Emergency Department Transfer Communications (EDTC) Data Specifications Manual

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Stratis Health, based in Bloomington, Minnesota, is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

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June 2026 Release Notes

- No substantive changes have been made to the measure specifications
- Updated to incorporate FAQs as an appendix
- Removed outdated information relating to the Medicare Promoting Interoperability Program
- Minor edits for clarity

Emergency Department Transfer Communication Measure Specifications

EDTC Quality Measure

Numerator Statement: Number of patients transferred to another health care facility whose medical record documentation indicated that all of the following relevant elements were documented and communicated to the receiving hospital promptly:

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

Denominator Statement: Transfers from an emergency department to another health care facility

Background of the Measure

In 2003, an expert panel convened by Stratis Health and the University of Minnesota Rural Health Research Center identified Emergency Department care as an important quality-assessment category for rural hospitals. Emergency care is particularly critical in rural hospitals, where a more limited scope of services and geographic realities make organizing triage, stabilization, and patient transfer essential aspects of care. Communication between hospitals and clinicians promotes continuity of care and may lead to improved patient outcomes. From 2005 to 2014, these measures were piloted by rural hospitals in Hawaii, Iowa, Maine, Minnesota, Missouri, Nebraska, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Utah, Washington, West Virginia, Wisconsin, and Wyoming. Results of the pilot projects indicated room for improvement in ED care and transfer communication.

Communication problems are a major contributing factor to adverse events in hospitals, accounting for 65% of sentinel events tracked by The Joint Commission. In addition, research indicates deficits in the transfer of patient information between hospitals and primary care physicians in the community, as well as between hospitals and long-term care facilities. Transferred patients are excluded from the calculation of most national quality measures, such as those used in Hospital Compare. The Hospital Compare website was created to display rates for Process of Care measures, using data voluntarily submitted by hospitals.

The Joint Commission has adopted National Patient Safety Goal 2, “Improve the Effectiveness of Communication Among Caregivers.” This goal required all accredited hospitals to implement a standardized approach to handoff communications, including nursing and physician handoffs from the emergency department (ED) to inpatient units, other hospitals, and other health care facilities. The process must include a method for communicating up-to-date information regarding the patient’s care, treatment, services, condition, and any recent or anticipated changes. (Note: The National Patient

Safety Goals are reviewed and modified periodically. In 2013, a communication goal focused on the communication of test results.)

Limited attention has been paid to developing and implementing quality measures focused on patient transfers between EDs and other health care facilities, for example, patients transferred between an ED and a skilled nursing facility. These measures are essential for all health care facilities, but especially for small rural hospitals that transfer a higher proportion of ED patients.

While many aspects of hospital quality are similar across urban and rural hospitals (e.g., providing aspirin to heart attack patients), contextual differences between urban and rural settings shape the emphasis on quality measurement. Because of its role in linking residents to urban referral centers, important aspects of rural hospital quality include triage-and-transfer decision-making about when to provide a particular type of care, patient transport, and coordination of information flows to specialists beyond the community.

Emergency care is important in all hospitals, but it is particularly crucial in rural hospitals. Rural residents often need to travel farther than urban residents to reach a hospital initially. Because of their size, rural hospitals are less likely to have specialized staff and services, such as cardiac catheterization or trauma surgery, found in larger tertiary care centers, so high-acuity patients are also more likely to be transferred. These size and geographic realities underscore the importance of organizing triage, stabilization, and transfer in rural hospitals, suggesting that measuring these processes is a key concern for them.

In 2018, as part of the Rural Quality Improvement Technical Assistance (RQITA) program, Stratis Health, in partnership with the University of Minnesota Rural Health Research Center, convened a Technical Expert Panel (TEP) to review, revise, and update the EDTC measures and the related specifications manual. The Panel members represented national experts in hospital ED physicians and nurses, quality measurement, electronic health records, and data analytics. The TEP met three times via conference call to review the measure specifications, and the discussion focused on three primary issues and challenges: EDTC in a “wired” world, the appropriate population for transfers, and the clinical relevance of specific data elements. The TEP recommended significant changes to help streamline and modernize the measure, including reducing the total number of data elements from 27 to 8, updating the definition of ‘sent’ to better address communication via EHR or HIE, and clarifying specific definitions of individual data elements.

The EDTC measure assesses how well key patient information is communicated from an ED to another health care facility. The measure data elements apply to patients with a wide range of medical conditions (e.g., acute myocardial infarction, heart failure, pneumonia, respiratory compromise, and trauma). They are relevant for both internal quality improvement purposes and external reporting.

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Population and Sampling

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 one of the following 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 Veterans Affairs – including emergency department
- Acute care facility – general inpatient care – including emergency department
- Hospice – health care facility
- Other health care facility, including:
  - Extended or intermediate care facility (ECF/ICF)
  - Long-term acute care hospital (LTACH)
  - Long-term care facility
  - Nursing home or facility, including Department of Veterans Affairs 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)

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 prisons
  - 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

Sample Size Requirements

Hospitals need to submit a minimum of 45 cases per quarter from the required population.
A hospital may choose to sample and submit more than 45 cases. Hospitals that choose to sample can do so quarterly or monthly. Hospitals whose initial patient population size is **less than** the minimum number of 45 cases per quarter for the measure cannot sample and should submit **all cases** for the quarter.

Hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Sample cases should be randomly selected so that each case in the population has an equal chance of being selected.

Measure Calculation

This measure is calculated using an all-or-none approach.

The overall EDTC Measure can be calculated as the percentage of patients who met all eight data elements.

Data elements not appropriate for an individual patient are scored as NA (not applicable), counted in the measure as a positive or 'yes' response, and the patient will meet that element's criteria. The patient will either need to meet the criteria for all data elements or have an NA.

For quality improvement purposes, facilities are encouraged to review their information at the data element level to identify opportunities for improvement in the transfer communication process.

Definition of *Sent* and Considerations for Electronic Transfer of Information

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared electronic health record (EHR) or health information exchange (HIE) (see definition below)

For purposes of this measure, an EHR is defined as one where data entered into the system is **immediately** available at the receiving site. Facilities using the same EHR vendor or an HIE cannot assume that the receiving facility will have immediate access to the transferred patient's records.

EDTC: All or Nothing Composite Calculation

Measure Name: Emergency Department Transfer Communication (EDTC)
Measure ID: EDTC-All

Description: Patients who are transferred from an ED to another health care facility have all necessary communication made available to the receiving facility promptly.

Rationale: Timely, accurate, and direct communication facilitates the handoff to the receiving facility, provides continuity of care, and avoids medical errors and redundant tests.

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred to another health care facility whose medical record documentation indicated that all of the following relevant elements were documented and communicated to the receiving hospital promptly:

1. Home Medications
2. Allergies and/or Reactions
3. Medications Administered in ED
4. ED Provider Note
5. Mental Status/Orientation Assessment
6. Reason for Transfer and/or Plan of Care
7. Tests and/or Procedures Performed
8. Tests and/or Procedures Results

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Denominator Statement: Transfers from an ED to another health care facility
Included Population: All transfers from an ED to another health care facility
Excluded Populations: None

Calculation:
# of patients who have a Yes or NA for all elements
All transfers from the ED to another health care facility

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Sampling: Yes, please refer to the measure-specific sampling requirements (pg. 7)

EDTC Data Elements

1. Home Medications

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that the patient's current home medication list was sent to the receiving facility?

Allowable Values:

- Y (Yes) Select this option if there is documentation that the patient's current home medication list was sent to the receiving facility.
- N (No) Select this option if there is no documentation that the patient's current home medication list was sent to the receiving facility.

Notes for Abstraction:

- If documentation indicates the patient is not on any home medications, select yes.
- If documentation is sent that home medications are unknown, select yes.
- If the patient is unable to respond, select yes.

Suggested Data Sources:

- Emergency department record
- Transfer summary

Inclusion Guidelines for Abstraction:

- Complimentary medications
- Over-the-counter (OTC) medications
- Prescription medications

Exclusion Guidelines for Abstraction: None

2. Allergies and/or Reactions

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that the patient's allergy history was sent to the receiving facility?

Allowable Values:

- Y (Yes) Select this option if there is documentation that the patient's allergy information (or "unknown" if allergies are not known) was sent to the receiving facility.
- N (No) Select this option if there is no documentation that the patient's allergy information was sent to the receiving facility.

Notes for Abstraction:

- Allergy information can include:
    - Food allergies/reactions
    - Medication allergies/reactions
    - Other allergies/reactions
- If there is documentation of either an allergy or its reaction, select yes.
- If the documentation states that allergies are unknown, select yes.
- If documentation of "No Known Allergies" is provided, select yes.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

3. Medications Administered in ED

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that the list of medication(s) administered IN the ED was sent to the receiving facility?

Allowable Values:

- Y (Yes) Select this option if there is documentation that the list of medications administered was sent to the receiving facility.
- N (No) Select this option if there is no documentation that the list of medications administered was sent to the receiving facility.
- NA (Not Applicable) Select this option if no medications were given.

Notes for Abstraction:

- Medication information documented anywhere in the ED record is acceptable.
- If no medications were given, select NA.

Suggested Data Sources:

- Emergency department record
- Medication administration record (MAR) if part of the ED documentation for the current encounter
- Transfer Summary document

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

4. ED Provider Note

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that an ED Provider Note was completed by the physician, advanced practice nurse (APN), or physician assistant (PA) and sent to the receiving facility?

Allowable Values:

- Y (Yes) Select this option if there is documentation that an ED Provider Note was completed and sent to the receiving facility.
- N (No) Select this option if there is no documentation that an ED Provider Note was completed and sent to the receiving facility.

Notes for Abstraction:

- Provider note must include, at a minimum:
- Reason for the current ED encounter (medical complaint or injury)
- History of present illness or condition
- A focused physical exam
- Relevant chronic conditions (Note - chronic conditions may be excluded if the patient is neurologically impaired/altered)

Suggested Data Sources:

- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

5. Mental Status/Orientation Assessment

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that a Mental Status/Orientation Assessment was completed and sent to the receiving facility?

Allowable Values:

- Y (Yes) Select this option if there is documentation that a mental status/orientation assessment was completed and sent to the receiving facility.
- N (No) Select this option if there is no documentation that a mental status/orientation assessment for the condition was completed and sent to the receiving facility.

Notes for Abstraction:

- Acceptable documentation includes, but is not limited to:
    - Alert
    - Oriented
    - Comatose
    - Confused
    - Demented
    - Unresponsive
    - Any coma/stroke scale (e.g., Glasgow Coma Scale)
    - Any mental status/orientation exam, scale, or assessment

Suggested Data Sources:

- Emergency department record
- Transfer summary document
- Glasgow Coma Scale
- Neuro flow sheets
- Vital signs flow sheets

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

6. Reason for Transfer and/or Plan of Care

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that a reason for transfer and/or plan of care was identified by the physician, advanced practice nurse, or physician assistant (physician, APN, PA) and sent to the receiving facility?

Allowable Values:

- Y (Yes) Select this option if there is documentation that a reason for transfer or plan of care was written and sent to the receiving facility.
- N (No) Select this option if there is no documentation that a reason for transfer or plan of care was written and sent to the receiving facility.

Notes for Abstraction:

- May include suggestions for care to be received at the receiving facility.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary
- EMTALA form

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

7. Tests and/or Procedures Performed

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that information was sent regarding any tests and procedures that were done in the ED?

Allowable Values:

- Y (Yes) Select this option if there is documentation that information on all tests and procedures that were done in the ED prior to transfer was sent to the receiving facility.
- N (No) Select this option if there is no documentation that information on all tests and procedures that were done in the ED prior to transfer was sent to the receiving facility.
- NA (Not Applicable) Select this option if no tests or procedures were done.

Notes for Abstraction:

- If no tests or procedures were done, select NA.

Suggested Data Sources:

- Emergency Department record
- Lab documentation
- Transfer Summary document

Inclusion Guidelines for Abstraction:

- Lab work ordered
- X-rays
- Procedures performed
- EKGs
- Cultures

Exclusion Guidelines for Abstraction: None

8. Tests and/or Procedure Results

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

Suggested Data Collection Question: Does the medical record documentation indicate that results were sent from completed tests and procedures done in the ED?

Allowable Values:

- Y (Yes) Select this option if there is documentation of results being sent either with the patient or communicated to the receiving facility when available.
- N (No) Select this option if there is no documentation of results being sent either with the patient or communicated to the receiving facility when available.
- NA (Not Applicable) Select this option if no tests or procedures were done.

Notes for Abstraction:

- If facilities have a shared EHR, then tests and procedure results are considered sent, select yes.
- If results are not sent and facilities do not share EHR, then documentation must include a plan to communicate results in order to select yes.
- If no plan to communicate results, select no.
- If no tests or procedures were done, select NA.

Suggested Data Sources:

- Emergency department record
- Lab documentation
- Transfer summary document

Inclusion Guidelines for Abstraction:

- Lab results
- X-ray results
- Procedure results
- EKG
- Cultures

Exclusion Guidelines for Abstraction: None

Appendix A: EDTC Data Collection Tool

CMS Certified Number (CCN): _____

Name of State: _____

Patient Name: _____

Patient Medical Record Number: _____

Select Patient Discharged Disposition: (Select one option)

_____Hospice – health care facility

_____Acute care facility – general inpatient care

_____Acute care facility – critical access hospital

_____Acute care facility – cancer hospital or children's hospital

_____Acute care facility – Department of Defense or Veterans Affairs

_____Other health care facility:

- Extended or intermediate care facility (ECF/ICF)
- Long-term acute care hospital (LTACH)
- Long-term care facility
- Nursing home or facility, including Department of Veterans Affairs 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)

Date of Patient Encounter: _____/_____/_____
(MM-DD-YYYY)

Date of Data Collection: _____/_____/_____
(MM-DD-YYYY)

NOTE: Prior to completing the data collection tool, please reference the Emergency Department Transfer Communication Measures Data Specifications Manual for detailed descriptions of each data element.

For ALL data elements, the definition of 'sent' includes the following documentation requirements:

- Hard copy sent directly with the patient, or
- Communicated via fax or phone within 60 minutes of patient departure, or
- Immediately available via shared EHR or HIE

1. **Medications Administered in ED:**

   _____Yes _____No_____N/A

2. **Allergies and/or Reactions:**

   _____Yes _____No

3. **Home Medications:**

   _____Yes _____No

4. **ED Provider Note:**

   _____Yes _____No

5. **Mental Status/Orientation Assessment**

   _____Yes _____No

6. **Reason for Transfer and/or Plan of Care**

   _____Yes _____No

7. **Tests and/or Procedures Performed:**

   _____Yes _____No_____N/A

8. **Tests and/or Procedure Results:**

   _____Yes _____No_____N/A

Appendix B: Frequently Asked Questions

Q: Is it true that we can only do 45 cases a quarter for the EDTC measure abstraction? We want to abstract all our cases that meet the population requirement.
A: You can abstract all your cases. The requirement is a minimum of 45 cases per quarter from the required population. A hospital may choose to sample and submit more than 45 cases. Hospitals whose initial patient population size is less than the minimum of 45 cases per quarter cannot sample and must submit all cases for the quarter.

Q: The patient is transferred from our emergency department (ED) to our hospital's swing bed. Are they included in the EDTC population?
A: Yes. Swing beds are listed as one of the inclusions under "Other Health Care Facilities" in the EDTC Data Specifications Manual. It does not matter that the swing bed is in your facility.

Q: The patient is being transferred to a nursing home that is part of our hospital. Should they be included in the EDTC population?
A: Yes. Nursing homes are included under "Other Health Care Facilities" in the EDTC Data Specifications Manual. It does not matter if the nursing home is part of or owned by your hospital.

Q: If a patient resides in a nursing home and is being discharged back to the nursing home, isn't that a discharge home?
A: For the EDTC abstraction, a transfer, discharge, or return to a nursing home is not considered to be a discharge status of "home". Nursing home is listed as one of the inclusions under "Other Health Care Facilities" and those patients should be included in the population for the measure.

Q: If the patient is just being sent back to where they live, such as back to the nursing home, why should they be included?
A: The resident was being sent to the ED for a reason. Was there a new diagnosis given, were meds changed, new ones added, etc.? Information about what occurred during the ED encounter needs to be communicated to the nursing home staff caring for the patient.

Q: Are patients seen in our ED and then sent to observation included in the EDTC population?
A: No, starting with Q1 2020 encounters, patients who are seen in the ED and then sent to observation are not included in the population. It does not matter where the observation unit is located in your hospital or where the patient is discharged/transferred to or from observation. Patients who are sent to observation from the ED are not included.

Q: What about patients seen in our ED and then admitted as acute care inpatients to our hospital? Are they part of the EDTC population?
A: Patients seen in your ED and directly admitted as acute care inpatients to the hospital are not included in the population. Even though at your facility the patient might need to be "discharged" from the ED and then admitted to acute care for billing purposes, that is not considered a 'discharge' for this abstraction. It is considered a direct admission, a continuation of the hospital encounter.

Q: Our patient was transferred to another health care facility, but went via private vehicle. Would they be included in the population?

A: Yes, the mode of transportation doesn't matter. The population for the EDTC measure is based on the facility the patient goes to upon leaving the ED.

Q: Would a patient discharge/transfer to detox (either alcohol or drug) facility be included in the population?
A: Yes, discharge/transfer to this type of facility would be included under "Other Health Care Facilities" and should be included in the population.

Q: We only want to report on our ED cases that get transferred to another acute care facility for a higher level of care. Is that acceptable?
A: No. There is no picking and choosing your population for the EDTC measure. The population requirements are as stated in the EDTC Data Specifications Manual.

Q: If you document "Copy of ED chart sent with the patient" would this be all that is required for verification that all the required data elements were included in the transfer?
A: You could take that to mean that the entire ED record was sent; however, you would still need to look in the record to make sure all the required data elements were documented.

Q: What if our hospital documentation states "Transfer Record" or "Transfer Summary" sent? Can we use this to verify the data elements were sent?
A: If your hospital uses a "Transfer Record" or "Transfer Summary", you must know what information is contained in those documents to indicate that the required data elements were sent. If a copy of that record or summary is not in the ED record, you have no documentation showing which data elements were sent. Documenting that those forms were sent without a copy in the record to see what they contain doesn't show the data elements were sent.

Q: What forms in the ED record can we use for verification that the data elements were sent?
A: The entire ED record is the source document you use to see if the data elements were sent. There is nothing in the manual about the data needing to be on a certain form or summary. This is all about needing to see documentation somewhere in the ED record that the required data elements were sent to the receiving facility.

Q: If there was documentation in the ED record indicating "report was given" to the receiving facility's nurse or that the provider in the transferring facility spoke to the provider at the receiving facility, is that enough to meet the measure?
A: You need to see documentation in the ED records that the required data elements were sent to the receiving facility. "Sent" for this abstraction does include communication by phone; however, you must know that the data elements were shared during the report or call. Documentation of "report given" or "phone call made" doesn't indicate specifically what was discussed, so there is no way of knowing if the data elements were 'sent'.

Q: If the only documentation regarding the patient's allergies and medications is in the ED provider note, can we say yes for those data elements being sent?

A: Yes. The entire ED record is a source document for documentation of the data elements being sent. The information doesn't have to be found on a specific form or location in the record. There just needs to be documentation that the note was sent.

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.

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. If a chest x-ray and a urine culture were performed, there must be documentation sent to the receiving facility indicating that they were performed. 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 documenting that they were done, and the other is for documenting 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 documentation was sent to the receiving hospital outlining how the urine culture results would be communicated when they became available.

Q: Would a patient discharge/transfer to a rural emergency hospital (REH) be included in the population?
A: Yes, discharge/transfer to this type of facility would be included under "Other Health Care Facilities" and should be included in the population.