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cost review commission

ED LOS Subgroup Meeting

February 2, 2024

HSCRC Quality Team

Subgroup 1 Members

First and Last Name	Title and Organization
Amanda Wright	Director of Patient Care Services – Northwest Hospital
Anene Onyeabo	Senior Analyst, Quality & Health Improvement - MHA
Brenda Watson	Advanta Government Services
Dan Lauth	Manager, Data Analytics and MedStar Health
David Goodmansen	Director of Performance Improvement
Eileen MacDonald, MD	Chief of Medicine, Physician Advisor, Luminis Health
Grace Kaeding	CRISP Representative
James McGarvey	Clinical Analyst Frederick Health Hospital
Jennifer Kramer	Executive Director of Emergency and Vascular Services
Kristen Geissler	Managing Director, BRG
Laura Fortman/Yvette Hicks b	Systems Architect, Johns Hopkins Emergency Medicine
Lauren Small	ID Director at Frederick.Health
Margarita Noel/Laura Wieber	Quality Engineer and Epic Liaison
Michael Staley	Executive Director; Quality and Accreditation at Meritus Medical Center
Mike Ward	UMMS Case Mix Manager
Shivani Bhatt	Sr. Data Analyst, hMetrix
Sophia Batallas/Theron Pappas backup	System Quality Director & Director of Data Analytics
Stephanie Cleaveland	Assistant CNO and Director of Emergency Services
Dr. Peter Hill	Senior Vice President of Medical Affairs at John Hopkins
Wendy Helms	Clinical Director Emergency Services, Trauma, and Forensic UPMC Western Maryland

Thank you to the industry and stakeholders for contributing your interest, time, and expertise to this work.

Workgroup information can be found on the HSCRC website:

https://hscrc.maryland.gov/Pages/ED-length-of-stay-workgroup.aspx

Workgroup Learning Agreements

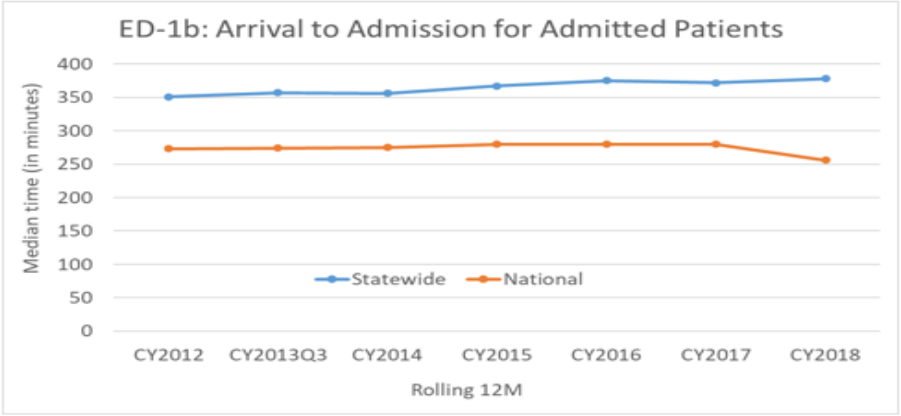
- **Be Present** – Make a conscious effort to know who is in the room, become an active listener. Refrain from multitasking and checking emails during meetings.
- **Call Each Other In As We Call Each Other Out** – When challenging ideas or perspectives give feedback respectfully. When being challenged - listen, acknowledge the issue, and respond respectfully.
- **Recognize the Difference of Intent vs Impact** – Be accountable for our words and actions.
- **Create Space for Multiple Truths** – Seek understanding of differences in opinion and respect diverse perspectives.
- **Notice Power Dynamics** – Be aware of how you may unconsciously be using your power and privilege.
- **Center Learning and Growth** – At times, the work will be uncomfortable and challenging. Mistakes and misunderstanding will occur as we work towards a common solution. We are here to learn and grow from each other both individually and collectively.

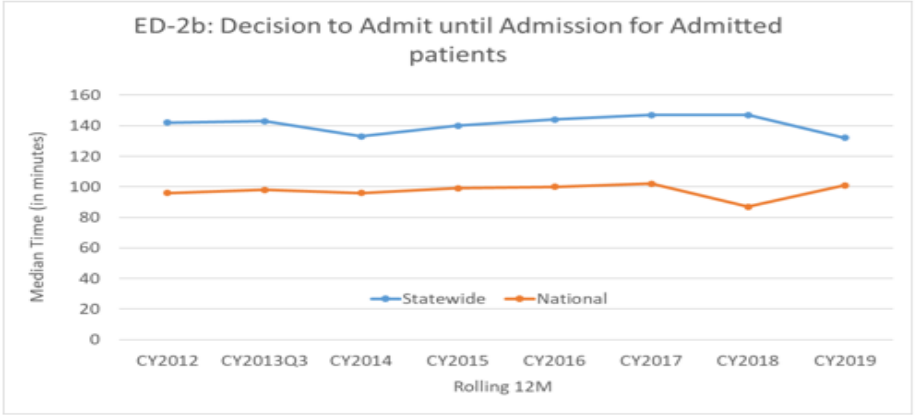
REMINDER:
These workgroup meetings are recorded.

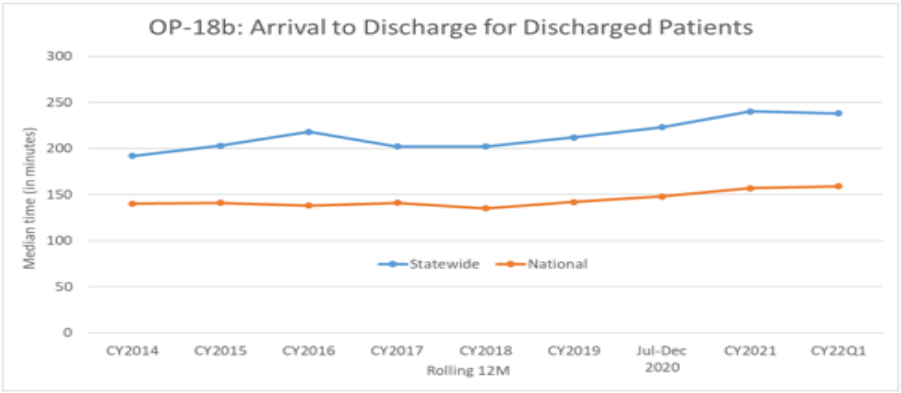
Agenda

- Background on ED wait times in MD
  - Overview of HSCRC initiatives to address concern
- Workgroup Charge
  - What are we trying to accomplish in today's meeting?
- ED-1 LOS Measure
  - Review ED-1 measure specifications
  - Methods of data collection/data sources
- Next Steps and Opportunities
  - Assess available timestamps
  - Understand patient flow

CMS ED LOS Data: Maryland performs worse than nation

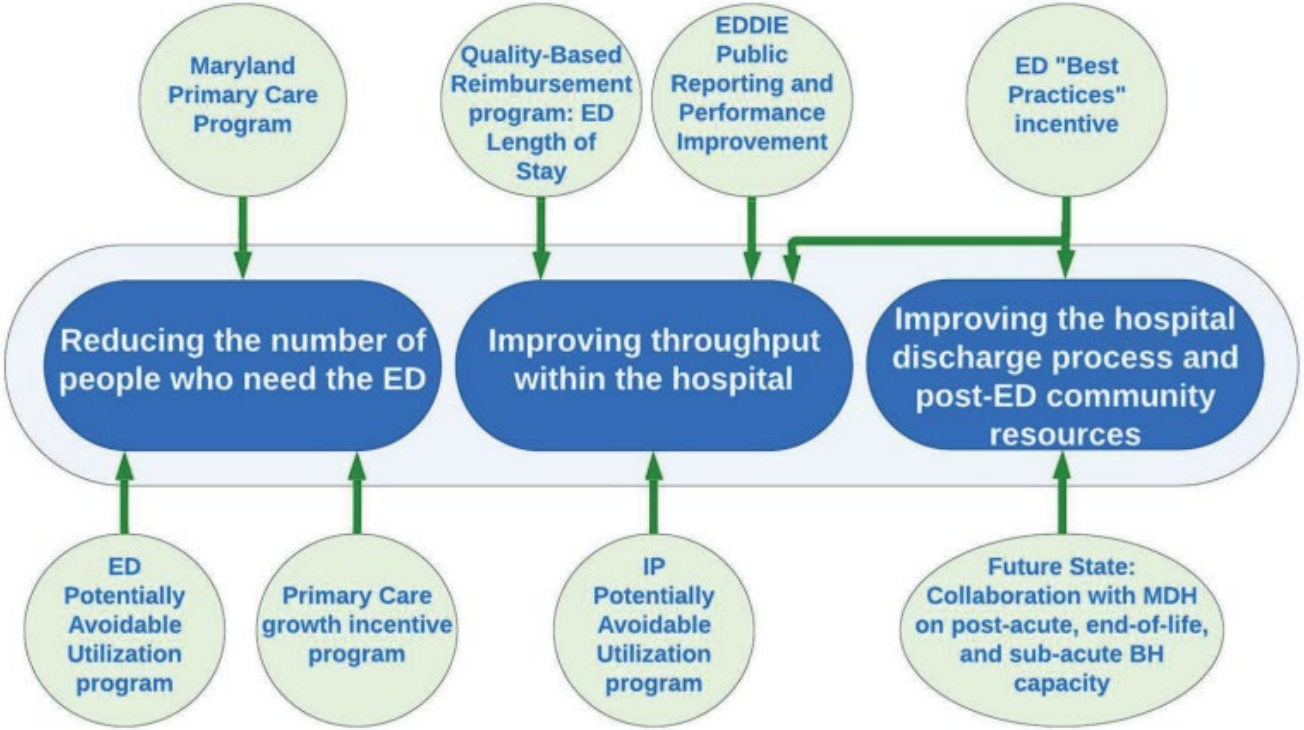






Measure ID	Measure Definition
ED-1	Median time from ED arrival to departure for admitted patients
ED-2	Median admit decision time to ED departure time for admitted patients
OP-18	Median time of ED arrival to departure for discharged patients

Interventions to Impact ED LOS



EDDIE Overview

- Maryland has underperformed most other states on ED throughput measures since before the start of the All-Payer model
- EDDIE is a Commission-developed quality improvement initiative that began in June 2023 with two components:

EDDIE: Improved ED Experience for Patients

Quality Improvement

- Rapid cycle QI initiatives to meet hospital set goals related to ED throughput/length of stay
- Learning collaborative
- Convened by MHA

Commission Reporting

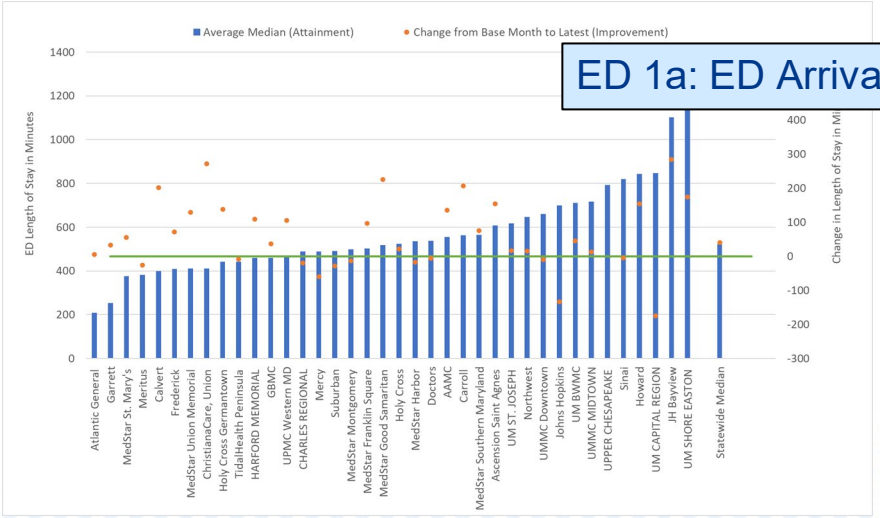
- Public reporting of monthly data for three measures
  - ED-1, OP18, EMS Turnaround times
- Led by HSCRC and MIEMSS

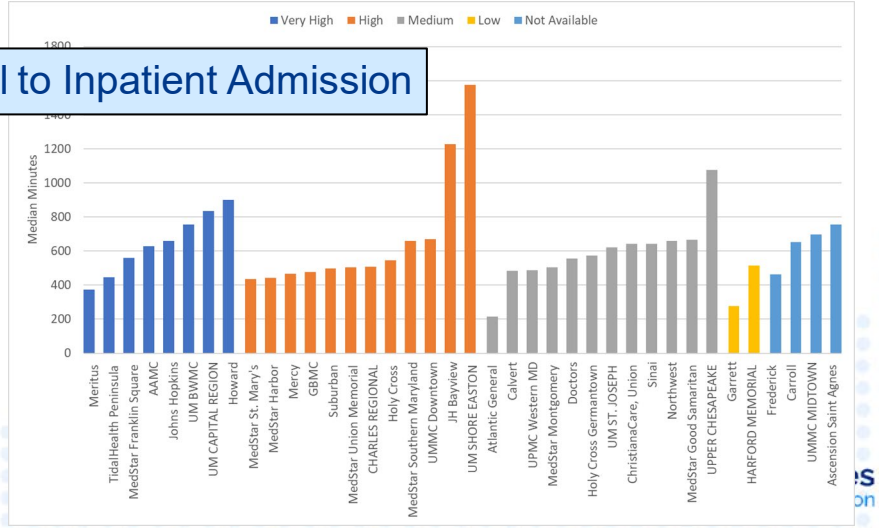
Monthly Commission Presentation

- Staff present EDDIE data at each monthly Commission meeting with any trends noted (presentations can be found in the post-meeting Commission packets)
- Changes over time and performance by volume are provided (overall and stratified by psychiatric status)

EDDIE data is submitted within a week of the end of the month (timely), but should be considered self-reported, unaudited, preliminary results for trending purposes.

ED 1a: ED Arrival to Inpatient Admission





Quality Based Reimbursement (QBR) Program

Purpose

To incentivize quality improvement across three patient-centered quality measurement domains:

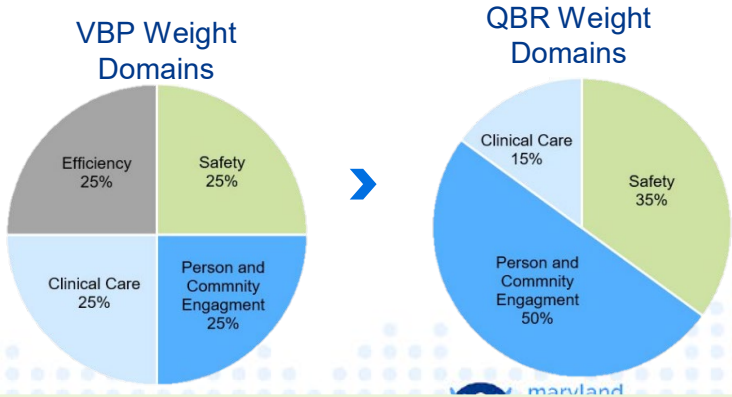
1. **Person and Community Engagement (HCAHPS)** - 8 survey-based measures + follow-up + ED Length of Stay
2. **Clinical Care** - inpatient mortality rate + hip/knee replacement complication rate
3. **Safety** - 6 measures of in-patient Safety (National Healthcare Safety Network (NHSN) Healthcare Associated Infections) + Patient Safety Index (PSI-90)

How it Works: Revenue-at-Risk

The Program puts **2 percent** of inpatient hospital revenue at risk (maximum penalty/reward)

Federal Alignment

The QBR program uses **similar measures to the federal Medicare Value-Based Purchasing (VBP) program** but has an all-payer focus and adjustable domain weights that focus on MD-specific improvements.



Weighting of ED LOS Measure

RY2026 Proposed Weighting (2% total at-risk)	Model 1: Current Policy w/o THA-TKA	Model 2: Draft Recommendation w/o THA-TKA	Model 3: Modified Staff Recommendation	Model 4: No Weight Changes w/o THA-TKA or ED LOS
PCE Domain	**50.0%**	**60%**	**60%**	**50%**
HCAHPS TopBox (8)	25.0%	25.0%	20%	25.0%
HCAHPS Consistency	10.0%	10.0%	10%	10.0%
HCAHPS Linear (4)	10.0%	5.0%	10%	10.0%
ED Wait Times	0.0%	10.0%	10% ⇦	0.0%
TFU Medicare	2.5%	3.3%	3.3%	1.7%
TFU Medicare Disparity Gap	0.0%	3.3%	3.3%	1.7%
TFU Medicaid	2.5%	3.3%	3.3%	1.7%
Clinical Care Domain	**15%**	**15%**	**10%**	**15%**
IP Mortality	15.0%	7.5%	5%	7.5%
30-Day Mortality	0.0%	7.5%	5%	7.5%
THA/TKA	0.0%	0.0%	0%	0%
Safety Domain	**35%**	**25%**	**30%**	**35%**
CAUTI	5.8%	4.2%	5%	5.8%
C. Diff	5.8%	4.2%	5%	5.8%
SSI (2)	5.8%	4.2%	5%	5.8%
CLABSI	5.8%	4.2%	5%	5.8%
MRSA	5.8%	4.2%	5%	5.8%
PSI 90 (10)	5.8%	4.2%	5%	5.8%

ED LOS is weighted at 10 percent, which is about $22.5 M statewide

Other HSCRC Initiatives

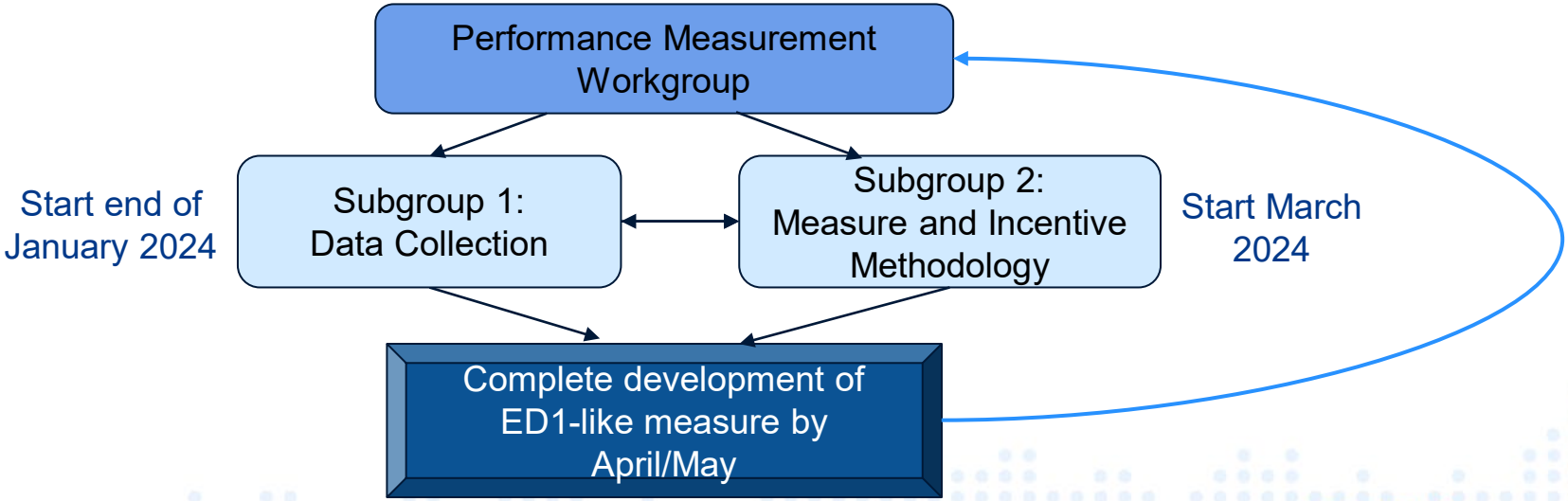
- Commissioners will vote on policy related to Multi-Visit Patients at the February Commission meeting
  - Designed to incentivize reduction in ED visits by Multi-Visit Patients on a reward-only and improvement only basis.
- Staff have been tasked by leadership to develop an ED Best Practices Incentive
  - Will incentivize hospital best practices, alignment with EDDIE initiative, and value based arrangements with non-hospital providers that will improve hospital throughput and by extension reduce ED LOS.
- Collaboration with MDH to address post-acute, end-of-life, and sub-acute behavioral health capacity

Subgroup 1: Workgroup Charge and Goals for today's meeting

QBR: ED LOS Measure Development Plan

Objective:

- Subgroup 1: Develop mechanism to collect ED length of stay for patients admitted to the hospital
- Subgroup 2: Develop ED LOS measure and incentive methodology for RY 2026 QBR



What are we trying to accomplish in today's meeting?

- Review ED-1 specifications and discuss decision points (e.g., whether and how to include observation stays)
- Discuss options for data collection of an ED-1 like measure and decide the direction that should be pursued or additional information needed to make decision
- Decide on next steps/opportunities

ED1 Measure Specifications

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ED-1 Specifications Overview

- Overview
- CMS requirements
- The Joint Commission (TJC) requirements
- Comparison of CMS and TJC requirements
- Discussion

ED-1 General Overview

Commissioners have expressed preference for total length of stay for patients who are admitted

- The length of time from the emergency department (ED) arrival to time of departure from the ED for patients admitted to the facility from the ED.
- The goal is to reduce patient time in the ED to improve access to treatment and increase quality of care.
- CMS is the steward of the National Quality Forum (NQF) #0495 electronic clinical quality measure (eCQM). (There is an eCQM version and a non-eCQM version of the measure).
- TJC collects data through manual data collection and provides detailed guides for each data collection element.

ED-1 CMS Requirements

- Process Measure
- Stratifying of cases that DO HAVE and DO NOT have a principal diagnosis of Psychiatric or Mental Health
- Is NOT risk adjusted
- ED-1 is National Quality Forum (NQF) #0495, CMS is the measure steward
- NQF endorsed measure from 10/2008 – 11/2018
- Supplemental data elements: payer, race, ethnicity, and sex

ED-1 CMS Requirements

- Population Criteria
  - Occurrence of ED visit encounter that is </= 1 hour(s) before or concurrent start with an Inpatient encounter (an ED encounter ends and within 60 minutes, the patient is admitted as an inpatient)
- Measure Population Exclusions
  - Transfer from hospital setting </=6 hour(s) before or concurrent with start of ED visit encounter (transfers are excluded, within a 6-hour' period)
- Measure Calculation
  - Difference of ED visit departure date/time and arrival data/time (i.e., arrival time to discharge time)
- Stratification
  - Inpatient encounter and NO principal diagnosis of psychiatric/mental health
  - Inpatient encounter with principal diagnosis of psychiatric/mental health
- Data Criteria, Quality Data Model Variables
  - Inpatient encounter is </=120 day(s) length of stay
  - Ends during measurement period

ED-1 TJC Requirements

- Is a process measure
- Is a TJC National Quality Measure Set, not required for certification
- Is chart abstracted using retrospective data sources
- Sampling criteria is used and is part of the Global Initial Patient Population Algorithm
- Data is entered in and calculated by the Direct Data Submission Platform (DDSP)

ED-1 TJC Requirements

- Is stratified
- Is NOT risk adjusted
- Data Elements include:
  - ED Patient (in the ED)
  - Arrival Date
  - Arrival Time
  - ED Departure Date
  - ED Departure Time
  - IC-10-CM Principal Diagnosis Code

Set Measure ID	Performance Measure Name
ED-1a	Median time from ED arrival to ED departure for admitted ED patients – **Overall Rate**
ED-1b	Median time from ED arrival to ED departure for admitted ED patients – **Reporting Measure (Non-Psych)**
ED-1c	Median time from ED arrival to ED departure for admitted ED patients – **Psychiatric/Mental Health Patients**

b + c = a

Comparison of Measure Requirements

Topic	CMS	TJC
Collection Method	eCQM, NQF #0495	Chart Abstraction
Population	All ED Admissions	Sample Population
Stratified	Yes - Psychiatric/Mental Health	Yes - Psychiatric/Mental Health
Risk Adjusted	No	No
Required	No – eCQM Retired in 2018	No – Not Required for Certification

Comparison of Measure Requirements

Data Elements	CMS	TJC
Required Data Elements		
ED Encounter	SNOWMED CT Value Set	ED Arrival and Departure Date & Time
Inpatient Encounter	SNOWMED CT Value Set	Admitted to hospital (not specific)
Diagnosis	Value Set	ICD-10
Suggested Data Elements		
Ethnicity	Ethnicity CDCREC Value Set	N/A
Race	Race CDCREC Value Set	N/A
Sex	ONC Administrative Sex Administrative Gender Value Set	N/A
Payer	Payer Source of Payment Value Set	N/A

Discussion

Observation Status:

1) How does your facility/organization define observation?

2) Can observation status level of care begin in the ED?

3) Where does your facility provide observation status level of care?

4) If other units are used for observation status or inpatient holding areas (i.e., recovery room, procedural areas, etc.) does your EHR capture if these patients are an OBV or inpatient status while in a holding area bed?

5) Does your EHR capture when observation orders are initiated?

Time stamps of data elements

1) Can you identify time stamps collected in your EHR for required data elements?

- ED Patient (in the ED)
- Arrival Date & Time – registration, arrival captured by RN, triage, when assume care from EMT, other considerations?
- ED Departure Date & time – ED depart captured by RN, clerk, transport team, activation of hospital/admit orders, other considerations?

2) Does your EHR capture ICD-10 diagnosis code in the admission orders?

Data Collection Discussion for ED1-like Measure

Options for Data Collection

Potential Ways to Collect Data:

1. Add date and timestamps and other needed variables to monthly HSCRC case-mix data
2. Allow hospitals to calculate summary measures and submit to HSCRC (similar to EDDIE reporting)
3. Use retired ED1 electronic clinical quality measure/Adapt ED2 eCQM to capture time of admission and observation stays
4. Other ideas?

What is Case Mix Data?

- Patient – level datasets containing Clinical, financial and demographic data for all patients receiving inpatient (IP) and outpatient (OP) services at MD hospitals
- Data is submitted from:
  - 46 acute care hospitals (IP and OP)
  - 7 Free-standing emergency department facilities (OP only)
  - 3 Private psychiatric hospitals (IP only)
  - 2 Rehabilitation hospitals (IP and OP)

What Kind of Data is in Case Mix?

Demographic:

- Unique patient identifiers (MRN, Patient Acc, EIDs)
- Physician identifiers (NPI, MedCHI)
- Date of Birth
- Sex
- Race and ethnicity
- Country of birth and preferred spoken language
- Residency (county & zip code)
- Marital status

Financial:

- Payer source (i.e., Commercial) and health plan payer (i.e., CareFirst)
- Charges and units by rate center
- UB04 billing information

Clinical:

- Admission & discharge dates
- Principle and secondary diagnosis and procedure codes (and dates of procedures)
- Source and nature of admission
- Discharge status of patient
- Types of services provided
- Flag for diagnosis present on admission (POA)

Data comes from the patient medical record as documented by the doctor

How Do We Receive Case Mix Data?

- HSCRC directs how hospitals submit data through annual data submission requirements. Hospital data are laid out into record types: IP and Psych has 4 records; OP has 3
- Hospitals (through 3rd party vendors or internally) abstract patient-level data from EMR and billing systems
- Data is submitted via direct, secure channels to St. Paul Group (SPG), the data repository vendor
- Data is picked up from the repository by hMetrix, the data processing vendor, and processed through edit checks, grouped, and combined into a statewide dataset. Other value-added variables (EIDs, PQIs, etc.) are included prior to being sent to HSCRC for use.
- Data must have an error rate of less than 10% monthly and 5% quarterly, to be accepted for processing
- The data submission requirements and production schedule is posted here: http://hscrc.maryland.gov/Pages/hsp_info1.aspx

Timing of Case Mix Data Submissions

Monthly

- Preliminary
- Due on the 15th of the following month
- Hospitals can request to skip or submit with errors via DAVE

Quarterly

- Final
- Due 60 days after the 3rd submission
- Hospitals can request an extension (no skip, submit with errors are rare), or reopen qtrs. via DAVE

Will require a retrospective data submission for historical data to be able to measure improvement

Submission of Summary Metrics

- Similar to EDDIE process, hospital could submit median times for each strata directly to the HSCRC
- If this option is picked, we would need to figure out how to validate the data. These would be some of the questions we would need to come back to:
  - How would HSCRC validate the data and specifications?
  - Could attestation of data accuracy from hospital leadership be used?
  - Could quality checks against case mix data for number of cases admitted through the ED be used?

Digital Measure Options

- HSCRC required submission of the ED-2 eCQM measure (Median time of order to admit until admission) for CY 2023.
- Significant differences were found in the number of encounters in the case mix data versus those captured using the ED-2 measure logic

	Case Mix ED Record Count	Observation > 1 Hour Removed	eCQM ED Record Count
Statewide Totals	317,443	223,138	169,232
Case Mix Data Delta from eCQM	+148,211	+53,906	

- There is large variation across hospitals in the use of observation (15%-85%)
- A sample of patient cases were reviewed that were present in the Case Mix file but **not** in the ED2 eCQM data; differences were due to eCQM measure logic requirements that were not met and records were excluded.
  - No Decision to Admit documented
  - Decision to Admit documented after admission

Digital Measure Reboot Efforts

- ED-2 measure retired after CY 2023
- CMMI and CMS have indicated they are extending contracts in order to update the measure for use in the state/possibly others that have interest; CMMI would assume stewardship of the measure.
- Hospitals have provided input that their EHR vendors would require additional resources in some cases to implement a Maryland measure or would not support implementation of the measure at all in other cases.

Discussion: Should Maryland make efforts to continue working with CMMI to update an eCQM ED LOS measure?

Options	Pros	Cons
1) HSCRC Case Mix Data	• Familiarity with case-mix submission process • Patient level to allow for additional analytics	• Level of effort to modify case-mix layout • Date and time stamps across entities need to be consistent
2) Calculate Summary Measures	• Hospitals can use current EDDIE process with modifications	• Need to develop way to do quality assurance for the data
3) Adapt ED2 eCQM	• Use of digital infrastructure should increase standardization and ease of reporting	• Measure must be maintained by CMMI • EHR vendor resistance to custom digital measures

Next Steps/Opportunities

- Assess EHR date and time stamps
- Understand patient flow out of the ED and decide how to handle observation cases
- Finalize measure specifications
- Develop timelines for data collection

Next Meeting of Subgroup 1:
Friday, March 1st 10-11:30 am

Appendix

ED-1 CMS Requirements

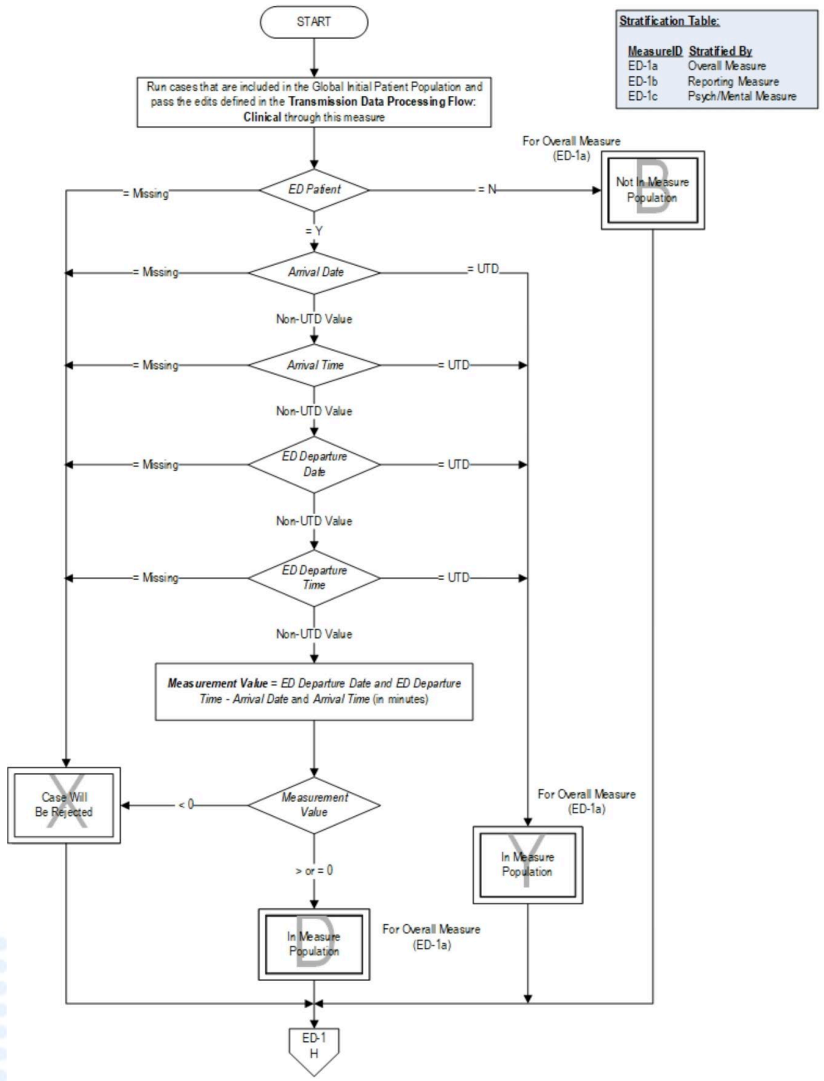
- Data Criteria, Quality Data Model Data Elements
  - ED visit encounter using “Emergency Department Visit SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.292)”
  - Inpatient encounter using “Encounter Inpatient SNOMEDCT Value Set (2.16.840.1.113883.3.666.5.307)”
  - Hospital Settings SNOMEDCT Value Set (2.16.840.1.113762.1.4.1111.126)
  - Principal diagnosis using “Psychiatric/Mental Health Patient Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.299)”

ED-1 CMS Requirements

- Supplemental Data Elements
  - Patient Ethnicity using "Ethnicity CDCREC Value Set (2.16.840.1.114222.4.11.837)"
  - Patient Race using "Race CDCREC Value Set (2.16.840.1.114222.4.11.836)"
  - Patient Sex using "ONC Administrative Sex Administrative Gender Value Set (2.16.840.1.113762.1.4.1)"
  - Payer using "Payer SOP Value Set (2.16.840.1.114222.4.11.3591)"

ED-1 TJC Data Elem

- Data Elements include:
  - ED Patient (in the ED)
  - Arrival Date
  - Arrival Time
  - ED Departure Date
  - ED Departure Time
  - IC-10-CM Principal Diagnosis Code



TJC ED-1 Data Element: ED Patient

- Definition: Patient received care in a dedicated emergency department of the facility.
- Question: Was the patient an ED patient at the facility?
- Allowable Values:
  - Yes, There is documentation the patient was an ED patient
  - No, There is no documentation the patient was an ED patient, or unable to determine from medical record documentation.
- Notes for Abstraction:
  - Select No, if the patient is transferred from another hospital ED, Observation Unit, outside hospital as an inpatient or outpatient status (even if in same hospital system)
- Suggested data sources: ED record, face sheet, registration form
- Exclusions: Urgent Care, Fast Track ED, Terms synonymous with Urgent Care

TJC ED-1 Data Element: Arrival Date

- Definition: The earliest documented month, day, and year the patient arrived at the hospital
- Question: What was the earliest documented date the patient arrived at the hospital?
- Allowable Values: MM-DD-YY (includes dashes) or UTD
  - MM = Month (01-12)
  - DD = Day (01-31)
  - YYYY = Year (20XX)
  - UTD = Unable to determine
- Notes for Abstraction:
  - The medical record must be abstracted as documented **(taken at "face value").** When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after the Discharge Date] and no other documentation is found that provides this information, the **abstractor should select "UTD."** An invalid date will be rejected from TJC's data warehouse; while UTD allows the case to be accepted into the warehouse.
  - Review the Only Acceptable Sources to determine the earliest date the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit.

***UTD = Unable to Determine**

TJC ED-1 Data Element: Arrival Date

- The only acceptable sources include:
  - Emergency Department record, includes any documentation from the time period that the patient was an ED patient
  - Nursing admission assessment/admitting note
  - Observation record
  - Procedure notes
  - Vital signs graphic record
- Exclusions
  - Addressographs/stamps
  - Pre-arrival orders

TJC ED-1 Data Element: Arrival Time

- Definition: The earliest documented time (military time) the patient arrived at the hospital
- Question: What was the earliest documented time the patient arrived at the hospital?
- Allowable Values: Military time, HH:MM (with or without a colon) or UTD
  - HH = Hour (00-23)
  - MM = Minutes (00-59)
  - UTD = Unable to determine
  - 00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the Arrival Date should remain 11-24-20xx or if it should be converted to 11-25-20xx.
- Notes for Abstraction:
  - The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD.”
- Only accepted sources include the
  - ED record
  - Nursing admission assessment/admitting note
  - Observation record
  - Procedure notes
  - Vital signs graphic record

TJC ED-1 Data Element: Departure Date

- Definition: The month, day, and year at which the patient departed from the ED.
- Question: What is the date the patient departed from the ED?
- Allowable Values: MM-DD-YY (includes dashes) or UTD
  - MM = Month (01-12)
  - DD = Day (01-31)
  - YYYY = Year (20XX)
  - UTD = Unable to determine
- Notes for Abstraction:
  - The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select "UTD."
  - If the date of departure is not documented, but the date can be determined from other documentation in the ED record, this is acceptable to use (the patient arrived and was transferred on the same day).
- Data fields representing ED Departure Date in electronic documentation for this specific episode of care are acceptable to use as long as the fields are easily understood to mean departure. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge date being abstracted. Examples include:
  - Patient departed
  - Patient transferred off the floor (OTF)
  - Check out time
  - Transported to

TJC ED-1 Data Element: Departure Date

- Only accepted source is the ED record.
- Inclusions:
  - ED checkout date
  - ED departure date
  - ED discharge date
  - ED leave date
  - ED transport date
- Exclusion: Patient admission date

TJC ED-1 Data Element: Departure Time

- Definition: The time represented in hours and minutes at which the patient departed from the ED.
- Question: What is the time the patient departed from the ED?
- Allowable Values: Military time, HH:MM (with or without a colon) or UTD
  - HH = Hour (00-23)
  - MM = Minutes (00-59)
  - UTD = Unable to determine
  - 00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the Arrival Date should remain 11-24-20xx or if it should be converted to 11-25-20xx.
- Notes for Abstraction:
  - The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD.”
  - Transmission of a case with an invalid time as described above will be rejected from the Joint Commission's Data Warehouse. Use of “UTD” for ED Departure Time allows the case to be accepted into the warehouse.
  - When more than one acceptable emergency department departure/discharge time is documented, abstract the latest time.
- Only accepted sources – ED record

TJC ED-1 Data Element: Departure Time

- Notes for Abstraction
  - Data fields representing ED Departure Time in electronic documentation for this specific episode of care are acceptable to use as long as the fields are easily understood to mean departure. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge time being abstracted.
    Examples
    - Patient departed
    - Patient transferred off the floor (OTF)
    - Check out time
    - Transported to ED
  - For patients who are placed into **observation** under the services of the emergency department, abstract the time of departure from the observation services.
    - If a patient is seen in the ED and admitted to an **observation unit of the ED**, then discharged from the observation unit, abstract the time they depart the observation unit.
    - Do not abstract the time they are placed into observation services or the time that the observation order was written. If the patient is placed into **observation services and remains in the ED or in a unit of the ED abstract the time they depart the ED or ED unit for the floor/surgery, transfer to another hospital, admission to an inpatient bed, etc**

TJC ED-1 Data Element: Departure Time

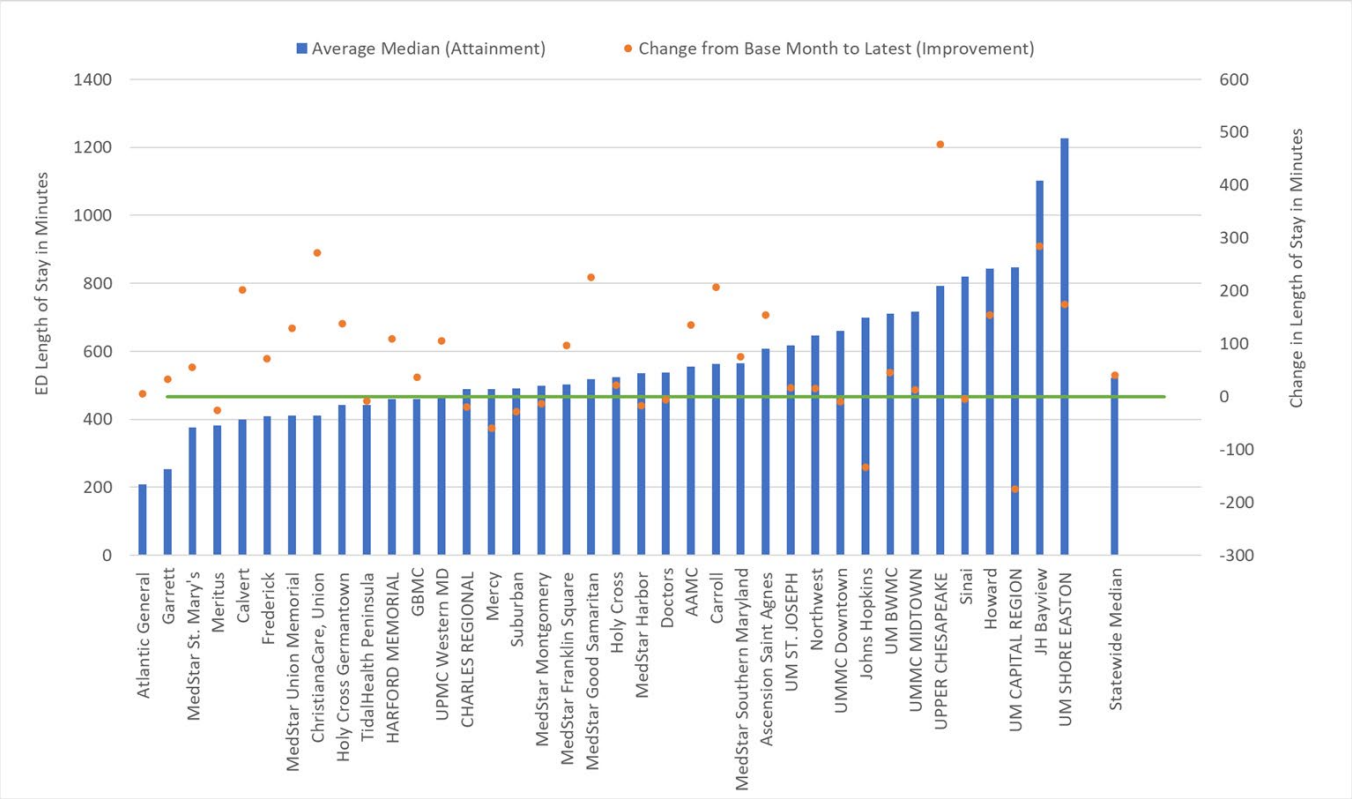
- If the patient expired in the ED, use the time of death as the departure time.
- Guidelines for abstraction

Inclusion	Exclusion
• ED check out time • ED departure time • ED discharge time • ED leave time • ED transport time	• Patient admission time • Report called time

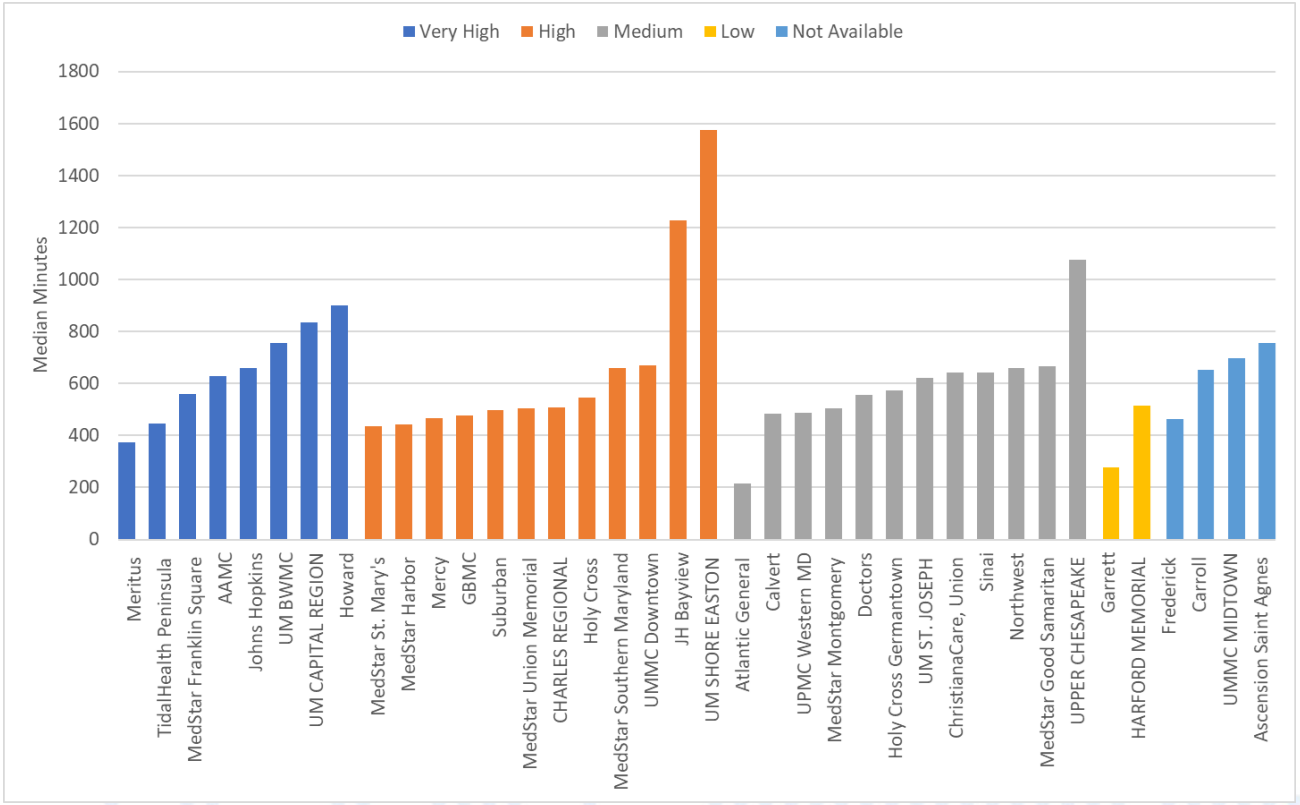
TJC ED-1 Data Element: ICD-10-CM Principal Diagnosis Code

- Definition: The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.
- Question: What was the ICD-10-CM code selected as the principal diagnosis for this record?
- Allowable Values: 3-7 characters (without decimal point or dot; upper or lower case). Any valid diagnosis code as per the CMS ICD-10-CM master code table: https://www.cms.gov/Medicare/Coding/ICD10/index.html
- Suggested data sources: Face sheet, discharge summary, UB-04

ED 1a: ED Arrival to Inpatient Admission



ED 1a: ED Arrival to Inpatient Admission Time
Latest Month Median By Volume--Latest Month



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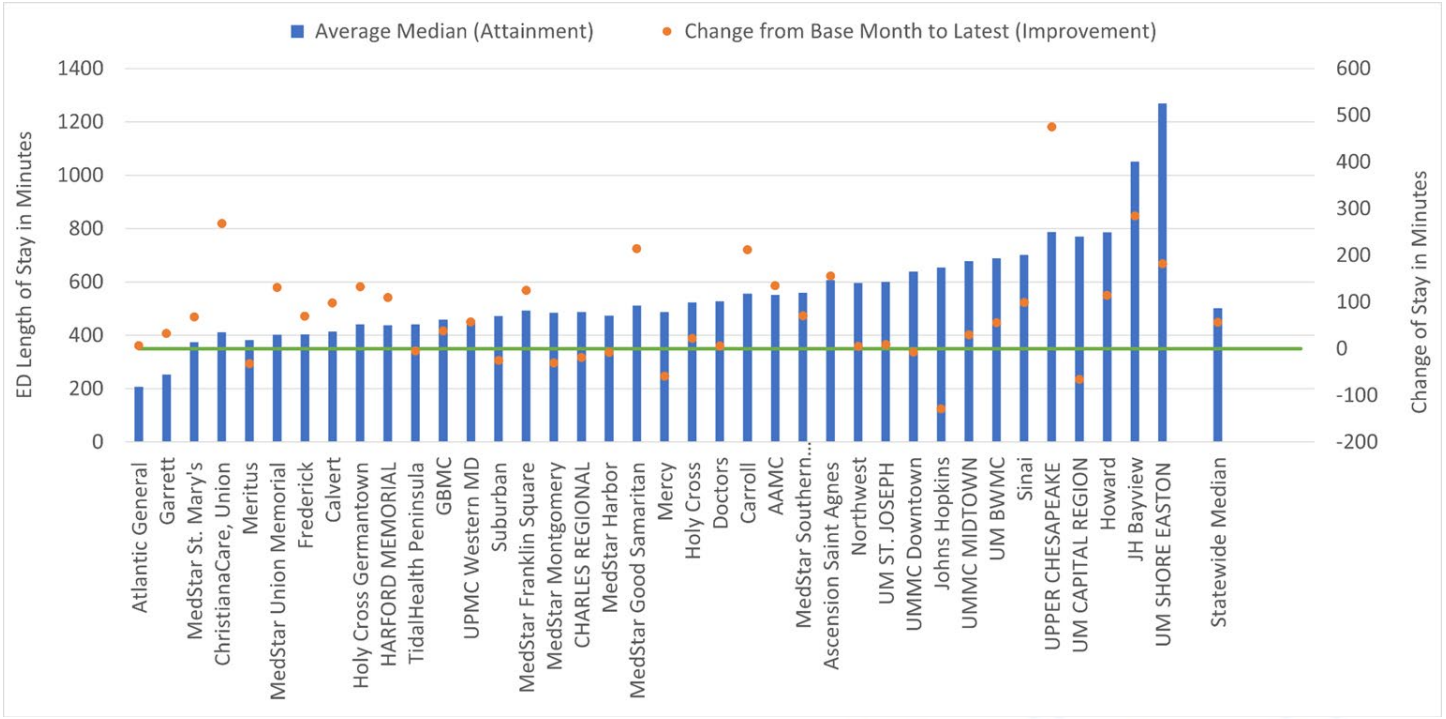
ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric



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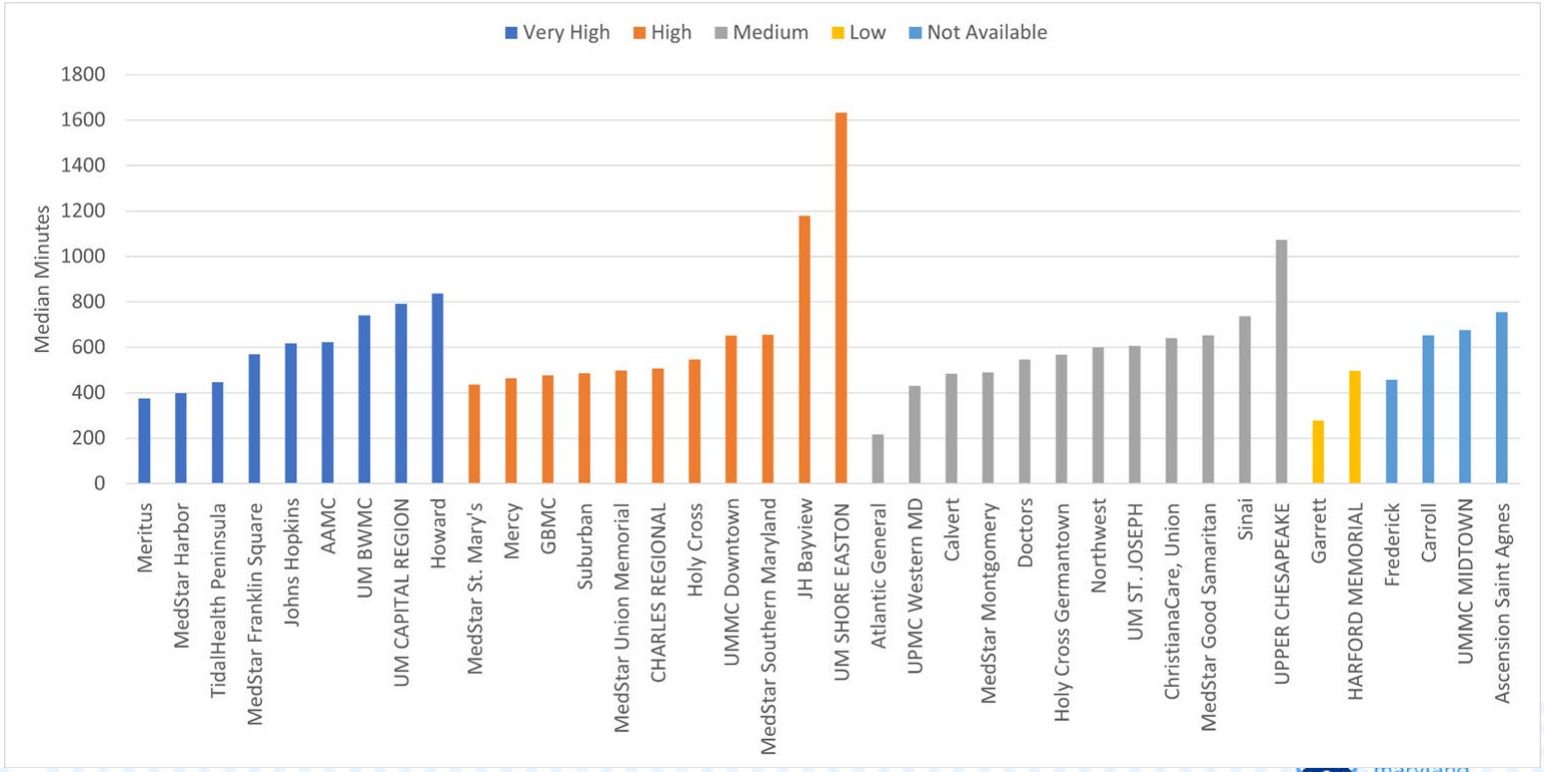
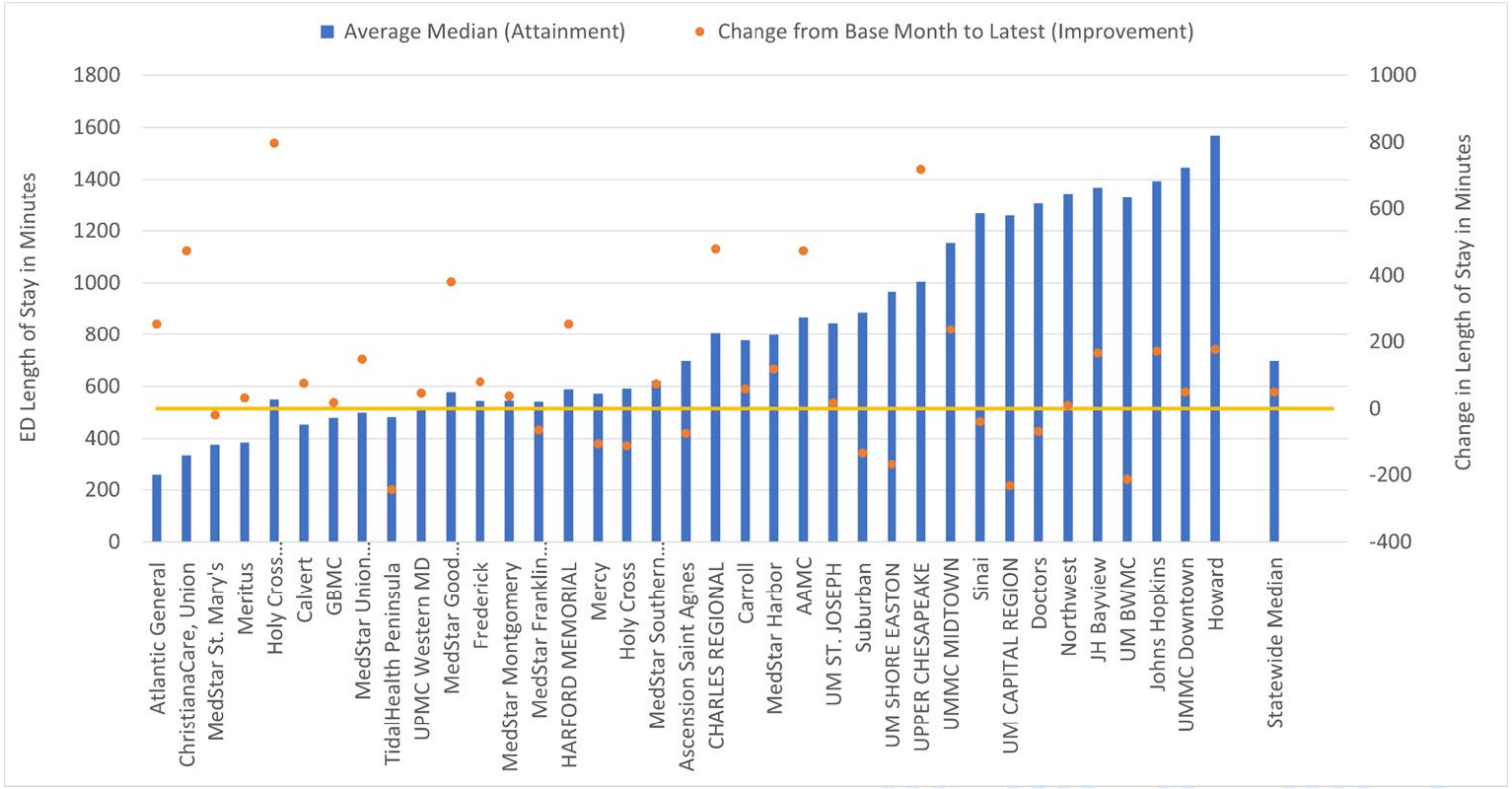
ED 1b: ED Arrival to Inpatient Admission Time by Volume Non-Psychiatric ED Visits



ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric



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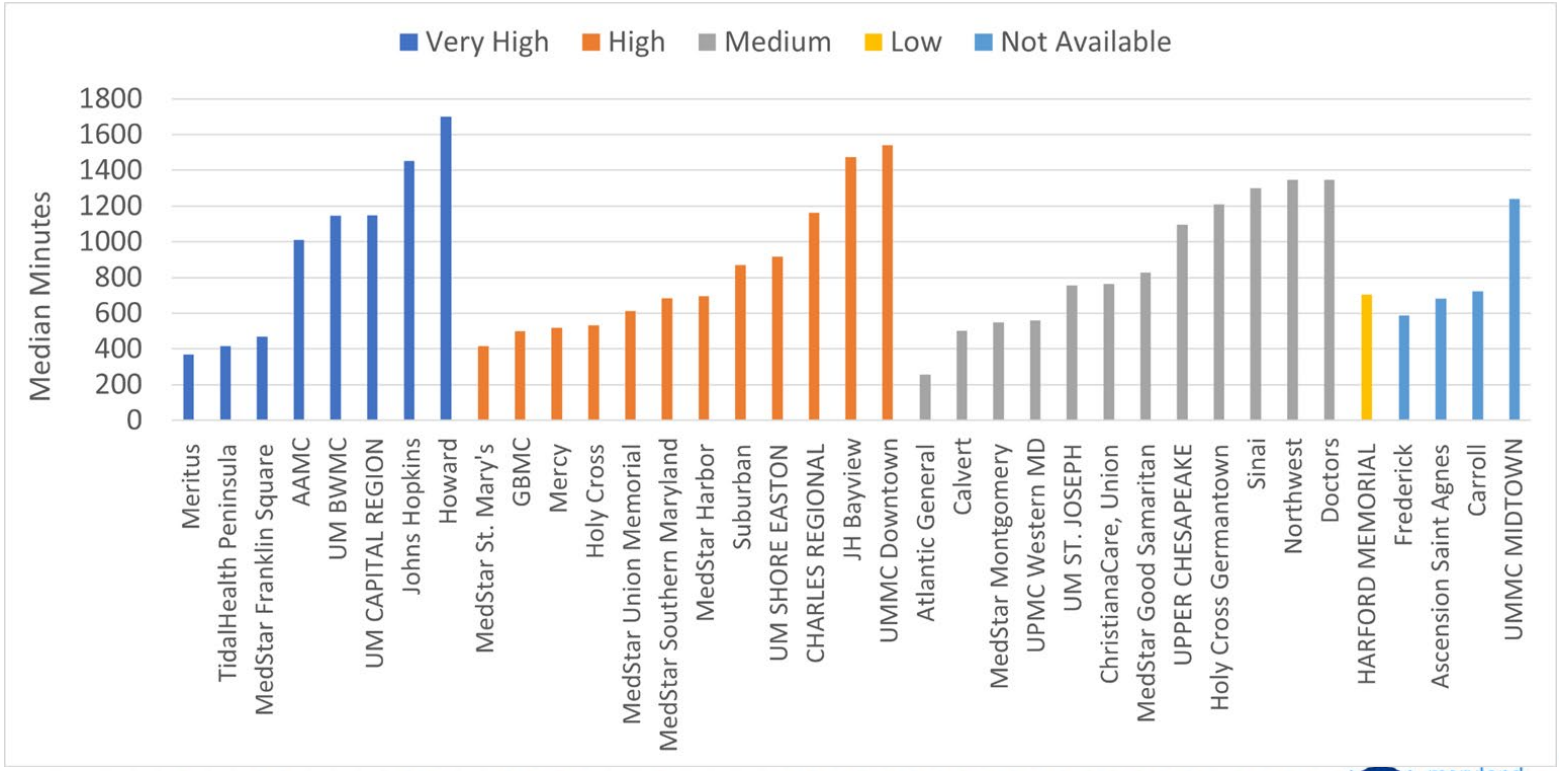
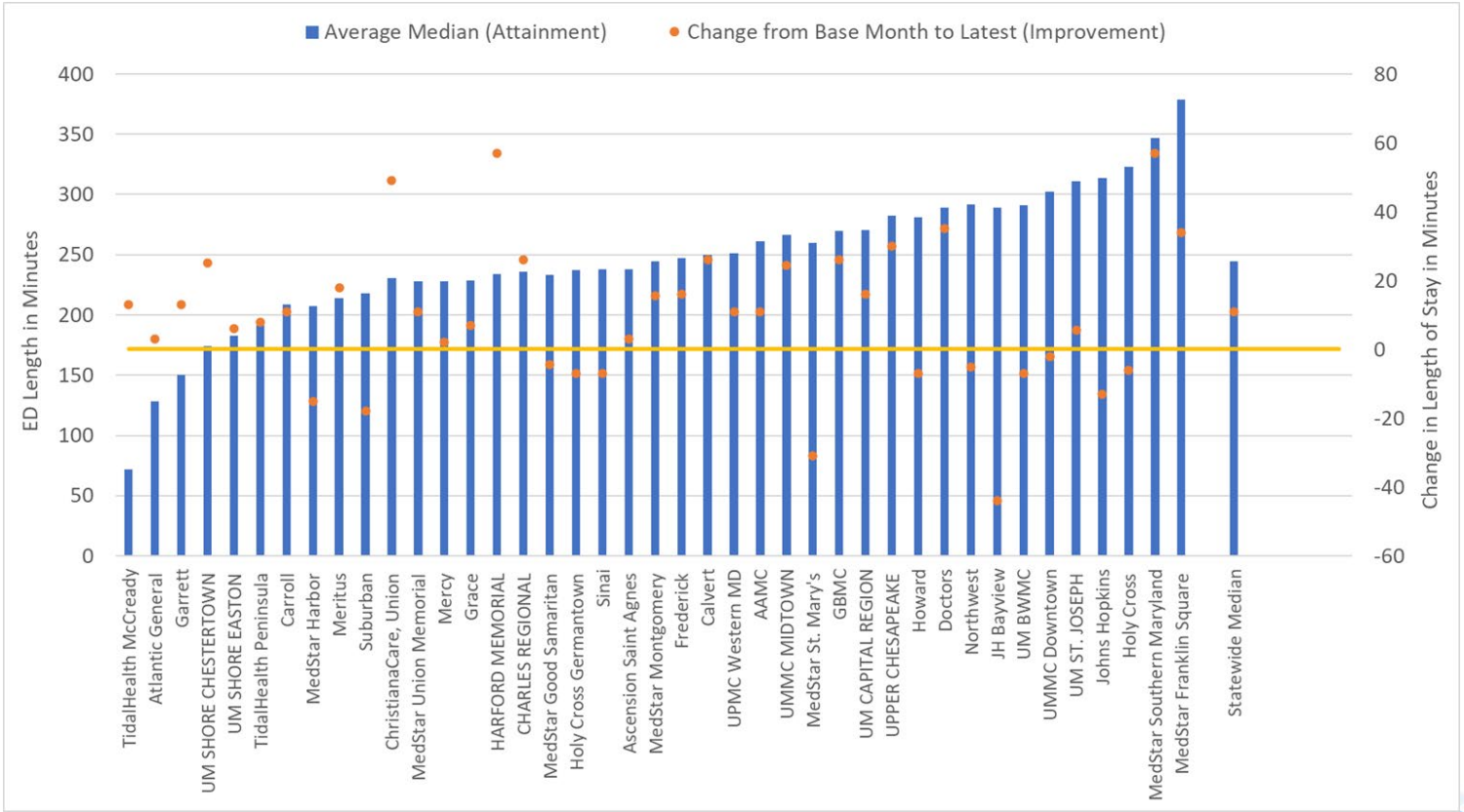
ED 1c: ED Arrival to Inpatient Admission Time by Volume Psychiatric ED Visits



OP18a: ED Arrival to Discharge Time by Month



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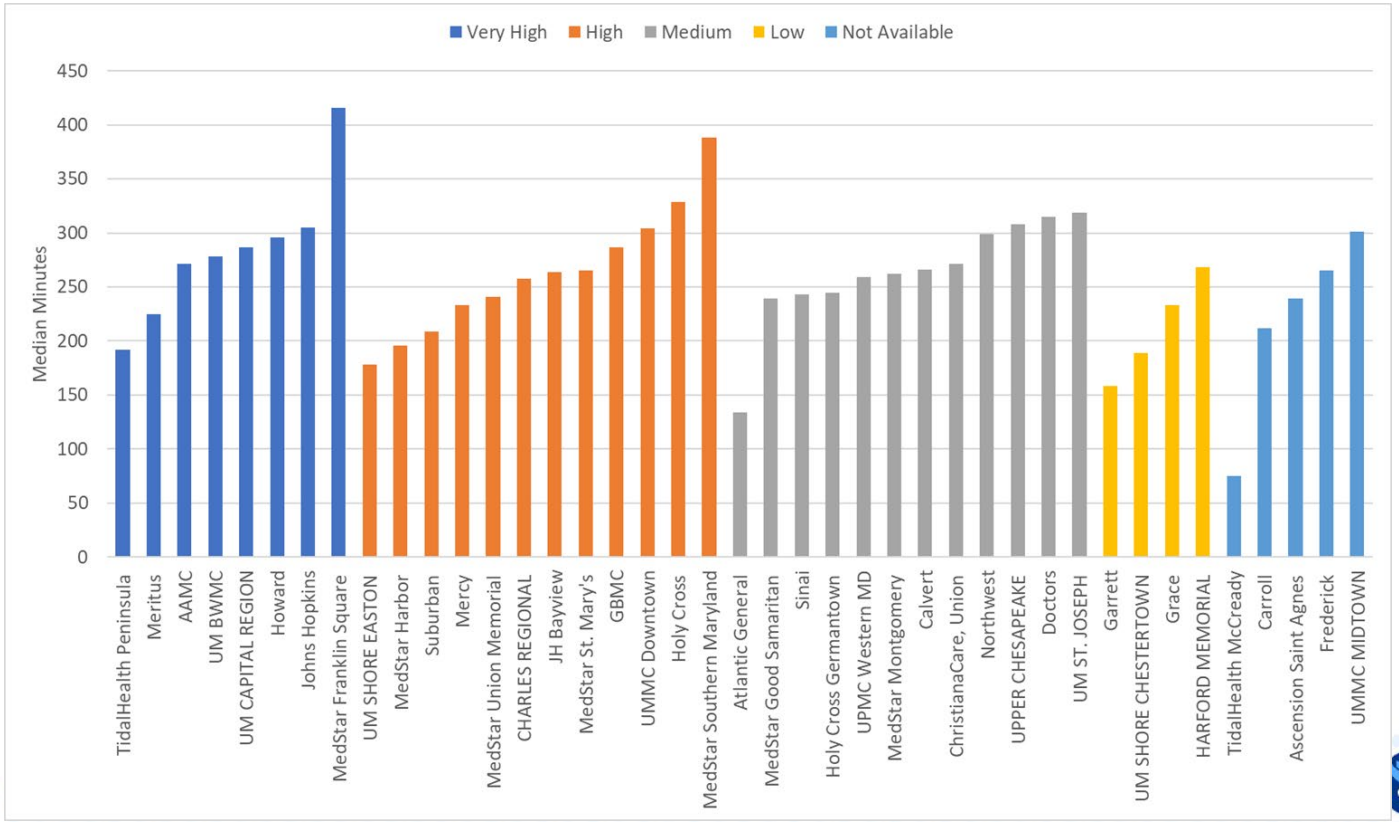
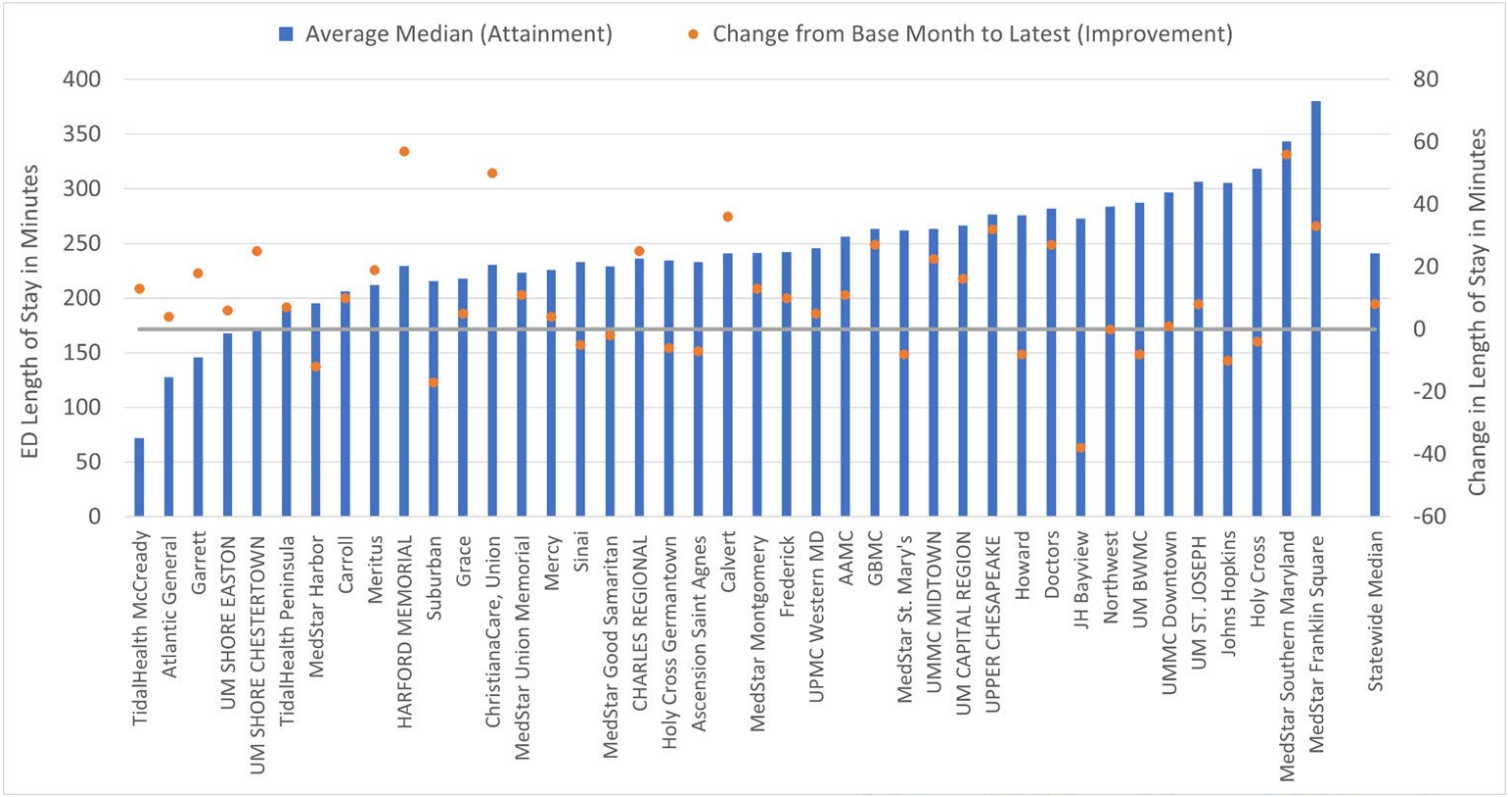
OP18a: ED Arrival to Discharge Time Latest Month Median By Volume--Latest Month



OP18b: ED Arrival to Discharge Time - Non Psychiatric



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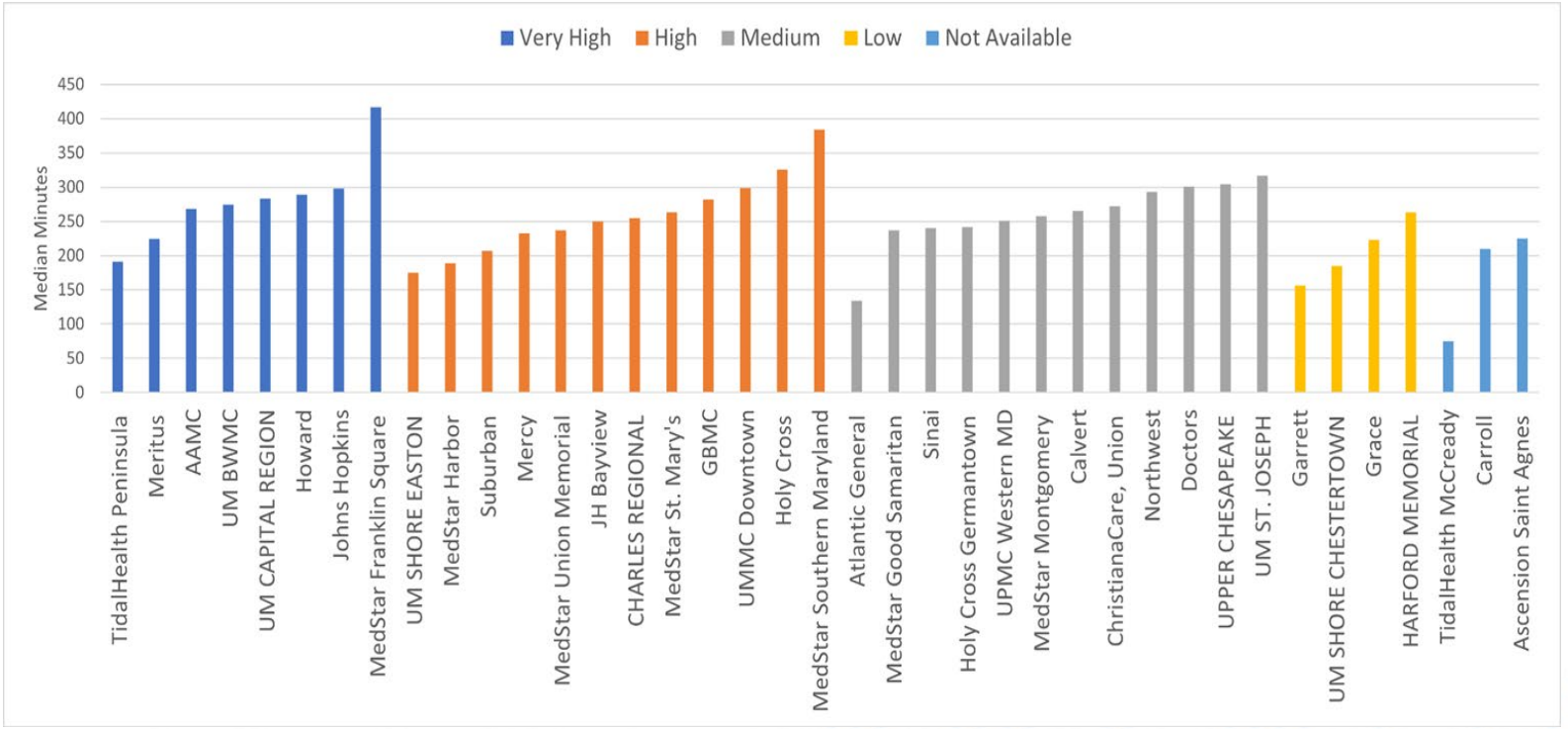
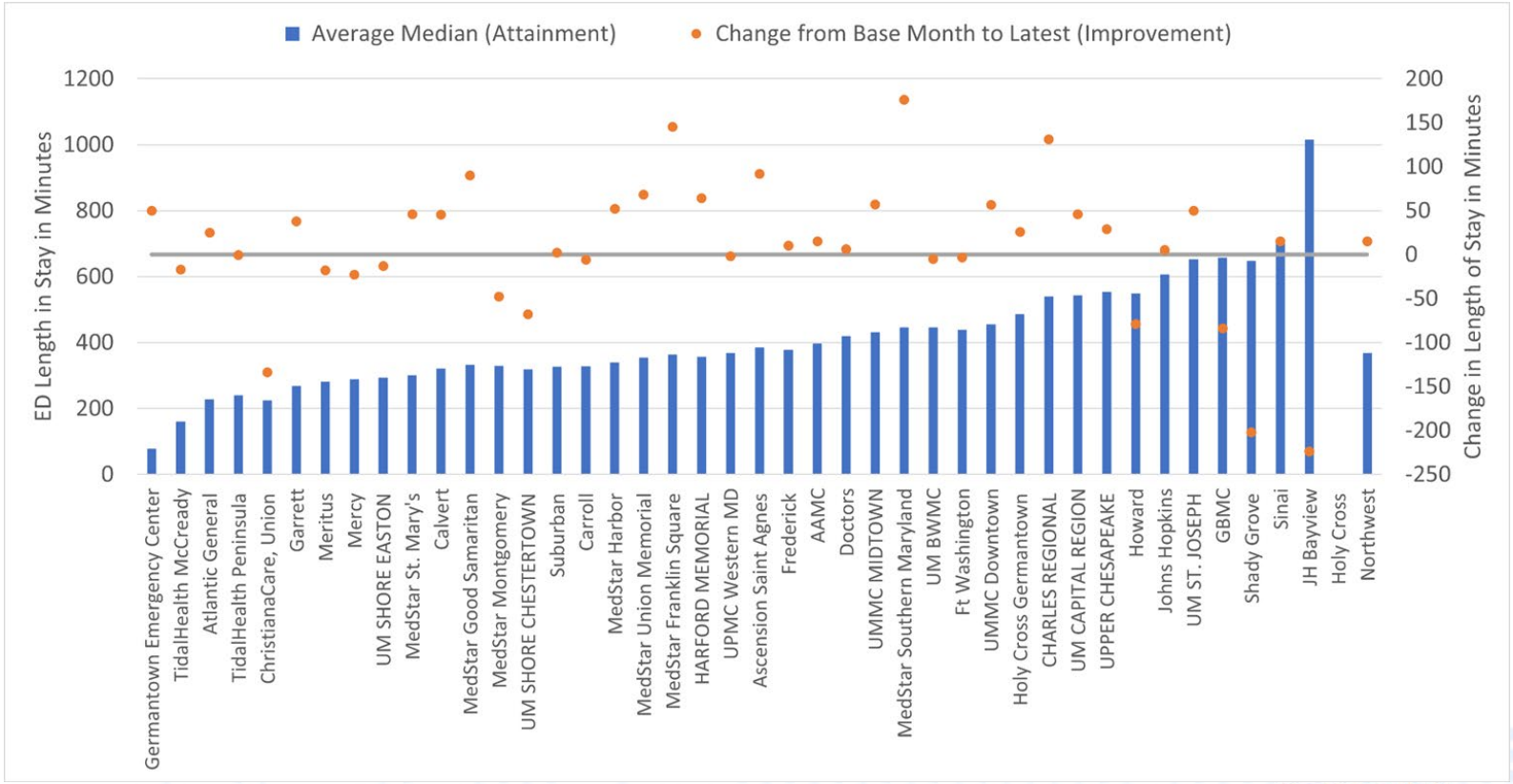
OP18b: ED Arrival to Discharge Time by Volume Non-Psychiatric ED Visits



OP18c: ED Arrival to Discharge Time by Month



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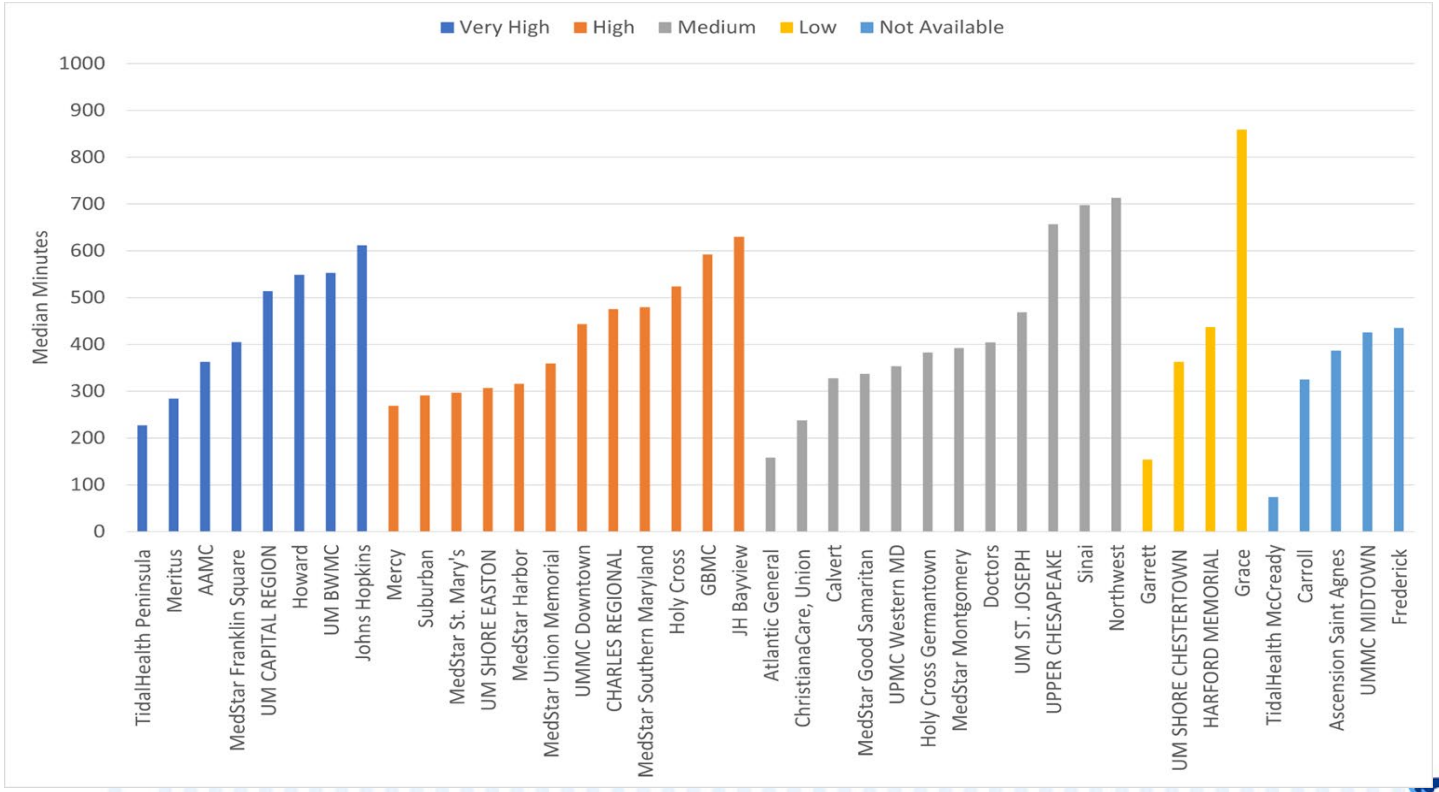
OP18c: ED Arrival to Discharge Time by Volume Psychiatric ED Visits



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