Data Specifications Manual

Emergency Department Transfer Communication Measure

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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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Emergency Department Transfer Communication Measure Specifications

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1. NQF National Quality Forum http://www.qualityforum.org/Home.aspx
2. NQMC National Quality Measure Clearinghouse http://www.qualitymeasures.ahrq.gov/

Background of the Measure

In 2003, an expert panel convened by the University of Minnesota Rural Health Research Center and Stratis Health identified ED care as an important quality assessment measurement category for rural hospitals. While emergency care is important in all hospitals, it is particularly critical in rural hospitals where the size of the hospital and geographic realities make organizing triage, stabilization, and transfer of patients more important. Communication between providers promotes continuity of care and may lead to improved patient outcomes. 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; projects took place from October 2005 through July 2014. Results of the pilot projects indicated room for improvement in ED care and transfer communication.

Aggregate project results are available at http://www.flexmonitoring.org/wp-content/uploads/2014/02/ds8.pdf and http://flexmonitoring.org/documents/FlexDataSummaryReport3.pdf.

Rationale

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 that deficits exist in the transfer of patient information between hospitals and primary care physicians in the community, and between hospitals and long-term facilities. Transferred patients are excluded from the calculation of most national quality measures, such as those used in Hospital Compare. The Hospital Compare Web site was created to display rates of Process of Care measures using data that are 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 hand- off communications, including nursing and physician handoffs from the emergency department (ED) to inpatient

units, other hospitals, and other types of health care facilities. The process must include a method of communicating up-to-date information regarding the patient's care, treatment, and services; condition; and any recent or anticipated changes. (Note: The National Patient Safety Goals are reviewed and modified periodically. In 2013 a communication goal focuses on the communication of test results.) http://www.jointcommission.org/assets/1/6/HAP_NPSG_Chapter_2014.pdf

Limited attention has been paid to the development and implementation of quality measures specifically focused on patient transfers between EDs and other health care facilities. Examples are patients transferred between an ED and a skilled nursing facility with their often vulnerable and fragile populations. These measures are important for all health care facilities, but especially so for small rural hospitals that transfer a higher proportion of ED patients.

While many aspects of hospital quality are similar for urban and rural hospitals (e.g., providing heart attack patients with aspirin), the urban/rural contextual differences result in differences in 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, transporting patients, and coordinating information flow to specialists beyond the community.

Emergency care is important in all hospitals, but it is particularly important in rural hospitals. Because of their size, rural hospitals are less likely to be able to provide more specialized services, such as cardiac catheterization or trauma surgery. Rural residents often need to travel greater distances than urban residents to get to a hospital initially. In addition, their initial point of contact is less likely to have specialized services and staff found in tertiary care centers, so they are also more likely to be transferred. These size and geographic realities increase the importance of organizing triage, stabilization, and transfer in rural hospitals which, in turn, suggest that measurement of these processes is an important issue for rural hospitals.

The ED Transfer Communication measure aims to provide a means of assessing how well key patient information is communicated from an ED to any healthcare facility. They are applicable to patients with a wide range of medical conditions (e.g., acute myocardial infarction, heart failure, pneumonia, respiratory compromise and trauma) and are relevant for both internal quality improvement purposes and external reporting to consumers and purchasers. The results of the field tests suggest that significant opportunity exists for improvement on these measures.

Selected References:

Baldwin LM, MacLehose RF, Hart LG, Beaver SK, Every N, Chan L. Quality of care for acute myocardial infarction in rural and urban US hospitals. J Rural Health 2004 Spring;20(2):99-108.

Cortes TA, Wexler S, Fitzpatrick JJ. The transition of elderly patients between hospitals and nursing homes. Improving nurse-to-nurse communication. J Gerontol Nurs 2004 Jun;30(6):10-5; quiz 52-3. [5 references]

Ellerbeck EF, Bhimaraj A, Perpich D. Organization of care for acute myocardial infarction in rural and urban hospitals in Kansas. J Rural Health 2004 Fall;20(4):363-7.

Joint Commission on Accreditation of Healthcare Organizations. Sentinel events statistics. [Internet]. [Accessed 2007 Jul 18].

Klingner J, Moscovice I, Washington Rural Healthcare Quality Network and Stratis Health, Minnesota Quality Improvement Organization. Rural hospital emergency department quality measures: aggregate data report. Minneapolis (MN): University of Minnesota, Division of Health Services Research & Policy; 2007 Mar. 12 p. (Flex Monitoring Team data summary report; no. 3).

Klingner J, Moscovice I. Development and testing of emergency department patient transfer communication measures. J Rural Health 2012 Jan;28(1):44-53. [16 references]

Kripalani S, Lefevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. JAMA 2007 Feb 28;297(8):831-41. [133 references]

Newgard CD, McConnell KJ, Hedges JR. Variability of trauma transfer practices among non-tertiary care hospital emergency departments. Acad Emerg Med 2006 Jul;13(7):746-54.

University of Minnesota Rural Health Research Center, Stratis Health (Minnesota's Quality Improvement Organization), HealthInsight (Nevada and Utah's Quality Improvement Organization). Refining and field testing a relevant set of quality measures for rural hospitals. Final report submitted to the Centers for Medicare & Medicaid Services under contract no. 500-02-MN01. Bloomington (MN): Stratis Health; 2005 Jun 30.

US Department of Health and Human Services. Hospital Compare Web site. [Web site]. [Accessed 2011 Feb 25].

Wakefield DS, Ward M, Miller T, Ohsfeldt R, Jaana M, Lei Y, Tracy R, Schneider J. Intensive care unit utilization and interhospital transfers as potential indicators of rural hospital quality. J Rural Health 2004 Fall;20(4):394-400.

Westfall JM, Van Vorst RF, McGloin J, Selker HP. Triage and diagnosis of chest pain in rural hospitals: implementation of the ACI-TIPI in the High Plains Research Network. Ann Fam Med 2006 Mar-Apr;4(2):153-8.

Population and Sampling

ED Transfer Communication (EDTC) Initial Patient Population

The population of the EDTC measure set is defined by identifying those patients admitted to the emergency department who were then transferred/discharged to these facilities:

Inclusions:

3 Hospice – healthcare facility

4a Acute Care Facility- General Inpatient Care – including emergency department

4b Acute Care Facility- Critical Access Hospital – including emergency department

4c Acute Care Facility- Cancer Hospital or Children's Hospital – including emergency department

4d Acute Care Facility – Department of Defense or Veteran's Administration – including emergency department

5 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 Veteran's Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility, including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), Sub-Acute Care, or Swing Bed
- Transitional Care Unit (TCU)

Note: ED patients that have been put in observation status and then are transferred to another hospital or health care facility should be included.

Exclusions:

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

Note: Discharge codes taken from the CMS Hospital Outpatient Quality Reporting Specifications Manual.

Sample Size Requirements

Hospitals need to submit a minimum of 45 cases.

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. Sample cases should be randomly selected in such a way that the individual cases in the population have an equal chance of being selected. Due to exclusions, hospitals selecting sample cases MUST submit AT LEAST the minimum required sample size.

The following sample size tables for each option automatically build in the number of cases needed to obtain the required sample sizes. For information concerning how to perform sampling, refer to the Population and Sampling Specifications section in this manual.

Hospitals performing quarterly sampling for ED Transfer Communication must ensure that their initial patient population and sample size meet the following conditions:

Population Per Quarter	**45-900**
Quarterly sample size	45
Monthly sample size	15
Population Per Quarter	**≤45**
Quarterly sample size	Use all cases
Monthly sample size	Use all cases

Measure Calculation

This measure is calculated using an all or none approach.

The overall EDTC Measure can be calculated as the percent of medical records that met all of the 27 data elements.

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

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

Considerations for Electronic Transfer of Information

For health systems with shared electronic medical records, documentation must indicate that data elements had been entered into the data system and were available to the receiving facility prior to transfer for Administrative Measures or within 60 minutes of discharge for all other measures. If there are not shared records, "sent" means that medical record documentation indicates the information went with the patient or was sent via fax, phone, or internet/Electronic Health Record within 60 minutes of patient discharge.

Measure EDTC-SUB 1

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 1
Performance Measure Name: Administrative communication
Description: Patients who are transferred from an ED to another healthcare facility have physician to physician communication and healthcare facility to healthcare facility communication prior to discharge.
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 healthcare facility whose medical record documentation indicated that both communication actions occurred prior to transfer.

- Healthcare facility to healthcare facility communication
- Physician to physician communication

Denominator Statement: All transfers from ED to another healthcare

facility Included Populations: ED Transfers to another healthcare facility
Excluded Populations: None

Rate calculation Sub 1

Numerator	# of patients who have a yes or NA for both measures: healthcare facility to healthcare facility communication and physician to physician communication
Denominator	All transfers from 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.
Measure Analysis Suggestions: The data elements for each of the two communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.

Measure EDTC-SUB 2

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 2
Performance Measure Name: Patient Information
Description: Patients who are transferred from an ED to another healthcare facility have patient identification information sent to the receiving facility within 60 minutes of discharge
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 healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of departure.

- Name
- Address
- Age
- Gender
- Significant others contact information
- Insurance

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 2

Numerator	# of patients who have a yes or NA for all measures: name, address, age, gender, contact, insurance
Denominator	All transfers from ED to another health care facility

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.
Measure Analysis Suggestions: The data elements for each of the six communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specification Section.

Measure EDTC-SUB 3

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 3
Performance Measure Name: Vital Signs
Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge for patient's vital signs
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 elements were communicated to the receiving facility within 60 minutes of discharge.

- Pulse
- Respiratory rate
- Blood pressure
- Oxygen saturation
- Temperature
- Glasgow score or other neuro assessment for trauma, cognitively altered or neuro patients only

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 3

Numerator	# of patients who have a yes or NA for all measures: pulse, respiration, blood pressure, oxygen saturation, temperature and neuro assessment
Denominator	All transfers from 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.
Measure Analysis Suggestions: The data elements for each of the six communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.

Measure EDTC-SUB 4

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 4
Performance Measure Name: Medication Information
Description: Patients who are transferred from an ED to another healthcare facility have communication
with the receiving facility within 60 minutes of discharge for medication information.
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 from an ED to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of departure.

- Medications administered in ED
- Allergies
- Home medications

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 4

Numerator	# of patients who have a yes or NA for all measures: Medications administered in ED, allergies and home medications
Denominator	All transfers from 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.
Measure Analysis Suggestions: The data elements for each of the three communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.

Measure EDTC-SUB 5

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 5
Performance Measure Name: Physician or Practitioner generated information
Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge for history and physical and physician plan of care.
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 healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of discharge.

- History and physical/ED provider note
- Reason for transfer and/or plan of care

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 5

Numerator	# of patients who have a yes for all measures: history and physical and reason for transfer and/or plan of care
Denominator	All transfers from 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.
Measure Analysis Suggestions: The data elements for each of the two communication elements provide
the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.

Measure EDTC-SUB 6

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 6
Performance Measure Name: Nurse Generated Information
Description: Patients who are transferred from an ED to another healthcare facility have communication
with the receiving facility within 60 minutes of discharge for key nurse documentation elements
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 healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of departure.

- Assessments/interventions/response
- Sensory Status (formerly Impairments)
- Catheters/ IV
- Immobilizations
- Respiratory support
- Oral limitations

Denominator Statement: Transfers from an ED to another healthcare facility

Included Populations: All transfers from an ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 6

Numerator	# of patients who have a yes or NA for all measures: assessments/interventions/response, sensory status (formerly impairments), catheter, immobilization, respiratory support, oral limitations
Denominator	All transfers from 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.
Measure Analysis Suggestions: The data elements for each of the six communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.

Measure EDTC-SUB 7

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 7
Performance Measure Name: Procedures and Tests
Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge of tests done and results sent.
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 healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of discharge.

- Tests and procedures done
- Tests and procedure results sent/ or plan to communicate

Denominator Statement: Transfers from an ED to another healthcare facility Included

Population: All transfers from an ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 7

Numerator	# of patients who have a yes or NA for all measures: test and procedures done and test and procedure results sent
Denominator	All transfers from 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.
Measure Analysis Suggestions: The data elements for each of the two communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.

Measure EDTC- Alternate All or None Composite Calculation

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-All or None
Performance Measure Name: All or None Measure
Description: Patients who are transferred from an ED to another healthcare facility have all necessary communication made available to the receiving facility
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 healthcare facility whose medical record documentation indicated that all of the relevant elements for each of the 7 sub-measures were documented and communicated to the receiving hospital within 60 minutes of discharge.

EDTC-SUB 1	Administrative communication
EDTC-SUB 2	Patient information
EDTC-SUB 3	Vital signs
EDTC-SUB 4	Medication information
EDTC-SUB 5	Physician or practitioner generated information
EDTC-SUB 6	Nurse generated information
EDTC-SUB 7	Procedures and tests

Denominator Statement: Transfers from an ED to another healthcare facility

Included Population: All transfers from an ED to another healthcare facility Excluded Populations: None

Calculation:

$$\frac{\text{\# of patients who have a yes or NA for all elements}}{\text{All transfers from ED to another healthcare facility}}$$

Risk Adjustment: No
Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.
Measure Analysis Suggestions: This measure can be used as an overall evaluation of performance on this measure set.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.

Emergency Department Transfer Communication

Data Elements

Data Element Name:

Healthcare Facility to Healthcare Facility Communication (indicating bed and services available)

Collected For: Emergency Department Records: EDTC-SUB 1

Suggested Data Collection Question: Does the medical record documentation indicate that healthcare facility to healthcare facility communication occurred prior to discharge of the patient from the ED to another healthcare facility?

Allowable Values:
Y (Yes) Select this option if there is documentation of the ED staff communicating with staff of the receiving facility.
N (No) Select this option if there is no documentation of the ED staff communicating with staff of the receiving
facility.

Notes for Abstraction:

- Documentation must indicate that healthcare facility to healthcare facility communication occurred prior to transfer.
- Date and time of contact can be used to verify that communication occurred prior to transfer.
- This does not need to be full report. Acceptable communication includes assuring the availability of appropriate bed and services for the patient.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary document
- Nursing note

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Physician to Physician Communication

Collected For: Emergency Department records: EDTC-SUB 1

Suggested Data Collection Question: Does the medical record documentation indicate that physician/advanced practice nurse/physician assistant (physician/APN/PA) to physician/APN/PA communication occurred prior to the transfer of the patient from the ED to another healthcare facility?

Allowable Values:
Y (Yes) Select this option if there is documentation of the ED physician/APN/PA discussion of the patient's condition with physician/APN/PA staff at the receiving facility.
N (No) Select this option if there is no documentation of the ED physician/APN/PA discussion of the patient's condition with physician/APN/PA at the receiving facility.
N/A (Not Applicable) Select this option if the transfer is to a non-acute care healthcare facility.

Notes for Abstraction:

- Must include the names of the two communicating providers.
- Documentation must indicate that ED physician/APN/PA to ED physician/APN/PA communication occurred prior to transfer.
- Date and time of contact can be used to verify that communication occurred prior to transfer.
- Documentation of a Practitioner transfer acceptance agreement that specifies advance approval for patients with specific conditions or medical needs would be acceptable.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary document
- EMTALA form

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:
Patient Name

Collected For: Emergency Department Records: EDTC-SUB 2

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

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

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient’s name was sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient’s name was sent to the receiving facility.
NA (Not Applicable) Select this option if this information was not available.

Notes for Abstraction:

- If the patient is a John/Jane Doe, and/or is altered neurologically select NA
- If the patient has a potential brain/head injury select NA.
- If the patient refuses to answer the question select NA.

Suggested Data Sources:

- Emergency Department record
- Face sheet
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Patient Address

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

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

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient’s address was sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient’s address was sent to the receiving facility.
NA (Not Applicable) Select this option if this information was not available

Notes for Abstraction:

- If the patient is a John/Jane Doe, and/or is altered neurologically select NA
- If the patient has a potential brain/head injury select NA
- If the patient refuses to answer the question select NA.

Suggested Data Sources:

- Emergency Department record
- Face sheet
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Patient Age

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

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

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient’s age was sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient’s age was sent to the receiving facility.
NA (Not Applicable) Select this option if this information was not available

Notes for Abstraction:

- If the patient is a John/Jane Doe, and/or is altered neurologically select NA.
- If the patient has a potential brain/head injury select NA
- If the patient refuses to answer the question select NA.
- If the patient’s date of birth was sent select yes.

Suggested Data Sources:

- Emergency Department record
- Face sheet
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Patient Gender

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient gender was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that gender was sent to the receiving facility.
N (No) Select this option if there is no documentation that gender was sent to the receiving facility.
NA (Not Applicable) Select this option if this information was not available or unable to be

determined Notes for Abstraction:

Suggested Data Sources:

- Emergency Department record
- Face sheet
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Patient Contact Information

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that contact information for a family member/significant other/friend was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that contact information was sent to the receiving facility.
N (No) Select this option if there is no documentation that contact information was sent to the receiving facility.
NA (Not Applicable) Select this option if this information was not available

Notes for Abstraction:

- The patient's contact can be a family member, significant other or friend.
- Contact information must include both a name and phone number.
- Can have more than one contact but must have at least one.
- If the patient is a John/Jane Doe and/or is altered neurologically select NA.
- If the patient has a potential brain/head injury select NA.
- If the patient refuses to answer the question select NA.

Suggested Data Sources:

- Emergency Department record
- Face sheet
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Patient Insurance Information

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

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

Allowable Values:
Y (Yes) Select this option if there is documentation that insurance information was sent to the receiving facility.
N (No) Select this option if there is no documentation that insurance information was sent to the receiving facility.
NA (Not Applicable) Select this option if this information was not available

Notes for Abstraction:

- Information must include both the insurance company name and policy number.
- If patient does not have insurance and uninsured status is documented, select yes.
- If the patient is a John/Jane Doe and/or is altered neurologically select NA.
- If the patient has a potential brain/head injury select NA.
- If the patient refuses to answer the question select NA.

Suggested Data Sources:

- Emergency Department record
- Face sheet
- Copy of insurance card
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Pulse

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient’s pulse was taken and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient’s pulse was taken and sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient’s pulse was taken and sent to the receiving facility.

Notes for Abstraction:

Suggested Data Sources:

- Emergency Department record
- Nursing Notes
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Respiratory Rate

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient's respiratory rate was taken and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient's respiratory rate was taken and sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient's respiratory rate was taken and sent to the receiving facility.

Notes for Abstraction:

Suggested Data Sources:

- Emergency Department record
- Nursing Notes
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Blood Pressure

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient's blood pressure was taken and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient's blood pressure was taken and sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient's blood pressure was taken and sent to the receiving facility.
NA (Not Applicable) Select this option if the patient is less than or equal to 3 years of age.
Select this option if a Blood Pressure is unable to be assessed due to patients' behavior or mental status.

Notes for Abstraction:

Suggested Data Sources:

- Emergency Department record
- Face sheet
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Oxygen Saturation

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient's oxygen saturation (O2 Sat) was taken and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient's oxygen saturation (O2 Sat) was taken and was sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient's oxygen saturation (O2 Sat) was taken and sent to the receiving facility.

Notes for Abstraction:

Suggested Data Sources:

- Emergency Department record
- Nursing Notes
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:
Temperature

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

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

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient's was taken and the temperature was sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient's temperature was taken and sent to the receiving facility.
NA (Not Applicable) Select this option if the temperature is not required. See notes for abstraction.

Notes for Abstraction:
Temperature is required for patients with physician/APN/PA documentation of suspected infection, hypothermia or heat disorder.

Suggested Data Sources:

- Emergency Department record
- Nursing Notes
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Neurological Assessment

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that a neurological assessment was done on patients at risk for altered consciousness and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that a neuro assessment was done and sent to the receiving facility.
N (No) Select this option if there is no documentation that a neuro assessment for the condition was done and sent to the receiving facility.
NA (Not Applicable) Select this option if a neurologic assessment is not required due to no documentation of altered consciousness, possible brain/head injury, trauma or post seizure, stroke, TIA condition.

Notes for Abstraction: Only required for patients with documentation of:

- Altered consciousness
- Possible brain/head injury
- Post seizure
- Trauma
- Stroke
- TIA

Suggested Data Sources:

- Emergency Department record
- Birth or delivery record
- Transfer Summary document
- Glasgow coma scale
- Neuro flow sheets

Exclusion Guidelines for Abstraction:
None

Data Element Name:
Medications Administered in ED

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the list of medication(s) administered or that no medications were 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 were sent to the receiving facility.
N (No) Select this option if there is no documentation that the list of medications administered were sent to the receiving facility.

Notes for Abstraction:

- If no medications were given during the ED visit, documentation must state that there were no medications given to select yes.
- Medication information documented anywhere in the ED record is acceptable.

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

Data Element Name:
Allergies/Reactions

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

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 the patient's allergy information was sent to the receiving facility.
N (No) Select this option if there is no documentation the patient's allergy information was sent to the receiving facility.

Notes for Abstraction:

- See inclusion guidelines for what should be contained in the allergy information.
- If documentation is sent that allergies are unknown, select yes.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:

- Food allergies/reactions
- Medication allergies/reactions
- Other allergies/reactions

Exclusion Guidelines for Abstraction:
None

Data Element Name:
Home Medications

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

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

Allowable Values:
Y (Yes) Select this option if there is documentation medication history was sent to the receiving facility.
N (No) Select this option if there is no documentation medication history was sent to the receiving facility.

Notes for Abstraction:

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

Suggested Data Sources:

- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:

- Complimentary medications
- Over the counter (OTC) medications

Exclusion Guidelines for Abstraction:
None

Data Element Name:
History and Physical/ED Provider Note

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that a history and physical/ED Provider Note was done by the physician/advanced practice nurse/physician assistant (physician/APN/PA) and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation a history and physical/ ED Provider Note was done and sent to the receiving facility.
N (No) Select this option if there is no documentation that a history and physical/ED Provider Note was done and sent to the receiving facility.

Notes for Abstraction:
Must minimally include history of the current ED episode, a focused physical exam and relevant chronic conditions. Chronic conditions may be excluded if the patient is neurologically altered.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Reason for Transfer/Plan of Care

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

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

Allowable Values:
Y (Yes) Select this option if there is documentation a reason for transfer or plan of care was done 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 done 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

Data Element Name:

Nursing Notes

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that nursing notes were sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that nursing notes were sent to the receiving facility.
N (No) Select this option if there is no documentation that nursing notes were sent to the receiving facility.

Notes for Abstraction:

- Examples of nursing notes may include nursing assessment, intervention, response or SOAP notes.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:
Sensory Status (formerly Impairments)

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient was assessed for impairments?

Allowable Values:
Y (Yes) Select this option if there is documentation that assessment of sensory status was done and information was sent to the receiving facility.
N (No) Select this option if there is no documentation that assessment of sensory status was done and information was sent to the receiving facility.

Notes for Abstraction:
Select Yes if documentation indicates that patient is unresponsive.
Documentation includes the patient being assessed for mental, speech, hearing, vision, and sensation impairment.
For example:

- A History and Physical that includes at least one the following would be acceptable
    - ENT WNL – indicates assessment of speech and hearing
    - Oriented - indicates assessment of mental status
    - Has or denies tingling/numbness – indicates assessment of sensation

- Nursing Notes that indicate the following would be acceptable:
    - Wears eyeglasses – indicates assessment of vision
    - Has hearing aid – indicates assessment of hearing

Suggested Data Sources:

- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None

Data Element Name:
Catheters/IV

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that treatment with IV or any other catheters was provided to the patient and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that catheter information was sent to the receiving facility.
N (No) Select this option if there is no documentation that catheter information was sent to the receiving facility.
NA (Not Applicable) Select this option if no catheters were placed.

Notes for Abstraction:
Select NA if no catheters were placed.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary document

Inclusion Guidelines for Abstraction:

- IV (intravenous)
- IT (intrathecal)
- Urinary
- Heparin Lock
- Central line

Exclusion Guidelines for Abstraction:
None

Data Element Name:
Immobilizations

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate information was sent regarding any immobilization provided for the patient?

Allowable Values:
Y (Yes) Select this option if there is documentation that immobilization was done and information was sent to the receiving facility.
N (No) Select this option if there is documentation that immobilization was done and information was not sent to the receiving facility.
NA (Not Applicable) Select this option if no immobilization was done

Notes for Abstraction:
Select NA if no immobilization was done.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary document

Inclusion Guidelines for Abstraction:

- Backboard
- Casts
- Neck brace
- Other braces

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Respiratory Support

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

Suggested Data Collection Question: Does the medical record documentation indicate information was sent regarding any respiratory support provided to the patient?

Allowable Values:
Y (Yes) Select this option if there is documentation that respiratory support was provided and information was sent to the receiving facility.
N (No) Select this option if documentation that respiratory support was provided and information was not sent to the receiving facility.
NA (Not Applicable) Select this option if no respiratory support was provided.

Notes for Abstraction:
If no respiratory support was provided select NA.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary document

Inclusion Guidelines for Abstraction:

- Bronchial drainage
- Intubations
- Oxygen
- Ventilator support

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Oral Restrictions

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate information was sent regarding any oral restrictions placed on the patient?

Allowable Values:
Y (Yes) Select this option if there is documentation that oral restriction were placed and information was sent to the receiving facility.
N (No) Select this option if there is documentation that oral restrictions were placed and information was not sent to the receiving facility.
NA (Not Applicable) Select this option if no oral restrictions were placed.

Notes for Abstraction:
Select NA if no oral restrictions were placed.

Suggested Data Sources:

- Emergency Department record
- Transfer Summary document

Inclusion Guidelines for Abstraction:

- NPO
- Clear liquids
- Soft diet
- Low NA diet

Exclusion Guidelines for Abstraction:
None

Data Element Name:

Tests/Procedures Performed

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

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

Allowable Values:
Y (Yes) Select this option if there is documentation that information on all tests and procedures completed 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 completed 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 test or procedure results were sent select yes.
- 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

Data Element Name:

Tests/Procedure Results

Definition: For this question, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge.

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 share medical records then tests and procedure results are considered sent – select yes.
- If results are not sent and facilities do not share medical records then documentation must include a plan to communicate results in order to select yes.
- If no plan to communicate results - select no.

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:
ED Transfer Paper Tool

ED Transfer Communication Measure Data Collection Tool

CMS Certified Number (CCN): _____

Name of State: _____

Patient Name: _____

Patient Medical Record Number: _____

Select Patient Discharged Disposition: (Select one option)

_____Hospice – healthcare 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 Veteran's Administration
_____Other health care facility

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.

Does the medical record documentation indicate that the following communication occurred prior to departure of the patient from ED to another healthcare facility?

1. **Healthcare Facility to Healthcare Facility Communication:**

_____Yes_____No

2. **Physician/Advanced Practice Nurse/Physician Assistant (Physician/APN/PA) to Physician/APN/PA communication/Agreement:**

_____Yes_____No ____N/A

Does the medical record documentation indicate that the following patient information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge?

3. **Patient Name:**

_____Yes_____No _____N/A

4. **Patient Address:**

_____Yes_____No _____N/A

5. **Patient Age:**

_____Yes_____No _____N/A

6. **Patient Gender:**

_____Yes_____No _____N/A

7. **Patient Contact Information (family member/significant other/friend):**

_____Yes_____No _____N/A

8. **Patient Insurance Information:**

_____Yes_____No _____N/A

Does the medical record documentation indicate that the following patient's vital signs were taken and the information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge?

9. **Pulse:**

_____Yes_____No

10. Respiratory Rate:

_____Yes_____No

11. Blood Pressure:

_____Yes_____No _____N/A

12. Oxygen Saturation:

_____Yes_____No

13. Temperature:

_____Yes_____No _____N/A

14. Neurological Assessment:

_____Yes_____No _____N/A

Does the medical record documentation indicate that the following patient's medication information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge?

15. Medications Administered in ED:

_____Yes_____No

16. Allergies/Reactions:

_____Yes_____No

17. Home Medications:

_____Yes_____No

Does the medical record documentation indicate that the following physician or practitioner generated information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge?

18. History and Physical/ED Provider Note:

_____Yes_____No

19. Reason for Transfer/Plan of Care:

_____Yes_____No

Does the medical record documentation indicate that the following nurse generated information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge?

20. Nursing Notes:

_____Yes_____No

21. Sensory Status (formerly Impairments):

_____Yes_____No

22. Catheters/IV:

_____Yes_____No _____N/A

23. Immobilizations:

_____Yes_____No _____N/A

24. Respiratory Support:

_____Yes_____No _____N/A

25. Oral Restrictions:

_____Yes_____No _____N/A

Does the medical record documentation indicate that the following procedures and tests information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge?

26. Tests/Procedures Performed:

_____Yes_____No _____N/A

27. Tests/Procedures Results/Plan:

_____Yes_____No _____N/A

Appendix B:
List of Data Elements

Emergency Department Transfer Communication Measure Required Data Elements

Data Element	Acceptable Values/Format
CMS Certified Number (CCN)	6 digit numeric
State	Two character postal code (MN)
Patient Discharge Status Code*	Two digit code: 03, 4a, 4b, 4c, 4d, 05
Date of Patient Encounter	Mm/dd/yyyy
Healthcare Facility to Healthcare Facility Communication	Y/N
Physician to Physician Communication	Y/N/NA
Patient Name	Y/N/NA
Patient Address	Y/N/NA
Patient Age	Y/N/NA
Patient Gender	Y/N/NA
Patient Contact Information	Y/N/NA
Patient Insurance Information	Y/N/NA
Pulse	Y/N
Respiratory Rate	Y/N
Blood Pressure	Y/N/NA
Oxygen Saturation	Y/N
Temperature	Y/N/NA
Neurological Assessment	Y/N/NA
Medications Administered in ED	Y/N
Allergies/Reactions	Y/N
Home Medication	Y/N
History and Physical	Y/N
Reason for Transfer Plan of Care	Y/N
Nursing Notes	Y/N
Sensory Status (formerly impairments)	Y/N
Catheters	Y/N/NA
Immobilizations	Y/N/NA
Respiratory Support	Y/N/NA
Oral Restrictions	Y/N/NA
Tests/Procedures Performed	Y/N/NA
Tests/Procedure Results	Y/N/NA

*Reference: www.qualitynet.org – Outpatient Reporting, Measure Resources, Discharge Code to Discharge Status Crosswalk

Appendix C:

Emergency Department Transfer Communication Measure: Crosswalk with Meaningful Use Stage Two Requirements

Eligible Hospital and Critical Access Hospital Meaningful Use Core Measures
Measure 12 of 16: Summary of Care
Date issued: November, 2012
Reference: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_HospitalCore_12_SummaryC are.pdf

Objective: The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.

A summary of care record must include the following elements:

Meaningful Use standard	ED transfer measures SUB #
Patient name.	2
Referring or transitioning provider's name and office contact information (EP only).	1
Procedures.	7
Encounter diagnosis	5
Immunizations.	Not included
Laboratory test results.	7
Vital signs (height, weight, blood pressure, BMI).	3
Smoking status.	5, 6
Functional status, including activities of daily living, cognitive and disability status	3, 6
Demographic information (preferred language, sex, race, ethnicity, date of birth).	2
Care plan field, including goals and instructions.	5
Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider	1
Discharge instructions	5
Current problem list (Hospitals may also include historical problems at their discretion) At a minimum a list of current, active and historical diagnoses. We do not limit the eligible hospital to just including diagnoses on the problem list.	5
Current medication list, and	4
Current medication allergy list.	4
Current allergy list: An exaggerated immune response or reaction to substances that are generally not harmful.	4,5,6,
Care Plan: The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).	5

Table by Jill M. Klingner, March 2013