Patients Discharged from Emergency Department within 4 hours

Full data definition sign-off complete.

Name of Measure	**Emergency Department Length of Sta**y: Percent of patients treated and discharged from the Emergency Department within 4 hours
Name of Measure (short)	Patients Discharged from Emergency Department or Urgent Care Centre within 4 hours
Definition	The Emergency Department or Urgent Care Centre (ED/UCC) length of stay (LOS) is the total time from the first documented time after arrival at emergency, whether triage or registration to the time the patient is discharged (leave the ED/UCC).
Domain	Domain: Health System Performance; Dimension: Accessibility
Type of Measure	Output Measure
Business Context	AHS Strategic Direction 2010-2012 AHS 2010 – 2015 Health Plan: Improving Health for All Albertans Becoming the Best: Alberta's 5-Year Health Action Plan 2011-2015 Health Plan 2010-2013 Ministry Business Plan 2011-2014 Ministry Business Plan
Rationale	Patients treated in an Emergency Department or Urgent Care Centre (ED/UCC) should be assessed and treated in a timely fashion. The length of stay in Emergency Department (ED LOS) is used to assess the timeliness of care delivery. Patients who are treated and then discharged from ED/UCC will typically have a distinctly shorter stay than patients subsequently admitted to hospital relating to complexity, admission processes and other factors. Therefore ED LOS is measured distinctly for these groups. Other discharge categories are also separated due to dissimilar ED LOS. These include left without being seen, left against medical advice, or death. Alberta is taking action to reduce wait times throughout the health system. Goal 1 of Alberta's 5-Year Health Action Plan is improved quality, safety and access for patients to acute care services [that] will be demonstrated by lower wait times across the province. The target length of stay in emergency departments is: Four hours for patients not needing admission to hospital, and Eight hours for patients needing admission to hospital. This performance measure is used to track progress toward reducing wait times for emergency department services and achieving these wait time targets.
Notes for Interpretation	Variation in complexity of patients, site capacity limitations and access to other primary care options (urgent care centres, family physicians, walk-in clinics) in a community vary significantly and can contribute to significant variation in demand for Emergency and Urgent Care services. Some emergency departments use a ticketing system that patients pull on arrival; this is not what is used as the start time. The triage date and time or registration date and time we capture may between 1 to 30 minutes after a patient walks in the door. The same methodology is applied at all sites in calculating the Emergency Department or Urgent Care Centre LOS.

Patients Discharged from Emergency Department within 4 hours *(Continued)*	
Organizational Strategy	Develop and implement initiatives for hospital-wide improvement of patient flow by decreasing length of stay as identified in Transformational Improvement Programs (TIP) #2: Improving Access & Reducing Wait Time. Work with primary care, Emergency Medical Services (EMS) and Health Link to increase the number and availability of community-based services such as physician clinics and urgent care centres (who provide expanded hours that provide care for less serious emergencies). Establish an Emergency Clinical Network Development of contingency plans for surge periods of patient demand.
Benchmark Comparisons	For those discharged from Emergency, a target of 90% of patients having ED LOS of less than 4 hours has been set by 2015 as per Alberta's 5-year Health Action Plan 2010-2015.
Cited References:	Position Statement on Emergency Department Overcrowding from the Canadian Association of Emergency Physicians: http://caep.ca/sites/default/files/caep/files/edoc_position_statement_board_approved_june_2009_gl.pdf Becoming the Best: Alberta's 5-year Health Action Plan 2010-2015: http://www.albertahealthservices.ca/3201.asp

Patients Discharged from Emergency Department within 4 hours *(Continued)*	
Technical Specifications	
Metric	1. Minutes 2. Percent
Preferred Display Format	1. 9,999 2. 99%
Numerator	1. Length of Stay will be captured in minutes between Start Time and End Time where the Start Time is the earliest of either the ED Triage Time or the ED Visit (Registered) Time as recorded on the ED record and the End Time of the ED visit is recorded as discharge time on the ED record. 2. Count of all valid records with a length of stay less than 4 hours. Valid records are defined by the inclusion and exclusion criteria for the numerator below.
Inclusion Criteria for Numerator	Include Emergency visits and Urgent Care Centre visits for discharged patients. <u>Emergency Visits</u>: **National Ambulatory Care Reporting System (NACRS):** Abstract_Type = E Includes visits with MIS Primary (MISPRIME) codes of • 713100000 – Emergency • 713102000 – General Emergency • 713104000 – Observation • 713106000 – Trauma AND • Scheduled ED Visit (SCHEDULED_ED) = N or blank **Alberta Ambulatory Care Report System (AACRS)**: Abstract_Type = E Includes visits with MIS Primary (MISPRIME) codes of • 71310 – Emergency • 7131020 – General Emergency • 7131025 – Hospital Urgent Care Centre • 7131040 – Interim Emergency Assessment • 7131060 – Trauma Emergency <u>Urgent Care Visits</u>: **NACRS:**Abstract_Type = U Includes visits with an MIS Primary (MISPRIME) code of • 713102500 – Urgent Care Centre • 715130000- Community Urgent Care • 715140000 - Community Advance Ambulatory Care **AACRS:**Abstract_Type = U Includes visits with an MIS Primary (MISPRIME) code of 71513 – Community Urgent Care

Patients Discharged from Emergency Department within 4 hours *(Continued)*	
Inclusion Criteria for Numerator (Continued)	**Disposition:** Include discharged patients based on disposition code. That patients identified in this group represent those who have completed a typical full course of care. See Appendix 1 for system specific disposition codes. **Disposition = 1:** Discharged Home **Disposition = 8:** Transferred to another acute care facility **Disposition = 9:** Transferred to another non-acute care facility **Disposition = 12:** Intra facility transfer to day surgery **Disposition = 14:** Intra-facility transfer to clinic **Disposition = 15:** Discharged to place of residence (Institution for example, Nursing or Retirement Home or Chronic Care; Private Dwelling with Home Care, VON, Meals on Wheels, etc.; or Jail).
Exclusion Criteria for Numerator	Exclude patients with an unknown ED discharge time: **NACRS:** A discharge time of 9999 is used to indicate a time that is unknown. Therefore, cases with this time recorded should not be used to calculate the LOS. **AACRS:** A discharge time of 2359 can be used to indicate a time was unknown. Therefore, cases with this time recorded should not be used to calculate LOS Exclude patients where the calculated time becomes negative reflecting an error. Exclude patients where the calculated time is greater than 7 days (168 hours) reflecting a likely data error. Discharged patients do not include patients who left without being seen, left against medical advice, died either before or during the visit or were admitted as an inpatient to the same facility.
Data Source(s) for Numerator	Data is collected by Coding Specialists in Health Information Management utilizing coding and abstracting software, and by Service Event/Service Log applications. Monthly data extracts which are provided to Data Integration, Measurement and Reporting (DIMR) from each facility are processed and loaded into an AHS database. For visits prior to March 31st, 2010 data is collected using the ACCRS. For visits after April 1st, 2010 data is collected using the NACRS. The Emergency Department Information System (EDIS) and Regional Emergency Department Information System (REDIS) sources are transactional Emergency Department information systems as defined in the Technical Notes.
Refresh Rate of Numerator	Monthly
Denominator	1. No denominator for number of minutes. 2. Count of all valid records for percent calculation.
Inclusion Criteria for Denominator	Same as numerator.
Exclusion Criteria for Denominator	Same as numerator.
Data Source(s) for Denominator	Same as numerator.
Refresh Rate of Denominator	Same as numerator.

Patients Discharged from Emergency Department within 4 hours *(Continued)*

Technical Notes

Data Sources:

Alberta Ambulatory Care Reporting System format (AACRS)
Includes data up to March 31, 2010 when AACRS is replaced by NACRS.
AHSDRRFLAT.Ambulatory_View
CPIRUP Server (temporary until data is available in the DIMR Data Repository)
AHS_Ambulatory

National Ambulatory Care Reporting System format (NACRS)
Will also include data prior to NACRS implementation with AACRS values mapped to NACRS values.
AHSDRRFLAT.NACRS_View
or
AHSDRR3NF.NACRS_View

Transactional Emergency Department Information Systems
CDR9 Server (temporary until data is available in the DIMR Data Repository)
has_tgt.EDIS_Visits
has_tgt.REDIS_Visits

Data Source Selection:
For the 9 urban sites the Emergency Department Information System (EDIS) and Regional Emergency Department Information System (REDIS) sources are used. For the other sites, AACRS is used up to March 31, 2010. From April 1, 2010 forward, NACRS is used.

EDIS sites:
- Grey Nuns Community Hospital
- Leduc Community Hospital
- Misericordia Community Hospital
- North East Community Health Centre
- Royal Alexandra Hospital
- Sturgeon Community Hospital
- University of Alberta Hospital
- Westview Health Centre

REDIS sites:
- Alberta Children's Hospital
- Foothills Medical Centre
- Peter Lougheed Centre
- Rockyview General Hospital
- Sheldon M Chumir Centre
- South Calgary Health Centre

All other sites use NACRS.

Data Linking:
Peer Group: Linking is done by matching the 3 digit institution number from the source data to the CPIRUDBA.ahs_institutions table (temporary until institutions table is available in AHSDRRP).

Patients Discharged from Emergency Department within 4 hours *(Continued)*	
Technical Notes *(continued)*	**Timestamp Definitions:** Start Time: **ACCS –** Earliest of either the ED Triage Time or the ED Registration Visit Time **NACRS –** Earliest of either the ED Triage Time or the ED Registration Visit Time **REDIS –** Earliest of either the ED Triage Time or the ED Registration Arrival Time **EDIS –** Earliest of either the ED Triage Time or the ED Registration Arrival Time End Time: **ACCS –** Determined by linking to inpatient visit to determine when the patient left ED as recorded on the Inpatient Discharge Abstract Data (DAD) record in fields ERDEPTDATE and ERDEPTTIME **NACRS –** Left ED as recorded in fields ERDEPTDATE and ERDEPTTIME **REDIS –** Discharge date and time **EDIS –** Discharge date and time **Institution Issues:** Data for the Stollery Children's Hospital are included within the University of Alberta Hospital. Any patient less than 16 years of age (AGE_ADMIT field) at the time of the visit to the University of Alberta Hospital (INST 88044) is recoded to be a patient of the Stollery Children's Hospital (INST 88153). **Peer Group Issues:** The Coaldale Health Centre (Inst 028) peer group classification is "pending." Therefore before any grouping the "pending" status must be removed and the grouping should be changed to "Community Ambulatory Care Centre."

Patients Discharged from Emergency Department within 4 hours *(Continued)*	
Calculation	1. Length of Stay will be captured in minutes between a Start Time and End Time where the Start Time is the earliest of either the ED Triage Time or the ED Visit (Registered) Time and the End Time is the valid discharge date and time. 2. "% of Discharged ED Visits < 4 hours" is calculated by dividing the number of valid records with a length of stay of less than 4 hours (240 minutes) by the total number of valid records multiplied by 100.
Relationship to Other Indicators	
Level of Reporting	Provincial, Zone, Site
Frequency of Reporting	Annual, quarterly, monthly
Limitations	• Urgent Care Centres where disposition data is not collected according the Alberta Coding Standards should be excluded from calculations. Currently a high proportion of "unknown discharge times" are being recorded (using time of 2359). 2359 was collected as a default time to March 31, 2010 under (AACRS) and now 9999 is being collected as of April 1, 2010 under NACRS. For sites reporting this time with high frequency the validity of the LOS time should be evaluated. If an ED or UCC discharge time of 2359 is recorded this can indicate that the time is unknown. For certain sites this time is currently being recorded at high frequency indicating that the LOS cannot be calculated for these patients. Data is affected substantially for some sites prior to March 2010. Data integrity intervention is underway at these sites. Evaluation after this date will be required. • Data for Emergency visits is collected by Coding Specialists in Health Information Management utilizing coding and abstracting software. Month end reconciliation ensures data has been collected on all ED visits. Data for Urgent Care visits in Calgary and Edmonton is collected using Service Event and Service Log applications. • Health Information Management (HIM) is working toward a completion target of 30 days following month end for submission to AHW. • AACRS standards and guidelines have been in place since 1995.

Patients Discharged from Emergency Department within 4 hours *(Continued)*

Document Version History

Version	Version Date	Summary of Changes
	March 5, 2010	Documentation of previously developed indicator
	May 4, 2010	Updates related to NACRS implementation. a) Inclusion criteria for ED visits and UCC visits. b) Exclusion criteria for ED and MH visits. c) NACRS disposition codes d) Technical notes – Table names.
1.0	May 18, 2010	Final version for initial use.
	May 25, 2010	Update to final template version
1.1	June 6, 2010	Completed notes for interpretation as well as other sections. Combined duplicate description of 2359 issue in Limitations section. Noted benchmark of 4 hours. Added Executive Lead.
	June 7, 2010	Review and modify format. Add calculation. Add AHS Executive Sponsor. Modified title to reflect Consolidated Dashboard.
	June 7, 2010	Aligned Definition to content in Performance Report. Added in Rationale about discharged grouping. Correct Exec Lead titles
	June 17, 2010	Final copy for Consolidated Report.
	June 30,2010	Add approval statement.
	July 14, 2010	Add % meeting target to calculation
	July 14, 2010	Add % meeting target to calculation
	July 14, 2010	Expand on calculation breakdown in the Numerator, Denominator and Calculation fields.
	July 28, 2010	Revise first contacted arrival time statement.
	August 17, 2010	Change percent precision to 99% from 99.9% to reflect correct accuracy.
	November 22, 2010	Add new sign off page.
1.2	November 23, 2010	Made the following modifications base on review between AHS & AHW: • Align measure title and name to reflect AHS tier 1 measure reference • Change word from “sum” to count” referenced in numerator, denominator and calculated fields • Added CAEP to cited references • Update contact information

Patients Discharged from Emergency Department within 4 hours *(Continued)*

Document Version History *(Continued)*

Version	Version Date	Summary of Changes
1.3	November 24, 2010	Added a paragraph explaining how to split out the Stollery from UAH.
1.4	December 20, 2010	Update business context.
1.5	January 11, 2010	Added text for CDR9 EDSI/REDIS data
1.6	January 17, 2011	Modified structure to be based on data source not “effective dates” because the AACRS/NACRS effective dates overlap with the use of EDIS/REDIS. Removed 16 site aggregation reference since we also do aggregation on the province and peer groupings levels without reference. Added data source selection, data linking, timestamp definition and peer group to Technical Notes section.
1,7	February 4, 2011	Place disposition codes into an appendix document which better illustrates how they align from the various systems and maintain this document in one place and can be referenced by other performance measures.
1.8	February 7, 2011	Updated changes, added comments.
1.9	February 16, 2011	Add disposition codes for each system into the appendix.
2.0	February 16, 2011	Version ready for signoff.
2.1	April 15, 2011	Version updated with comments.
2.2	May 10, 2011	Reviewed and added comments.
2.3	June 28, 2011	Added additional comments. Added names to sign-off sheet.
2.4	July 5, 2011	Update based on joint AHS/AHW discussion.
2.5	July 14, 2011	Completed Rationale field.
3.0	July 18, 2011	Signoff process re-initiated.
3.0	July 18, 2011	Updated Header and Footer
3.1	September 2, 2011	Full data definition signoff completed.
3.2	October 18, 2011	Updated hyperlink in Cited References.

APPENDIX I

11-Feb-2011

ED Disposition Data Mapping
ACCS
as of February 2011

1 of 1

DISP ID	DISP Short Desc	DISP LONG DESC	ACCS ID	ACCS Desc
1	Discharged Home	Discharged Home (private dwelling, not an institution; no support services)	0	No doctor available, service recipient asked to return later.
			1	Discharged - visit concluded.
			2	Discharged from program or clinic - will not return for further care. (This refers only to the last visit of a service recipient discharged from a treatment program at which he/she has been seen for repeat services).
2	LWBS	Patient registered, left without being seen (LWBS), or treated by a service provider (before triage if ED visit)	9	Left without being seen. (Not seen by a professional service provider).
3	Left w/o Being Registered	Patient triaged and then left the emergency department before further assessment by a service provider (for example, physician, nurse, allied health provider) (patient registered).		
4	Left w/o Treatment	Patient triaged (if ED visit), registered and assessed by a service provider (for example, physician) and left without treatment		
5	LAMA	Patient triaged (if ED visit), registered, and assessed by a service provider and treatment initiated; left against medical advice (LAMA) before treatment completed	3	Left against medical advice. (Intended care not completed.)
6	Admitted to Critical Care or OR	Admitted into reporting facility as an inpatient to critical care unit or operating room directly from an ambulatory care visit functional centre.	4	Service recipient admitted as an inpatient to Critical Care Unit or OR in own facility.
7	Admitted to other area	Admitted into reporting facility as an inpatient to another unit of the reporting facility directly from the ambulatory care visit functional centre	5	Service recipient admitted as an inpatient to other area in own facility.
8	Transferred to another Acute Care	Transferred to another acute care facility directly from an ambulatory care visit functional centre. Includes transfers to another acute care facility with entry through the emergency department	6	Service recipient transferred to another acute care facility (includes psychiatric, rehab, oncology and pediatric facilities).
9	Transferred to another Non-Acute Care	TRANS OUT-OTHER FACILITY		
10	DAA	Death after arrival (DAA)—Patient expires after initiation of the ambulatory care visit. Resuscitative measures (for example, cardiopulmonary resuscitation or CPR) may occur during the visit but are not successful.	7	DAA – Service recipient expired in ambulatory care service.
11	DOA	Death On Arrival (DOA)—Patient is dead on arrival to the ambulatory care service. Generally there is no intent to resuscitate (for example, perform CPR). Includes cases where the patient is brought in for pronouncement of death.	8	DOA – Service recipient dead on arrival to ambulatory care service.
12	To Day Surgery	Intra-facility transfer to day surgery		
13	To ED	Intra-facility transfer to the emergency department.		
14	To Clinic	Intra-facility transfer to clinic		
15	Discharged to Residence	Discharged to place of residence (institution for example, Nursing or Retirement Home or Chronic Care; Private Dwelling with Home Care, VON, Meals on Wheels, etc.; or Jail)		
16	Unknown	Unknown		

Data Integration, Measurement Reporting

ED Disposition Data Mapping - Feb 2011.xls - Disposition Conform Map ACCS

ED Dispositon Data Mapping
EDIS
as of February 2011

DISP ID	DISP Short Desc	DISP LONG DESC	EDIS AM ID	EDIS AM CODE	EDIS AM DESC	EDIS AM ACTIVE	Effective Start Date	Effective End Date
1	Discharged Home	Discharged Home (private dwelling, not an institution; no support services)	1	DWA	DISCHARGED WITH APPROVAL	Y	2005-Apr-01	
			20	DDP	DISCHARGE DISASTER PATIENT	Y	2007-Feb-07	2009-Aug-16
			27	FT	FAST TRACK	N	2005-Apr-01	2005-Jun-22
			30	FTI	FAST TRACK	N	2005-Apr-01	2005-Jun-23
2	LWBS	Patient registered, left without being seen (LWBS), or treated by a service provider (before triage if ED visit)	5	DWBS	LEFT WITHOUT BEING SEEN	Y	2005-Jun-23	
			11	DPS	DISCHARGED PRIOR TO BEING SEEN	N	2005-Apr-01	2005-Jun-22
3	Left w/o Being Registered	Patient triaged and then left the emergency department before further assessment by a service provider (for example, physician, nurse, allied health provider) (patient registered).	25	NER	EXPECTED ELSEWHERE NOT ER	Y	2005-Apr-03	
			26	DBR	LEFT WITHOUT BEING REGISTERED	Y	2005-Apr-17	
			19	11	LEFT W/O BEING REGISTERED	N	2005-Apr-08	2005-Jun-23
4	Left w/o Treatment	Patient triaged (if ED Visit), registered and assessed by a service provider (for example, physician) and left without treatment	28	LWCT	LEFT PRIOR TO COMPLETION OF TX	Y	2005-Apr-04	
			9	LWOT	LEFT WITHOUT TREATMENT	N	2005-Apr-01	2005-Jun-23
5	LAMA	Patient triaged (if ED Visit), registered, and assessed by a service provider and treatment initiated; left against medical advice (LAMA) before treatment completed	10	DAA	LEFT AGAINST MEDICAL ADVICE	Y	2005-Apr-01	
			4	DAMA	LEFT AGAINST MEDICAL ADVICE	N		
6	Admitted to Critical Care or OR	Admitted into reporting facility as an inpatient to critical care unit or operating room directly from an ambulatory care visit functional centre.	13	AD	ADMITTED	Y	2005-Apr-01	
			6	SIH	STILL IN HOSPITAL	N		
			22	DTH	DISCHARGED TO TX AREA WITHIN HOSPITAL	N		

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ED Dispositon Data Mapping
EDIS
as of February 2011

DISP ID	DISP Short Desc	DISP LONG DESC	EDIS AM ID	EDIS AM CODE	EDIS AM DESC	EDIS AM ACTIVE	Effective Start Date	Effective End Date
7	Admitted to other area	Admitted into reporting facility as an inpatient to another unit of the reporting facility directly from the ambulatory care visit functional centre	32	FCP	FCP-ADMITTED	Y	2007-Apr-18	
8	Transferred to another Acute Care	Transferred to another acute care facility directly from an ambulatory care visit functional centre. Includes transfers to another acute care facility with entry through the emergency department	17	TF	TRANSFER WITH APPROVAL	Y	2005-Apr-01	
			2	DOF	DISCHARGED TO OTHER FACILITY	N	2005-Apr-13	2005-Apr-13
9	Transferred to another Non-Acute Care	TRANS OUT-OTHER FACILITY	12	DTO	DISCHARGED TRANSFERRED OUT	N	2005-Apr-10	2005-Jun-08
10	DAA	Death after arrival (DAA)—Patient expires after initiation of the ambulatory care visit. Resuscitative measures (for example, cardiopulmonary resuscitation or CPR) may occur during the visit but are not	31	DIE	DIED IN EMERGENCY	Y	2005-Jun-24	
			7	D	DECEASED	N	2005-Apr-01	2005-Jun-21
			21	M	MORGUE	N	2005-Apr-03	2005-Jun-21
11	DOA	Death On Arrival (DOA)—Patient is dead on arrival to the ambulatory care service.	8	DOA	DEAD ON ARRIVAL	Y	2005-Jul-01	
12	To Day Surgery	Intra-facility transfer to day surgery						
13	To ED	Intra-facility transfer to the emergency department.	18	AIP	ALREADY IN PATIENT	Y	2005-Apr-01	
14	To Clinic	Intra-facility transfer to clinic						
15	Discharged to Residence	Discharged to place of residence (Institution for example, Nursing or Retirement Home or Chronic Care; Private Dwelling with Home Care, VON, Meals on Wheels, etc.; or Jail)	3	DHC	DISCHARGED WITH HOMECARE	N		
26	Unknown	Unknown	29	WI	WRONG INFORMATION ENTERED	Y	2005-Apr-01	
			15	IHRN	INCORRECT HRN	N	2005-Apr-22	2005-Jun-14
			16	C	SHOULD BE SEEN IN CLINIC NOT EMERG		2005-Apr-22	2005-Jun-14
			14	DT	DOUBLE TRIAGED	Y	2005-Apr-01	

Data Integration, Measurement Reporting

ED Disposition Data Mapping pg2 - Feb 2011.xls - Disposition Conform Map EDIS

11-Feb-2011

ED Disposition Data Mapping

Meditech
as of February 2011

DISP ID	DISP Short Desc	DISP LONG DESC	Disposition Seq	Disposition Code	Disposition Desc
1	Discharged Home	Discharged Home (private dwelling, not an institution; no support services)	DCL	HOME, SELF-CARE	DISCHARGE TO CLINIC
			DDS	HOME, SELF-CARE	DISCHARGED TO DAY SURGERY
			DED	HOME, SELF-CARE	DISCHARGE TO EMERGENCY
			DEN	HOME, SELF-CARE	DISCHARGED TO ENDOSCOPY
			DFP	HOME, SELF-CARE	DISCHARGE PROGRAM/CLINIC
			DRP	SIGNOUT	DID NOT RETURN FROM PASS
			H	HOME, SELF-CARE	HOME,SELF CARE
2	LWBS	Patient registered, left without being seen (LWBS), or treated by a service provider (before triage if ED visit)	LWS	AGAINST MEDICAL ADVICE	LEFT WITHOUT BEING SEEN
3	Left w/o Being Registered	Patient triaged and then left the emergency department before further assessment by a service provider (for	NDA	HOME, SELF-CARE	NO DOCTOR AVAILABLE(ED ONLY)
4	Left w/o Treatment	Patient triaged (if ED visit), registered and assessed by a service provider (for example, physician) and left without treatment	LWT	AGAINST MEDICAL ADVICE	LEFT WITHOUT TREATMENT
5	LAMA	Patient triaged (if ED visit), registered, and assessed by a service provider and treatment initiated; left against medical advice (LAMA) before treatment completed	AMA	SIGNOUT	AGAINST MEDICAL ADVICE
			LWA	AGAINST MEDICAL ADVICE	LEFT WITHOUT ASSESSMENT
6	Admitted to Critical Care or OR	Admitted into reporting facility as an inpatient to critical care unit or operating room directly from an ambulatory care visit functional centre.	ACCU	STILL A PATIENT	ADMIT-CRITICAL CARE UNIT
7	Admitted to other area	Admitted into reporting facility as an inpatient to another unit of the reporting facility directly from the ambulatory care visit functional centre	AAC	STILL A PATIENT	ADMIT-ACUTE CARE
8	Transferred to another Acute Care	Transferred to another acute care facility directly from an ambulatory care visit functional centre. Includes transfers to	TOAC	TRANSFER	TRANS OUT-ACUTE CARE
9	Transferred to another Non-Acute Care	TRANS OUT-OTHER FACILITY	TOOC	TRANSFER	TRANS OUT-OTHER FACILITY
10	DAA	Death after arrival (DAA)—Patient expires after initiation of the ambulatory care visit. Resuscitative measures (for example, cardiopulmonary resuscitation or CPR) may occur	E	EXPIRED	EXPIRED
11	DOA	Death On Arrival (DOA)—Patient is dead on arrival to the ambulatory care service. Generally there is no intent to	DOA	EXPIRED	DEAD ON ARRIVAL
			DOF	EXPIRED	DIED OUT OF FACILITY
12	To Day Surgery	Intra-facility transfer to day surgery	ASUR	STILL A PATIENT	ADMIT-SURGERY
13	To ED	Intra-facility transfer to the emergency department.			
14	To Clinic	Intra-facility transfer to clinic			
15	Discharged to Residence	Discharged to place of residence (institution for example, Nursing or Retirement Home or Chronic Care; Private Dwelling with Home Care, VON, Meals on Wheels, etc.; or	TOCC	TRANSFER	TRANS OUT-CONT CARE
			HWS	HOME, SELF-CARE	HOME,WITH SUPPORT
16	Unknown	Unknown			

11-Feb-2011

ED Disposition Data Mapping
NACRS
as of February 2011

DISP ID	DISP Short Desc	DISP LONG DESC	NACRS ID	NACRS DESC
1	Discharged Home	Discharged Home (private dwelling, not an institution; no support services)	01	Discharged Home (private dwelling, not an institution; no support services)
2	LWBS	Patient registered, left without being seen (LWBS), or treated by a service provider (before triage if ED visit)	02	Patient registered, left without being seen (LWBS), or treated by a service provider (before triage if ED visit)
3	Left w/o Being Registered	Patient triaged and then left the emergency department before further assessment by a service provider (for example, physician, nurse, allied health provider) (patient registered).	03	Patient triaged and then left the emergency department before further assessment by a service provider (for example, physician, nurse, allied health provider) (patient registered)
4	Left w/o Treatment	Patient triaged (if ED Visit), registered and assessed by a service provider (for example, physician) and left without treatment	04	Patient triaged (if ED Visit), registered and assessed by a service provider (for example, physician) and left without treatment
6	LAMA	Patient triaged (if ED Visit), registered, and assessed by a service provider and treatment initiated; left against medical advice (LAMA) before treatment completed	06	Patient triaged (if ED Visit), registered, and assessed by a service provider and treatment initiated; left against medical advice (LAMA) before treatment completed
5	Admitted to Critical Care or OR	Admitted into reporting facility as an inpatient to critical care unit or operating room directly from an ambulatory care visit functional centre.	05	Admitted into reporting facility as an in-patient to critical care unit or operating room directly from an ambulatory care visit functional centre
7	Admitted to other area	Admitted into reporting facility as an inpatient to another unit of the reporting facility directly from the ambulatory care visit functional centre	07	Admitted into reporting facility as an in-patient to another unit of the reporting facility directly from the ambulatory care visit functional centre
8	Transferred to another Acute Care	Transferred to another acute care facility directly from an ambulatory care visit functional centre. Includes transfers to another acute care facility with entry through the emergency department	08	Transferred to another acute care facility directly from an ambulatory care visit functional centre. Includes transfers to another acute care facility with entry through the emergency department
9	Transferred to another Non-Acute Care	TRANS OUT-OTHER FACILITY	09	Transferred to another non-acute care facility directly from an ambulatory care visit functional centre (for example, standalone rehabilitation or stand-alone mental health facility).
10	DAA	Death after arrival (DAA)—Patient expires after initiation of the ambulatory care visit. Resuscitative measures (for example, cardiopulmonary resuscitation or CPR) may occur during the visit but are not successful.	10	Death after arrival (DAA)—Patient expires after initiation of the ambulatory care visit. Resuscitative measures (for example, cardiopulmonary resuscitation or CPR) may occur during the visit but are not successful.
11	DOA	Death On Arrival (DOA)—Patient is dead on arrival to the ambulatory care service. Generally there is no intent to resuscitate (for example, perform CPR). Includes cases where the patient is brought in for pronouncement of death.	11	Death On Arrival (DOA)—Patient is dead on arrival to the ambulatory care service. Generally there is no intent to resuscitate (for example, perform CPR). Includes cases where the patient is brought in for pronouncement of death.
12	To Day Surgery	Intra-facility transfer to day surgery	12	Intra facility transfer to day surgery
13	To ED	Intra-facility transfer to the emergency department.	13	Intra-facility transfer to the emergency department
14	To Clinic	Intra-facility transfer to clinic	14	Intra-facility transfer to clinic
15	Discharged to Residence	Discharged to place of residence (institution for example, Nursing or Retirement Home or Chronic Care; Private Dwelling with Home Care, VON, Meals on Wheels, etc.; or Jail)	15	Discharged to place of residence (institution for example, Nursing or Retirement Home or Chronic Care; Private Dwelling with Home Care, VON, Meals on Wheels, etc.; or Jail)
16	Unknown	Unknown		

11-Feb-2011

ED Dispositon Data Mapping
REDIS
as of February 2011

DISP ID	DISP Short Desc	DISP Long Desc	REDIS AM ID	REDIS AM CODE	REDIS AM DESC	REDIS AM ACTIVE	Effective Start Date	Effective End Date
1	Discharged Home	Discharged Home (private dwelling, not an institution; no support services)	5	U/S	REFERRAL FOR U/S	Y	2005-Apr-01	
			9	OTRAN	TRANSFER OUT OF REGION	Y	2005-Apr-02	
			10	IVT	REFERRED FOR IVT	Y		
			11	HPTP	REFERRED TO HPTP	Y	2005-Apr-01	
			12	GOGP	REFERRED TO FAMILY MD	Y	2005-Apr-01	
			14	ADVIC	DISCHARGED WITH ADVICE	Y	2005-Apr-01	
			15	FOLUP	FOR FOLLOWUP IN ED	Y	2005-Apr-01	
			18	DI	RETURN FOR DI	Y	2005-Apr-02	
			21	MHOP	MENTAL HEALTH OUTPATIENT PROGRAM	Y	2005-Apr-06	
			24	DCHM	DISCHARGED WITH HOLTER MONITOR	Y	2005-Apr-03	
			31	CLC	REFERRED TO CONSULTATION LIASON CLINIC	Y	2005-Apr-07	
			32	OC	REFERRED TO ORTHO CLINIC	Y	2005-Apr-01	
			33	PHYS	REFERRED TO PHYSIO	Y	2005-Apr-06	
			34	ID	REFERRED TO I.D. CLINIC	Y	2005-Apr-01	
			35	ASTHM	REFERRED TO ASTHMA CLINIC	Y	2005-Apr-13	
			36	CT	RETURN FOR CT	Y	2005-Apr-03	
			37	OUT	REFERRED TO OUTPATIENT SPECIALIST	Y	2005-Apr-01	
			38	DENT	DENTISTRY	Y	2005-May-09	
			39	CSART	CSART	Y	2009-Jan-07	
			40	DOPTH	OPHTHALMOLOGY CLINIC - RGH	Y	2005-Apr-11	
			42	HMAWR	SENT HOME AWAITING RESULTS	Y	2005-Apr-03	
			43	HMRR	AT HOME RESULTS REVIEWED	Y	2005-Apr-04	
			64	EMSS	EMERGENCY SOCIAL SERVICES	Y	2005-Apr-09	
			65	COAG	ANTICOAGULATION CLINIC	Y	2005-Apr-03	

Data Integration, Measurement Reporting

Disposition Conform Map REDIS - ED Disposition Data Mapping - Feb 2011.xls

ED Dispositon Data Mapping
REDIS
as of February 2011

DISP ID	DISP Short Desc	DISP Long Desc	REDIS AM ID	REDIS AM CODE	REDIS AM DESC	REDIS AM ACTIVE	Effective Start Date	Effective End Date
1	Discharged Home (Continued)	Discharged Home (private dwelling, not an institution; no support services) (Continued)	66	D OPC	DISCHARGE - FOLLOW UP WITH OUTPATIENT CLINIC	N		
			67	CATH	CATH LAB	Y	2005-Oct-29	
			68	PH_OT	DISCHARGE TO PHYSIO / OT	Y	2006-Jun-13	
			69	DM	REFERRED TO DAY MEDICINE	Y	2006-Nov-02	
			70	STI	STI	Y	2008-Apr-02	
			71	SAC	SAC	Y	2008-Aug-11	2010-Mar-02
			73	COMMD	TO COMMUNITY MD	Y	2008-Apr-01	
			74	WLKIN	REFERRED TO WALK-IN CLINIC	Y	2008-Apr-11	2010-Jun-30
			75	DISWR	DISCHARGED FROM WAITING ROOM	Y	2008-Dec-03	
			76	FOLLO	REFERRED TO CHUMIR FOLLOW UP CLINIC	Y	2009-Mar-08	
			77	CHUM	REFERRED TO SHELDON CHUMIR	Y	2009-Nov-26	
			45	R_UCC	RETURN TO UCC FOR FOLLOW UP	Y	2005-Apr-01	
			46	ASTH	ASTHMA CLINIC	Y	2005-Sep-22	2008-Sep-09
			47	DIAG	DI	Y	2005-May-04	
			48	DIAB	DIABETIC CLINIC	Y	2008-Dec-13	2008-Dec-13
			49	FPLAN	FAMILY PLANNING CLINIC	Y	2005-Jul-04	
			51	MENH	MENTAL HEALTH CLINIC	Y	2005-May-03	
			52	REHA	REHAB	Y	2005-Apr-17	2009-Nov-08
			53	WOUND	WOUND CLINIC	Y	2005-Apr-15	
2	LWBS	Patient registered, left without being seen (LWBS), or treated by a service	4	LWBS	LWBS	Y	2005-Apr-01	
3	Left w/o Being Registered	Patient triaged and then left the emergency department before further assessment by a service provider (for example, physician, nurse, allied health provider) (patient registered).	44	N_UCC	NON UCC PATIENT	Y	2005-Apr-14	
			26	DNRG	DID NOT REGISTER	Y		
			20	NONED	NON ED PATIENT	Y	2005-Apr-01	
4	Left w/o Treatment	Patient triaged (if ED Visit), registered and assessed by a service provider (for example, physician) and left without treatment						
5	LAMA	Patient triaged (if ED Visit), registered, and assessed by a service provider and treatment initiated; left against medical advice (LAMA) before treatment completed	13	AMA	AMA	Y	2005-Apr-01	
6	Admitted to Critical Care or OR	Admitted into reporting facility as an inpatient to critical care unit or operating room directly from an ambulatory care visit functional centre.	1	ADMIT	ADMITTED	Y	2005-Apr-01	
7	Admitted to other area	Admitted into reporting facility as an inpatient to another unit of the reporting facility directly from the ambulatory care visit functional centre	78	MAU_R	MEDICAL ASSESSEMENT UNIT RGH	Y		

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ED Dispositon Data Mapping
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as of February 2011

DISP ID	DISP Short Desc	DISP Long Desc	REDIS AM ID	REDIS AM CODE	REDIS AM DESC	REDIS AM ACTIVE	Effective Start Date	Effective End Date
8	Transferred to another Acute Care	Transferred to another acute care facility directly from an ambulatory care visit functional centre. Includes transfers to another acute care facility with entry through the emergency department	58	ACHT	TRANSFERRED TO ACH BY EMS / TRANSPORT TEAM	Y	2005-Apr-03	
			59	FMCT	TRANSFERRED TO FMC BY EMS / TRANSPORT TEAM	Y	2005-Apr-01	
			60	RGHT	TRANSFERRED TO RGH BY EMS / TRANSPORT TEAM	Y	2005-Apr-01	
			61	PLCT	TRANSFERRED TO PLC BY EMS / TRANSPORT TEAM	Y	2005-Apr-06	
			6	ATRAN	TRANSFER TO ACH	Y	2005-Apr-03	
			7	FTRAN	TRANSFER TO FMC	Y	2005-Apr-01	
			8	PTRAN	TRANSFER TO PLC	Y	2005-Apr-01	
			22	RTRAN	TRANSFER TO ROCKYVIEW	Y	2005-Apr-01	
			64	ACH_P	TO ACH BY PRIVATE VEHICLE	Y	2005-Apr-06	
			65	FMC_P	TO FMC BY PRIVATE VEHICLE	Y	2005-May-16	
			66	RGH_P	TO RGH BY PRIVATE VEHICLE	Y	2005-Apr-01	
			67	PLCP	TO PLC BY PRIVATE VEHICLE	Y	2005-Apr-11	
9	Transferred to another Non-Acute Care	TRANS OUT-OTHER FACILITY						
10	DAA	Death after arrival (DAA)—Patient expires after initiation of the ambulatory care visit. Resuscitative measures (for example, cardiopulmonary resuscitation or CPR) may occur during the visit but are not successful.	2	DIED	DIED	Y	2005-Apr-02	
11	DOA	Death On Arrival (DOA)—Patient is dead on arrival to the ambulatory care service. Generally there is no intent to resuscitate (for example, perform CPR). Includes cases where the patient is brought in for pronouncement of death.	3	DOA	DOA	Y	2005-May-19	
12	To Day Surgery	Intra-facility transfer to day surgery	26	DAY S	DAY SURGERY	Y	2005-Apr-04	
13	To ED	Intra-facility transfer to the emergency department.						
14	To Clinic	Intra-facility transfer to clinic	30	DAYME	DAY MEDICINE	Y	2005-Apr-13	
			72	RCSAR	TO CSART	Y	2009-Jan-07	
15	Discharged to Residence	Discharged to place of residence (Institution for example, Nursing or Retirement Home or Chronic Care; Private Dwelling with Home Care, VON, Meals on Wheels, etc.; or Jail)	19	CROSS	TRANSFER TO CROSSBOW	Y		
			23	DIC	DROP IN CENTRE	Y	2005-Apr-01	
			27	DCNHM	D/C TO NURSING HOME	Y	2005-Apr-01	
			41	POLIC	DISCHARGED WITH POLICE	Y	2005-Apr-01	
			62	GLENM	D/C TO TRANSITION BED - GLENMORE PARK	Y	2005-Apr-02	
			63	FANN	D/C TO TRANSITION BED - FANNING CENTRE	Y	2005-Apr-01	
28	Unknown	Unknown	16	DRYRU	DRY RUN PATIENT	Y		