EDTC 4-part Series Review

(Elements covered: Home Medications, ED Provider Note, Mental Status Assessment, Tests and Procedures Performed, Tests and Procedure Results)

General Notes

- Ensure your measure population is correct. For the purposes of MBQIP, hospice inpatient, nursing home and swing bed patients (among others) **are** included. Assisted Living, home health, hospice to the home, acute to our own facility, and observation (among others) **are not** included. See page 6 of specifications manual for listing of patients included/excluded. Link at end of document.
- Sample size is **45 a quarter**. If you have less than 45 then you would not be eligible to sample and would abstract all of them.
- Ensure chart abstractors are looking in all places in the chart where info could be documented as sent.
- **Documentation** that info was sent is what you are looking for in order to say yes to the element
- Measure is all or none, meaning if you miss one of the 8 elements then your hospital does not get credit for any for that patient record
- Contact your IT department to ask what EMR forms may already be available that you are not aware of or if customizable options exist to assist staff in being compliant with their documentation
- Dot phrases to assist in documentation have been very helpful, again check with IT. We know for sure one exists in EPIC, and other facilities have worked with IT to build their own
- Paper checklists are helpful and still used to help with staff compliance and to remind them
- Some facilities still send a paper copy of the items with the patient
- Involve someone in the ED besides yourself as an ED champion
- Real time auditing is helpful. One hospital shared that they review ED patient charts the next morning and talk with the staff if there are any missed items. Real time discussions work better than addressing it weeks later.

- Make staff accountable…if it wasn't documented it wasn't done. Can also add an item for "complete and timely documentation" to employee performance evaluations to help with this
- Explaining the WHY to staff can help with compliance. Patients deserve their information to be communicated so the receiving facility can provide the best care possible. Nobody likes to have to try to care for someone you know hardly anything about.
- Some facilities have added EDTC elements to their EMTALA form
- One facility has the unit secretary in charge of making sure all EDTC elements are present before patient leaves
- Hard stops in charting could be an option for items staff are regularly forgetting
- Verbally reporting all EDTC elements by phone is acceptable as long as you have documentation of this occurring and elements that were discussed
- Information must be sent to receiving facility **within 60 minutes** of patient departure
- Consider auditing across different shifts of staff to see if fall outs are occurring in one group more than another
- Transferring between providers with same EMR can assume the information was sent, but still need documentation of "available in EPIC," etc. You also should verify that it is indeed immediately available a couple of times by asking receiving staff if they are able to access the documents. Don't just assume.
- Goal of this measure is **100% of patients have all 8 elements sent** to receiving facility within 60 minutes of departure
- Definition of "sent" is that you have documentation that it was done
- Select one place in the record where elements are documented and educate staff on this location
- Review EDTC performance at team meetings
- Consider making it fun and competitive between shifts or staff types such as between nurses and physicians or between day shift and night shift to see who can have fewer missed EDTC items in a month
- Review the specifications manual if you have not. Each element has a separate section with easy to read specifics. Link at end of this document
- Read through the FAQ document if you have not. Its specific to EDTC and has some common scenarios you might find helpful. Link at end of this document

Home Medications—Session 1

- If med list is incomplete and you are unable to get additional information on the meds, communicate this to the receiving facility. If you communicate it and document that you did this, you can say "yes" in your chart abstraction.
- If provider documents home meds in his provider note, this can count as "yes" as long as you have documentation that it was there and sent
- If there are no home meds, communicate this to receiving facility and document that it was communicated, and you can say "yes" to this element

ED Provider Note—Session 2

- Provider note does not need to be signed in order for it to be sent. If it seems like your EMR requires it to be signed maybe check with IT to see if this can be changed to allow you to be able to send it sooner
- Must have documentation that note was sent to be able to say "yes"

Mental Status Assessment—Session 3

- Any healthcare professional (nurse, social worker, etc) can document mental status assessment (as long as within their scope of practice), does not have to be the physician, however if the physician does document this and its in his provider note this can count as long as you have it documented
- Any assessment/words can be used to document mental status. It does not just have to be the Glasgow-coma scale.

Tests Performed/Test Results—Session 4

- These are 2 separate elements. You are looking for documentation that tests performed were communicated and then the results of those tests were communicated.
- If all test results are not back by the time the patient transfers out, that is ok. Just communicate this to the receiving facility and state how you will let them know of additional test results once they are complete. Then document this, and you can say "yes" to this element.

Data Specifications Manual: https://www.telligen.com/wp-content/uploads/2025/03/EDTC-Data-Specs-Manual-2019-1.pdf

Link to FAQ document: https://www.telligen.com/wp-content/uploads/2025/03/EDTC-FAQ.pdf

How to use your MBQIP reports: If you do not receive reports about your data, please reach out to Michelle or Terri. These are sent out by Terri as the data becomes available.
https://www.flexmonitoring.org/sites/flexmonitoring.umn.edu/files/media/MBQIP_Reports_User_Guide_for_CAHs_v4.1.30.26.pdf

Population and Sampling

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:**
  - Extended or Intermediate Care Facility (ECF/ICF)
  - Long Term Acute Care Hospital (LTACH)
  - Long Term Care Facility
  - Nursing Home or Facility, including Veteran's Administration Nursing Facility
  - Psychiatric Hospital or Psychiatric Unit of a Hospital
  - Rehabilitation Facility, including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
  - Skilled Nursing Facility (SNF), Sub-Acute Care, or Swing Bed
  - Transitional Care Unit (TCU)

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

Exclusions:

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

Q: Does the Mental Status/Orientation Assessment data element need to be completed by the provider?

A: No. There is nothing in the EDTC Data Specifications Manual that indicates that the mental status/orientation assessment needs to be done by the provider (physician, advanced practice nurse (APN) or physician assistant (PA). The only data element that requires provider documentation is the ED Provider Note data element.

Q: What is the difference between the data elements Tests and/or Procedures Performed and Test and/or Procedure Results?

A: The data element Tests and/or Procedures Performed requires that if any tests and/or procedures were done in the ED, that information must be sent to the receiving facility. Say a chest x-ray and a urine culture were done, there must be documentation sent to the receiving facility that they were done. The results of that chest x-ray and urine culture must be sent to the receiving facility to say yes for the Tests and/or Procedure Results data element. So, one data element is for documentation they were done, and the other is for documentation of the results. Say the chest x-ray was sent, but the urine culture wasn't done at the time the patient was discharged/transferred. You could only answer yes to the Tests and/or Procedures Results if there was documentation sent to the receiving hospital on how the results of the urine culture were going to be communicated when they were available.