



## 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 #:** 0495

**Corresponding Measures:**

**De.2. Measure Title:** Median Time from ED Arrival to ED Departure for Admitted ED Patients

**Co.1.1. Measure Steward:** Centers for Medicare and Medicaid Services

**De.3. Brief Description of Measure:** Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department

**1b.1. Developer Rationale:** Reducing the time patients remain in the emergency department (ED) can improve access to treatment and increase quality of care. Reducing this time potentially improves access to care specific to the patient condition and increases the capability to provide additional treatment. In recent times, EDs have experienced significant overcrowding. Although once only a problem in large, urban, teaching hospitals, the phenomenon has spread to other suburban and rural healthcare organizations. According to a 2002 national U.S. survey, more than 90% of large hospitals report EDs operating "at" or "over" capacity. Approximately one third of hospitals in the US report increases in ambulance diversion in a given year, whereas up to half report crowded conditions in the ED. In a recent national survey, 40% of hospital leaders viewed ED crowding as a symptom of workforce shortages. ED crowding may result in delays in the administration of medication such as antibiotics for pneumonia and has been associated with perceptions of compromised emergency care. For patients with non-ST-segment-elevation myocardial infarction, long ED stays were associated with decreased use of guideline-recommended therapies and a higher risk of recurrent myocardial infarction. Overcrowding and heavy emergency resource demand have led to a number of problems, including ambulance refusals, prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised.

**S.4. Numerator Statement:** Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

**S.6. Denominator Statement:** Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

**S.8. Denominator Exclusions:** Patients who are not an ED Patient

**De.1. Measure Type:** Process

**S.17. Data Source:** Electronic Health Records, Other, Paper Medical Records

**S.20. Level of Analysis:** Facility

**IF Endorsement Maintenance – Original Endorsement Date:** Oct 24, 2008 **Most Recent Endorsement Date:** Sep 09, 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?** The measure does not HAVE to be reported with 0497, but it may be valuable for internal quality improvement within a facility.

### 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**

[0495\\_MeasSubm\\_Evidence\\_1.8.14-636426334979114692.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.

**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.*

Reducing the time patients remain in the emergency department (ED) can improve access to treatment and increase quality of care. Reducing this time potentially improves access to care specific to the patient condition and increases the capability to provide additional treatment. In recent times, EDs have experienced significant overcrowding. Although once only a problem in large, urban, teaching hospitals, the phenomenon has spread to other suburban and rural healthcare organizations. According to a 2002 national U.S. survey, more than 90% of large hospitals report EDs operating "at" or "over" capacity. Approximately one third of hospitals in the US report increases in ambulance diversion in a given year, whereas up to half report crowded conditions in the ED. In a recent national survey, 40% of hospital leaders viewed ED crowding as a symptom of workforce shortages. ED crowding may result in delays in the administration of medication such as antibiotics for pneumonia and has been associated with perceptions of compromised emergency care. For patients with non-ST-segment-elevation myocardial infarction, long ED stays were associated with decreased use of guideline-recommended therapies and a higher risk of recurrent myocardial infarction. Overcrowding and heavy emergency resource demand have led to a number of problems, including ambulance refusals, prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised.

**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.

Median Time From ED Arrival to ED Departure for Admitted ED Patients:

1Q2012 top tenth percentile: 175    1Q2012 National median time: 260  
2Q2012 top tenth percentile: 176    2Q2012 National median time: 256  
3Q2012 top tenth percentile: 178    3Q2012 National median time: 257  
4Q2012 top tenth percentile: 177    4Q2012 National median time: 258  
1Q2013 top tenth percentile: 179    1Q2013 National median time: 264

Scores by decile are available as an attachment in the "Additional" section. Disparities data and distribution is also available in attachment."

**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.

Information on patient characteristics (gender, race and age) is provided in the review of testing data. For Disparities Data, see appendix under "Hospital Level Distribution - ED-1b"

**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

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

Elderly

**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.)

[https://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228890621170&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3D2\\_5\\_ED\\_v5\\_2a.pdf&blobcol=urldata&blobtable=Mungo](https://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228890621170&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3D2_5_ED_v5_2a.pdf&blobcol=urldata&blobtable=Mungo)

**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)

Attachment Attachment: NQF\_0495\_-ED-1-\_Codes-636153999021285277-636371811885712491-636426334978020942.xlsx

**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.

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.

**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.

Since the last measure update in 2015, clarification was added to the ED Departure Time data element regarding patients that expire in the ED or have an ED departure time that is prior to arrival time. The following two bullet points were added to the Notes for Abstraction for the ED Departure Time data element to provide this clarification:

- If the documented ED Departure Time is prior to arrival, enter “UTD.”
- If the patient expired in the ED, use the time of death as the departure time.

**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).*

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

**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).*

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

Data Elements:

- Arrival Date
- Arrival Time
- ED Departure Date
- ED Departure Time
- ED Patient
- ICD-10-CM Principal Diagnosis Code

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

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

**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).*

Any ED Patient from the facility's emergency department.

Data Element Name: ED Patient

Definition: Patient received care in a dedicated emergency department of the facility.

Suggested Data Collection Question: Was the patient an ED patient at the facility?

Allowable Values:

Y (Yes) There is documentation the patient was an ED patient.

N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.

Notes for Abstraction:

- For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department.
- Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).
- Patients presenting to the ED who do not receive care or services in the ED abstract as a “No” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).
- Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a “Yes”.

ED:

- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select “No”. This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select “No”, even if the transferred patient is seen in this facility’s ED.
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select “No”. This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select “No”, even if the transferred patient is seen in this facility’s ED.

Suggested Data Sources:

- Emergency department record
- Face sheet
- Registration form

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

- Urgent Care
- Fast Track ED
- Terms synonymous with Urgent Care

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

Patients who are not an ED Patient

**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.)*

All non-ED patients are excluded from this measure.

Data Element Name: ED Patient

Definition: Patient received care in a dedicated emergency department of the facility.

Suggested Data Collection Question: Was the patient an ED patient at the facility?

Allowable Values:

Y (Yes) There is documentation the patient was an ED patient.

N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.

Notes for Abstraction:

- For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department.
- Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).
- Patients presenting to the ED who do not receive care or services in the ED abstract as a “No” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).
- Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a “Yes”.

ED:

- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select “No”. This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select “No”, even if the transferred patient is seen in this facility’s ED.
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select “No”. This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select “No”, even if the transferred patient is seen in this facility’s ED.

Suggested Data Sources:

- Emergency department record
- Face sheet
- Registration form

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

- Urgent Care
- Fast Track ED
- Terms synonymous with Urgent Care

**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.)*

ED-1a Median Time from ED Arrival to ED Departure for Admitted ED Patients – Overall Rate (All reported cases)

ED-1b Median Time from ED Arrival to ED Departure for Admitted ED Patients – Reporting Measure (Cases without an ICD-10-CM Principal Diagnosis of a Psychiatric or Mental Health Disorder. Refer to attached NQF 0495 (ED-1) Codes.)

ED-1c Median Time from ED Arrival to ED Departure for Admitted ED Patients – Psychiatric/Mental Health Patients (Cases with an ICD-10-CM Principal Diagnosis of a Psychiatric or Mental Health Disorder. Refer to attached NQF 0495 (ED-1) Codes.)

**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

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 = Lower 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.*)

Emergency Department (ED)-1: Median Time from Emergency Department Arrival to ED Departure for Admitted ED Patients

Continuous Variable Statement: Time, in minutes, from ED arrival to ED departure for patients admitted to the facility from the emergency department.

1. Start processing. Run cases that are included in the Global Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.
2. Check ED Patient
  - a. If ED Patient is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-1a, proceed to step 9.
  - b. If ED Patient equals No, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Assign the Measure Category to B for ED-1a, proceed to step 9.
  - c. If ED Patient equals Yes, continue processing and proceed to check Arrival Date.
3. Check Arrival Date
  - a. If the Arrival Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-1a, proceed to step 9.
  - b. If the Arrival Date equals Unable To Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Assign the Measure Category to Y for ED-1a, proceed to step 9.
  - c. If Arrival Date equals a Non Unable To Determine Value, continue processing and proceed to check Arrival Time.
4. Check Arrival Time
  - a. If the Arrival Time is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-1a, proceed to step 9.
  - b. If the Arrival Time equals Unable To Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Assign the Measure Category to Y for ED-1a, proceed to step 9.
  - c. If Arrival Time equals a Non Unable To Determine Value, continue processing and proceed to check ED Departure Date.
5. Check ED Departure Date
  - a. If the ED Departure Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-1a, proceed to step 9.
  - b. If the ED Departure Date equals Unable To Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Assign the Measure Category to Y for ED-1a, proceed to step 9.
  - c. If ED Departure Date equals a Non Unable To Determine Value, continue processing and proceed to check ED Departure Time.
6. Check ED Departure Time
  - a. If the ED Departure Time is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-1a, proceed to step 9.
  - b. If the ED Departure Time equals Unable To Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Assign the Measure Category to Y for ED-1a, proceed to step 9.
  - c. If ED Departure Time equals a Non Unable To Determine Value, continue processing and proceed to Calculate Measurement Value.
7. Calculate Measurement Value. Measurement Value, in minutes, is equal to the ED Departure Date and ED Departure Time minus the Arrival Date and Arrival Time. Continue processing and proceed to check Measurement Value.
8. Check Measurement Value
  - a. If the Measurement Value is greater than or equal to zero minutes, the case will proceed to a Measurement Category Assignment of D and will be in the Measure Population. Assign the Measure Category to D for ED-1a. Proceed to step 9.
  - b. If the Measurement Value is less than zero minutes, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-1a. Proceed to step 9.
9. Initialize the Measure Category Assignment for measures (ED-1b, 1c) to equal 'B'. Continue processing and proceed to check Overall Rate Category Assignment.
10. Check Overall Rate Category Assignment



- a. If the Overall Rate is “D or Y or X” continue processing and proceed to check ICD-10-CM Principal Diagnosis Code. NOTE: X is for The Joint Commission Only.
- b. If the Overall Rate is equal to B stop processing.
11. Check ICD-10-CM Principal Diagnosis Code
  - a. If the ICD-10-CM Principal Diagnosis Code is on Table 7.01, set the Measure Category Assignment for measure ED-1c equal to ED-1a. Stop processing. Note: Copy Measurement value from ED-1a to ED-1c if ED-1c equals D.
  - b. If the ICD-10-CM Principal Diagnosis Code is not on Table 7.01, set the Measure Category Assignment for measure ED-1b equal to ED-1a. Stop processing. Note: Copy Measurement value from ED-1a to ED-1b if ED-1b equals D.

**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.

Global is an umbrella name for four measure sets, Emergency Department (ED), Immunization (IMM), Substance Use (SUB) and Tobacco Treatment (TOB).

The purpose of defining an umbrella name was to apply one population flow and one sampling on the Global population and reduce the burden of sampling for four measure sets or any number of these four measure sets that are selected.

Therefore, if only two of the Global measure sets are selected and reported, the process would only apply for those two measure sets.

The Global Initial Patient Population is defined by two data elements:

- Admission Date
- Discharge Date

All patients discharged from acute inpatient care with Length of Stay (Discharge Date minus Admission Date) less than or equal to 120 days are included in the Global Initial Population and are eligible for sampling.

The cases that are accepted into the Global Initial patient population and are sampled would be selected for the specific measure set and return to the Transmission Data Processing Flow: Clinical in the Data Transmission section.

For The Joint Commission, hospitals must submit the same case for all applicable measure sets (i.e., ED, IMM, SUB and TOB) under the Global Initial Patient Population. Example:

If a hospital has elected to submit ED, TOB and IMM to The Joint Commission, for every ED case that is submitted the same case must also be submitted as a TOB case and an IMM case to The Joint Commission’s Data Warehouse. The same holds true regardless of the combination of measure sets (ED, IMM, SUB, TOB) the hospital has elected to submit to The Joint Commission.

For CMS, if the hospital is submitting both ED and IMM as chart abstracted measures, the hospital is encouraged to submit the same case to the QIO Clinical Warehouse for both measure sets. If the hospital is submitting the ED measure set electronically only (as eMeasures), only the chart abstracted IMM cases would be submitted to the QIO Clinical Warehouse.

The Global Initial Patient Population only contains the population information and flow. There is no measure associated to Global; therefore there is no measure flow or MIF for Global.

For Emergency Department (ED), Immunization (IMM), Substance Use (SUB) and Tobacco Treatment (TOB) Initial Patient Population definitions, please refer to the Global Initial Patient Population. For Emergency Department, Immunization, Substance Use and Tobacco Treatment Initial Patient Population Algorithms please refer to the Global Initial Patient Population Algorithm.

Global Initial Patient Population Algorithm

Variable Key:

Length of Stay

TOB Initial Patient Population Reject Case Flag (TJC only)

SUB Initial Patient Population Reject Case Flag (TJC only) ED Initial Patient Population Reject Case Flag

IMM Initial Patient Population Reject Case Flag

1. Start Global Initial Patient Population logic sub-routine. Process all cases that have successfully reached the point in the Transmission Data Processing Flow: Clinical, which calls this Initial Patient Population Algorithm. Do not process cases that have been rejected before this point in the Transmission Data Processing Flow: Clinical.

2. Calculate the Length of Stay, in days, which is equal to the Discharge Date minus the Admission Date.

3. Check Length of Stay

a. If the Length of Stay is greater than 120 days, the patient is not in the Global Initial Patient Population and is not eligible to be sampled for the Global measure sets. For CMS and The Joint Commission, set ED and IMM Initial Patient Population Reject Case Flag to equal Yes. For The Joint Commission Only, set TOB and SUB Initial Patient Population Reject Case Flag to equal Yes. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.

b. If the Length of Stay is less than or equal to 120 days, the patient is eligible to be sampled for all (any selected) of the Global measure sets. All Cases in the Global Initial Patient Population are in ED, IMM, SUB, and TOB measure sets Initial Patient Population.



For each selected measure set, all the sampled cases should be submitted to Hospital Clinical Data. Continue processing.

4. For CMS and The Joint Commission set the ED and IMM Initial Patient Population Reject Case Flag to equal No. For The Joint Commission Only set the TOB and SUB Initial Patient Population Reject Case Flag to equal No. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.

#### Global Sample Size Requirements

Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. A hospital may choose to use a larger sample size than is required. Hospitals whose Initial Patient Population size is less than the minimum number of cases per quarter for the measure set cannot sample.

Regardless of the option used, hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Due to exclusions, hospitals selecting sample cases MUST submit AT LEAST the minimum required sample size.

To reduce the burden of multiple sampling for different measure sets, those hospital's that are submitting any of the measure sets under the Global Initial Patient Population, the pulled sample must be used to identify the data for all measure sets or stratum that are transmitted to the QIO Clinical Warehouse and The Joint Commission's Data Warehouse. For more information concerning how to perform sampling and using the Global sample size for other measure sets, please refer to the Population and Sampling Specifications section in this manual.

The following sample size tables for each option automatically build in the number of cases needed to obtain the required sample sizes for the measure sets under the Global initial patient population.

#### Quarterly Sampling

Hospitals performing quarterly sampling for Global must ensure that its Initial Patient Population and sample size meet the following conditions:

$\geq 1530$ , sample is 306

765 – 1529, sample is 20% of Initial Patient Population size

153 – 764, sample is 153

6 – 152, sample is: No sampling; 100% Initial Patient Population required

0 - 5, sample is: Submission of patient level data is encouraged but not required.

**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.

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

If other, please describe in S.18.

Electronic Health Records, Other, 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.

Data collection occurs through vendors or via the CART tool which can be found at

<http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1205442057026>

**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 at measure-specific web page URL identified in S.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

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

[0495\\_MeasSubm\\_MeasTesting\\_1.8.14-635253135351775806-636426334980052192.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.*

### 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.*

### 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.*

## 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.

[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 a combination of electronic sources](#)

**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).

**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.

Specifications (including codes and data elements) are modified every 6 months according to feedback received from clinicians, facilities and experts. Data is available in the medical record and there are no feasibility or implementation issues identified. Missing data regarding timing issues can result in cases being assigned to a noncalculable outcome which does not impair the integrity of our data results but provides a mechanism for facilities to evaluate internal quality improvement efforts to assure accuracy and completion of data collection.

**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).

**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)
Quality Improvement (Internal to the specific organization)	<p>Public Reporting CMS HIQR Program <a href="https://www.qualitynet.org/dcs/ContentServer?c=Page&amp;pagename=QnetPublic%2FPage%2FQnetTier2&amp;cid=1138115987129">https://www.qualitynet.org/dcs/ContentServer?c=Page&amp;pagename=QnetPublic%2FPage%2FQnetTier2&amp;cid=1138115987129</a></p> <p>Payment Program CMS HIQR Program <a href="https://www.qualitynet.org/dcs/ContentServer?c=Page&amp;pagename=QnetPublic%2FPage%2FQnetTier2&amp;cid=1138115987129">https://www.qualitynet.org/dcs/ContentServer?c=Page&amp;pagename=QnetPublic%2FPage%2FQnetTier2&amp;cid=1138115987129</a></p> <p>Regulatory and Accreditation Programs Joint Commission Accreditation <a href="http://www.jointcommission.org/accreditation_process_overview/">http://www.jointcommission.org/accreditation_process_overview/</a></p>

**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

CMS HIQR Program has approximately 3700 hospitals participating nationwide. See link above for purpose details.

Joint Commission Accreditation; geographic area and other information unknown. See link above for purpose details.

**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?)**

N/A

**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.)**

N/A

**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.**

N/A

**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.**

N/A

**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.**

N/A

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

N/A

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

N/A

**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.**

N/A

### **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.**

**It may be valuable to determine whether times decrease in small volume EDs as compared to large volume EDs. The larger volume EDs handle the patients with higher acuity. The Technical Panel supporting this measure set have requested stratification based on**

acuity for the Hospital Compare display. Consumer testing may be performed before CMS will agree that stratification is valuable to the consumer.

#### 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.

No unintended consequences identified.

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

### 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.  
Yes

##### 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.

There are Australian measures that look at wait time in the ED, but none in the United States.

#### 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?

No

##### 5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

0495 is the total time in the ED, 0497 is time in ED AFTER decision to admit. The same population is targeted, but the measure focus is different. Both may be equally important to represent.

#### 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.)

Based on a search of the NQF QPS system and NQMC, there are no competing or similar measures in the United States. Australia has

several measures that look at ED patients and timing.

## 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:** [Hosp\\_Level\\_Distribution\\_ED1B-636426334981145942.xlsx](#)

## Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** [Centers for Medicare and Medicaid Services](#)

**Co.2 Point of Contact:** [Kristie, Baus, Kristie.baus@cms.hhs.gov, 410-786-8161-](#)

**Co.3 Measure Developer if different from Measure Steward:** [Centers for Medicare & Medicaid Services](#)

**Co.4 Point of Contact:** [Fiona, Larbi, Fiona.larbi@cms.hhs.gov, 410-786-7224-](#)

## 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.**

The measure set has a Technical Expert Panel that provides direction and support. The TEP is involved in revision of measure specifications based on guidelines and emerging science. All changes are vetted through this group.

[James Adams, MD-Professor and Chair, Department of Emergency Medicine, Feinberg School of Medicine, Northwestern Memorial Hospital Chicago, IL](#)

[James Augustine, MD - Director of Clinical Operations, EMP Management Group, Ltd.](#)

[Atlanta, GA](#)

[Rahul Khare, MD-Assistant Professor, Department of Emergency Medicine, Feinberg School of Medicine, Northwestern University Chicago, IL](#)

[Stephen J. Traub, MD- Chairman, Department of Emergency Medicine, Mayo Clinic Phoenix, AZ](#)

[Kathy Szumanski, RN, MSN- Director, Institute for Quality, Safety and Injury Prevention, Emergency Nurses Association Des Plaines, IL](#)

[Shari Welch, MD- Intermountain Health, Quality Matters Consulting Salt Lake City, UT](#)

[Fiona Larbi, RN, BSN, CPAN- Government Task Leader, Centers for Medicare and Medicaid Services Baltimore, MD](#)

[Dale Bratzler, DO, MPH- Associate Dean and Professor, Health Sciences Center, University of Oklahoma Oklahoma City, OK](#)

### Measure Developer/Steward Updates and Ongoing Maintenance

**Ad.2 Year the measure was first released:** [2008](#)

**Ad.3 Month and Year of most recent revision:** [10, 2014](#)

**Ad.4 What is your frequency for review/update of this measure?** [Twice yearly](#)

**Ad.5 When is the next scheduled review/update for this measure?** [07, 2015](#)

**Ad.6 Copyright statement:**

**Ad.7 Disclaimers:**

**Ad.8 Additional Information/Comments:**