November 1, 2021

To: Maryland Hospital Case Mix Liaisons

From: Claudine Williams, Deputy Director, MEDA

 Geoff Dougherty, Deputy Director, Population Health

Re: Collection of Emergency Department Triage Assessment Values for ED Visits in the Case Mix Data Beginning January 1, 2022

This memo is to notify the Maryland Hospital industry of the HSCRC’s intent to **collect emergency department (ED) triage assessment values, effective January 1, 2022 (FY 2022 Q3).** The HSCRC is requesting two new variables: an initial (or first recorded) triage value, as well as a final (or last recorded) triage value. **These revisions must be implemented by the FY 2022 Q3 Final submission (due June 1, 2022).**

**Background**

Over the summer of 2021, the HSCRC convened a subgroup to discuss potentially avoidable Emergency Department utilization. The purpose of this subgroup was to determine an appropriate methodological approach to measuring potentially avoidable utilization in the ED, and to evaluate whether the HSCRC could accomplish such an approach with the available data.

In August 2021, during the final meeting of the subgroup, it was determined that the most feasible next step would be to collect additional data from Maryland Hospitals. The subgroup recommended the collection of triage values to incorporate into a comprehensive analysis of ED utilization. Upon this recommendation, the HSCRC conducted a survey of Case Mix Liaisons to determine the methods by which Maryland Hospitals collect triage assessment data, and followed up with individual outreach to hospitals in the State to understand concerns and challenges in the recommended approach.

The HSCRC’s goal is to use this data in tandem with existing fields to identify potentially avoidable ED visits. The determination of the subgroup was that existing data alone may not capture the full picture of ED visit acuity, and therefore a data point that ostensibly records the perceived acuity of presenting ED patients is an important addition to the methodological goal.

**New Variables Effective January 1, 2022 (FY 2022 Q3)**

In the hopes of making this more seamless for our hospitals, the added variables should be populated with the triage values that your hospital uses, without any additional standardization. HSCRC staff will connect with individual hospitals with further questions as needed.

The FY 2022 DSR sent with this memo has been updated with these changes and is also available on the HSCRC website at <https://hscrc.maryland.gov/Pages/hsp_info1.aspx>.

The two new ED Triage variables are defined below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Data Item** | **Data Item Name** | **Description** | **HSCRC Variable Name** | **Data Type** | **Max Length** |
| 265 | Initial ED Triage Value | Enter the **FIRST** (**initial or earliest**) triage assessment value recorded for a patient visit to the ED. This value should be a numeric value that indicates the urgency designated to the visit by the triage assessment **on arrival**, (1) being the highest urgency, (5) or higher being the lowest urgency. | EDTRIAGE | CHAR | 10 |
| 266 | Final ED Triage Value | Enter the **LAST** triage assessment value recorded for a patient visit to the ED. This value should be a numeric value that indicates the urgency designated to the visit by the triage assessment, (1) being the highest urgency, (5) or higher being the lowest urgency. **This value should reflect patient triage status at the time closest to the time at which the patient’s ED stay ended (discharge, death, admission, transfer, etc.) This value may be missing for non-ED encounters, or if there is only one triage value assigned to the patient.**  | EDTRIAGE2 | CHAR | 10 |

Below are some example values that can be reported in these fields:

**Emergency Severity Index (ESI) categories:**

1 = Patient requires immediate life-saving intervention

2 = Patient is in a high risk situation, is disoriented, in sever pain, or vitals are in danger zone

3 = If multiple resources are required to stabilize the patient, but vitals are not in the danger zone

4 = If one resource is required to stabilize the patient

5 = If patient does not require any resources to be stabilized

**Australasian Triage Scale (ATS) categories:**

1 = Immediate

2 = 10 minutes max waiting time for medical assessment

3 = 30 minutes max waiting time for medical assessment

4 = 60 minutes max waiting time for medical assessment

5 = 120 minutes max waiting time for medical assessment

HSCRC staff understands that hospitals may be using different systems to collect these variables and the values may have different interpretations.

**Submission of Historical ED Triage Data**

In order to have triage data for modeling, the HSCRC is also requiring hospitals to submit the initial ED Triage Status for all ED patients visits for the following periods by the deadline indicated below

* CY 2021 January - June: **Due** **January 15, 2022**
* CY 2021 July - September: **Due** **March 15, 2022**
* CY 2021 October - December: **Due June 15, 2022**

Hospitals shall provide the following information for each ED patient in a pipe delimited text file so that the HSCRC data processing vendor can incorporate this information into the existing datasets:

* Hospital ID
* Medical Record Number
* Patient Account Number
* From Date (MMDDYYYY)
* Through Date (MMDDYYYY)
* Initial triage status code

Please submit the text file to hMetrix via the Adhoc folder in RDS. If you are not able to access this folder, please contact the St.Paul Group (ops@thestpaulgroup.com) for assistance.

**Questions**

For questions related to the Avoidable ED Policy, please contact Geoff Dougherty (geoff.dougherty@maryland.gov) or Zach Goldberg (zach.goldberg@maryland.gov).

For questions or concerns related to the FY 2022 Data Submission Requirements and submission deadlines, please contact me (claudine.williams@maryland.gov) or Oscar Ibarra (oscar.ibarra@maryland.gov).