and setting: CAH Emergency Departments is the setting for the measure. CAHs collect data on individual patients and report numerators and denominators for the overall measure and each of the sub-measures on a quarterly basis to their state Flex program.

Minnesota Statewide Quality Reporting and Measurement System (SQRMS)

- Name of program and sponsor: Minnesota Statewide Quality Reporting and Measurement System (SQRMS), Minnesota Department of Health. Data is publically reported on the MN HealthScores website: <http://www.mnhealthscores.org/>
- Purpose: Minnesota's 2008 Health Reform Law requires the Commissioner of Health to establish a standardized set of quality measures for health care providers across the state. The goal is to create a uniform approach to quality measurement to enhance market transparency and drive health care quality improvement through an evolving measurement and reporting strategy. MN CAHs are not exempt from the SQRMS program (CAHs are exempt from Federal hospital reporting programs). The EDTC measure is a required SQRMS measure for CAHs in MN.
- Geographic area and number and percentage of accountable entities and patients included:
All 78 MN CAHs reported the EDTC measure the most recent reporting quarter available (Q2 2017). CAHs report at least 45 eligible cases each quarter. If they have more than 45 eligible cases they are allowed to use a sampling process, if they have less than 45 cases they report on all eligible cases.
- Level of measurement and setting: CAH Emergency Departments is the setting for the measure. CAHs collect data on individual patients and report numerators and denominators for the overall measure and each of the sub-measures on a quarterly basis to their state Flex program.

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program,

certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

MBQIP has this measure included in its phase 3 reporting plan.

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

This measure is currently reported through MBQIP.

The Medicare Beneficiary Quality Improvement Project (MBQIP) is a quality improvement activity under the Medicare Rural Hospital Flexibility (Flex) grant program of the Health Resources and Services Administration's Federal Office of Rural Health Policy (FORHP). This is the process through which CAHs are required to report improvement measures.

<https://www.ruralcenter.org/resource-library/flex-eligibility-criteria-for-mbqip-participation-and-waiver-templates>

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

Feedback of scores and comparison scores, national and local averages are provided as above.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

Reports are produced by a contractor to HRSA FORHP on a quarterly basis. Each quarter, the FORHP Project Officer for each state Flex program distributes the individual hospital and state summary data to the individual state Flex programs, who then in turn distribute the reports to the CAHs in their state. Individual state Flex programs provide support to CAHs on interpretation and use of the measure, but a guide on how to use the reports is also available: <https://www.ruralcenter.org/resource-library/interpreting-mbqip-hospital-data-reports-for-quality-improvement>. MN CAHs receive their data through this same process even though the measure is also used for public reporting through the MN SQRMS program.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

Reports are produced by a contractor to HRSA FORHP on a quarterly basis. Each quarter, the FORHP Project Officer for each state Flex program distributes the individual hospital and state summary data to the individual state Flex programs, who then in turn distribute the reports to the CAHs in their state. Individual state Flex programs provide support to CAHs on interpretation and use of the measure, but a guide on how to use the reports is also available: <https://www.ruralcenter.org/resource-library/interpreting-mbqip-hospital-data-reports-for-quality-improvement>. MN CAHs receive their data through this same process even though the measure is also used for public reporting through the MN SQRMS program.

4a2.2.2. Summarize the feedback obtained from those being measured.

Voluntary participants appreciate the feedback and have made simple process design improvements. Non-voluntary participants struggle with the indications of inadequate process completion.

4a2.2.3. Summarize the feedback obtained from other users

Non-users have not been available to the measure sponsors. Some ideas may be that because CAHs have limited resources, their quality measurement resources may be focused on other issues. Some CAH may have improved their scores on these measures to near 100% and shifted their focus on other issues.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Feedback and frequently asked questions are used for the annual update and clarification of specifications.

Tools developed by those being measured are sought by new reporters. Newsletters from Stratis Health contain clarifications and updates by the MBQIP monitor.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

Marked improvement is documented in all areas. Improvement is still needed for transfers to non-acute settings.

Improvement: Data and Trends (Q1 2015 – Q3 2016)

Every EDTC sub-measure and the composite EDTC-All measure has consistently improved between Q1 2015 and Q3 2016. Most markedly, EDTC-All has risen from 51.8% to 74.3% (a 22.5 percentage point increase).

Table 2: Timeframe

		EDTC-1 Percent	EDTC-2 Percent	EDTC-3 Percent	EDTC-4 Percent	EDTC-5 Percent	EDTC-6 Percent	EDTC-7 Percent	EDTC-All Percent
Q1	2015	84.5%	86.8%	87.6%	86.1%	84.1%	77.0%	90.2%	51.8%
Q2	2015	86.2%	89.6%	88.5%	87.2%	85.4%	78.9%	90.5%	56.8%
Q3	2015	90.4%	92.9%	92.1%	91.1%	89.8%	84.3%	94.8%	63.7%
Q4	2015	87.7%	90.2%	89.7%	88.4%	87.1%	81.9%	92.2%	65.6%
Q1	2016	92.8%	94.8%	93.8%	91.6%	91.5%	86.8%	94.7%	70.6%
Q2	2016	92.9%	93.6%	93.1%	91.0%	91.3%	86.6%	94.7%	72.2%
Q3	2016	93.2%	93.6%	93.5%	91.7%	91.6%	87.5%	94.9%	74.3%

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

None. These measures occur after care is provided. It impacts communication of care provided and may improve care at the next facility.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

None.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures The measure specifications are harmonized with related measures; OR The differences in specifications are justified 5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications harmonized to the extent possible? 5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.
5b. Competing Measures The measure is superior to competing measures (e.g., is a more valid or efficient way to measure); OR Multiple measures are justified. 5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Appendix
A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed. Attachment Attachment: Revised_EDTC_Measure_Specifications_Manual_Oct_2019-Final_-1-.pdf
Contact Information
Co.1 Measure Steward (Intellectual Property Owner): University of Minnesota Rural Health Research Center Co.2 Point of Contact: JILL, KLINGNER, KLIN0089@UMN.EDU, 218-726-8626- Co.3 Measure Developer if different from Measure Steward: University of Minnesota Rural Health Research Center Co.4 Point of Contact: JILL, KLINGNER, KLIN0089@UMN.EDU, 218-726-8626-
Additional Information
Ad.1 Workgroup/Expert Panel involved in measure development Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development. All work group members reviewed the specifications and results related to the measure and results. Ira Moscovice PhD Principal Investigator University of Minnesota RHRC SHAILEY PRASAD MD FP Shailey Prasad MD FP Tom Dean MD Rural FP Physician John Supplitt AHA Rural Panel Director Cathy Pfaff RN Rural Quality Improvement Consultant Tim Size – Rural Health Network Director Jennifer Lundblad - CEO Stratis Health QIO
Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2003 Ad.3 Month and Year of most recent revision: 10, 2019 Ad.4 What is your frequency for review/update of this measure? ANNUALLY Ad.5 When is the next scheduled review/update for this measure? 10, 2020
Ad.6 Copyright statement: X Ad.7 Disclaimers: X
Ad.8 Additional Information/Comments: X