Data Collection Guide
ED Transfer Communication Measures

Includes: Specifications, Definitions
and Data Collection Tool

Quality Reporting and Measurement System
2013 Hospital Measures

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Overview

The goal is to create a uniform approach to quality measurement, to enhance market transparency and improve health care quality. This document supports the seven National Quality Forum (NQF)-endorsed emergency department (ED) transfer communication measures:

(1) Administrative communication
(2) Patient information
(3) Vital signs
(4) Medication information
(5) Physician information
(6) Nurse information
(7) Procedures and tests

Background on the Measures

In 2003, an expert panel convened by the University of Minnesota Rural Health Research Center 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 in these hospitals more important. Communication between providers promotes continuity of care and may lead to improved patient outcomes. These measures also were previously piloted by some rural Minnesota hospitals in a project that took place during the period October 2005 through March 2006. Results of the pilot project indicated room for improvement in ED care and transfer communication.

Measures Specifications

Description: Percent of charts that had medical record documentation indicating that the following pre-transfer communication occurred and was documented and that the following patient care elements were sent with the patient or sent within 60 minutes of departure.

Measurement collection is done by the sending hospital. These measures assess the sending hospital's completeness of communication to a receiving facility. The elements are separated into **7 sub categories**.

Sources Used For Development of Measure: Coordination of Care Record (CCR), EMTALA

Denominator Statement: All patients who are transferred to another Healthcare Facility. This is for all 7 of the measures.

Include patients with a discharge disposition code of 3, 4, 5:

3 Hospice – Health Care Facility
4a Acute Care Facility- General Inpatient Care
4b Acute Care Facility- Critical Access Hospital
4c Acute Care Facility- Cancer Hospital or Children's Hospital
4d Acute Care Facility – Department of Defense or Veteran's Administration
5 Other Health Care Facility

Exclusions
Exclude patients with a discharge code of 1, 2, 6, 7, 8:

1 Home
2 Hospice - Home
6 Expired
7 Left Against Medical Advice/AMA

8 Not Documented or Unable to Determine (UTD)

Each of the 7 sub categories listed below is calculated using an all-or-none approach. Each element included in each sub category must be documented in the medical record for every patient transferred to another healthcare facility to be included in the numerator for that sub category.

For hospital 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 hospital within 60 minutes of departure. Test and procedure results that become available after the 60-minute timeframe are assumed to be entered into the data system and available to the receiving hospitals when the tests are completed.

Items scored as NA (not applicable) are counted in the measure as a positive, or 'yes,' response. Please see the Data Collection section found on page 15 for more detailed instructions.

Administrative (i.e., Pre-Transfer) Communication

Total of 2 elements:

- Nurse communication with receiving facility
- Physician or mid-level practitioner communication with receiving physician or mid-level practitioner
-

Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that communication occurred with the receiving facility and the accepting MD or mid-level prior to the patient's departure.

Patient Information

Total of 6 elements:

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

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.

Vital Signs

Total of 6 elements:

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

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.

Medication Information

Total of 3 elements:

- Medications given
- Allergies
- Medications from home

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.

Physician or Practitioner Generated Information

Total of 2 elements:

- History and physical: Physical exam, history of current event, chronic conditions
- Physician or practitioner orders and plan

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

Nurse Generated Information

Total of 6 elements:

Nurse documentation includes:

- Assessment/interventions/response
- Impairments
- Catheters
- Immobilizations
- Respiratory support
- Oral limitations

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

Procedures and Tests

Total of 2 elements:

- Tests and procedures done
- Tests and procedure results sent

Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the applicable elements were communicated to the receiving facility within 60 minutes of departure, or were sent when available.

Note: Some test results may not be available within 60 minutes of the patient's departure, but it is important to have a mechanism in place to ensure communication of test and procedure results that become available after the 60-minute window of time.

Data Abstraction Definitions

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
Question1: Does the medical record documentation indicate that nurse-to-nurse communication occurred prior to the patient's departure from the ER to another facility?	**Yes:** Select this option if there is documentation of the ER nurse arranged acceptance and bed availability with nursing staff of the receiving facility. Must include minimally the date and time report was given, and the communication means (i.e., phone, fax, other). **No:** Select this option if there is no documentation of the ER nurse giving report to the nursing staff of the receiving facility. Must include minimally the date and time report was given, and the communication means (i.e., phone, fax, other). Giving report to a transfer coordinator, who is not a nurse, is not adequate.	Nursing note Transfer summary document	None	None
Question 2: Does the medical record documentation indicate that Practitioner/physician-to-practitioner/ physician communication occurred prior to the transfer of the patient from the ER to another facility?	**Yes:** Select this option if there is documentation of the ER physician's or mid-level practitioner's discussion of the patient's condition with physician or mid-level staff at the receiving facility. Must include minimally the names of the two providers, the date and time of communication, and the communication means (i.e., phone, fax, other). **No:** Select this option if there is no documentation of the ER physician's or mid-level practitioner's discussion of the patient's condition with physician or mid-level staff at the receiving facility. Must include minimally the names of the two providers, the date and time of communication, and the communication means (i.e., phone, fax, other).	Practitioners/Physician's note Transfer summary document Practitioners/Physician's orders	None	None

	For the remaining questions, "sent" refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/EHR connection availability within 60 minutes of [illegible]			
QUESTION	**INSTRUCTIONS**	**RECOMMENDED LOCATIONS**	**INCLUSIONS**	**EXCLUSIONS**
Question 3:a-c Does the medical record documentation indicate that patient information, including name, address, and age was sent with the patient?	**Yes:** Select this option for each of the 3 elements sent with the patient: name, address, age. **No:** Select this option for each of the 3 elements not sent with the patient: name, address, age. **NA**: Select this option if patient is a John/Jane Doe and/or is altered neurologically or has potential brain/head injury, or if the patient refuses to answer the question.	Face sheet	None	None
Question 3:d Does the medical record documentation indicate that patient gender was sent with the patient?	**Yes:** Select this option if gender was sent with the patient. **No:** Select this option if gender was not sent with the patient.	Face sheet	None	None
Question 3:e Does the medical record documentation indicate that contact information for significant others and family members was sent with the patient?	**Yes:** Select this option if the name and phone number for at least one of the patient's family or friends was sent with the patient. **No:** Select this option if the name and phone number for at least one of the patient's family or friends was not sent with the patient. **NA**: Select this option if patient is a John/Jane Doe and/or is altered neurologically or has potential brain/head injury, or if the patient refuses to answer the question.	Face Sheet Nursing notes	None	None

Question 3:f Does the medical record documentation indicate that insurance information was sent with the patient?	**Yes:** Select this option if insurance company and number were sent with the patient. **No:** Select this option if insurance company and number were not sent with the patient. **NA:** Select this option if patient is a John/Jane Doe and/or is altered neurologically or has potential brain/head injury, or if the patient refuses to answer the question.	Face Sheet Copy of insurance card	None	None

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
Question 4:a-f Does the medical record documentation indicate that vital signs were taken and sent with the patient?	**Yes:** Select this option if vital signs documented as sent include: pulse, respiratory rate, blood pressure*, oxygen saturation, temperature**. *If patient is less than or equal to 2 years of age, select **NA** for blood pressure. ** If infection, hypothermia, or heat disorder is suspected from the physician notes, a temperature is required. Otherwise answer for temperature is **NA**. **No:** Select this option if vital signs documented as sent do not include: pulse, respiratory rate, blood pressure, oxygen saturation, temperature*.	ER flow sheet Nursing notes	None	None

Question 4:g Does the medical record documentation indicate that appropriate neuro assessments were done and sent with the patient?	**Yes:** Select this option if vital signs documented as sent include: a. Glasgow coma scale or neuro flow sheet if patient has altered consciousness. (This is required for trauma, cognitively altered, or neuro patients only.) **NA** if patient is not at risk for altered consciousness. **No:** Select this option if vital signs documented as sent do not include: a. Glasgow coma scale or neuro flow sheet if patient has altered consciousness. **NA** if patient is not at risk for altered consciousness.	Flow sheets Nursing notes MD notes Flow sheets Nursing notes MD notes Birth or delivery record	All patients with altered consciousness levels or with possible brain/ head injury. Patients post seizure. All trauma patients.	None
Question 5:a-b Does the medical record documentation indicate that practitioner/physician communication was sent with the patient?	**Yes:** Select this option if information documented as sent includes minimally: a. History and Physical (includes focused physical exam, history of current ER episode, and relevant chronic conditions). Chronic conditions may be excluded if patient is neurologically altered. b. Reason for the transfer and/or a plan of care (may include suggestions for care to be received at the receiving hospital). **No:** Select this option if information documented as sent does not include minimally: a. History and Physical (includes focused physical exam, history of current ER episode, and relevant chronic conditions).Chronic conditions may be excluded if patient is neurologically altered. b. Reason for the transfer and/or a plan of care (may include suggestions for care to be received at the receiving hospital).	MD notes Transfer summary	None	None

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
Question 6:a-d Does the medical record documentation indicate that nursing communication was sent with the patient?	**Yes:** Select this option if information documented as sent includes minimally: a. Medication history (including complimentary medications, OTC medications and oxygen). This may be not available (NA) if patient is neurologically altered. b. Allergies (food, medication, other), reactions. This may be not available (NA) if patient is neurologically altered. c. Impairments (mental, speech, hearing, vision, sensation). d. Nurse notes. For example: nurse assessment / intervention / response or SOAP. **No:** Select this option if information documented as sent does not include minimally: a. Medication history (including complimentary medications, OTC medications and oxygen). This may be not available (NA) if patient is neurologically altered. b. Allergies (food, medication, other) reactions. This may be not available (NA) if patient is neurologically altered. c. Impairments (mental, speech, hearing, vision, sensation). d. Nurse notes. For example: nurse assessment/ intervention/response or SOAP.	Nurse notes Flow sheets MD notes	None	None

Question 7:a-e Does the medical record documentation indicate that information was sent on the treatment provided in the originating hospital?	**Yes:** Select this option if information documented as sent includes minimally: a. Medication administration record (MAR). b. Catheters (IV, IT, Urinary). c. Oral restrictions (NPO, clear liquids, etc.). d. Immobilizations (splints, neck brace, back board, etc.). e. Respiratory support provided (ventilator support, intubations, bronchial drainage, etc.). **No:** Select this option if information documented as sent does not include minimally: a. Medication administration record, (MAR). b. Catheters (IV, IT, Urinary). c. Oral restrictions (NPO, clear liquids, etc.). d. Immobilizations (splints, neck brace, back board, etc.). e. Respiratory support provided (ventilator support, intubations, bronchial drainage, etc.). **NA**: Select this option if no treatment provided in the originating ER.	Nursing notes Flow sheets MAR	None	None

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
Question 8: Does the medical record documentation indicate that information was sent on the tests and procedures that were done in the ER (and are pertinent to the emergency condition)?	**Yes:** Select this option if information documented as sent includes minimally: List of labs, X-rays and procedures completed in the ER prior to transfer. **No:** Select this option if information documented as sent does not includes minimally: List of labs, X-rays and procedures completed in the ER prior to transfer. **NA:** Select this option if no tests, X-rays, or procedures were performed.	MD orders and notes Nursing notes Flow sheets Lab documentation	None	None
Question 9: Does the medical record documentation indicate that results from the completed tests and procedures that are done in the ER (and are pertinent to the emergency condition) were sent?	**Yes:** Select this option if information documented as sent includes minimally: Documentation of the results being sent either with the patient or communicated when available. **No:** Select this option if information documented as sent does not includes minimally: Documentation of the results being sent either with the patient or communicated when available. **NA:** Select this option if no tests, X-rays or procedures were performed.	MD orders and notes Nursing notes Flow sheets Lab documentation	None	None

Step by Step Guide to Data Collection

Step 1: Review the Measure Specifications

Step 2: Identifying the Patient Population (Denominator)

All patients who are transferred to another acute care hospital are included in the measure for all 7 sub categories.

Inclusions
All patients who are transferred to another healthcare facility

Include patients with a discharge disposition code of 3, 4, 5:

3 Hospice – Health Care Facility
4a Acute Care Facility- General Inpatient Care
4b Acute Care Facility- Critical Access Hospital
4c Acute Care Facility- Cancer Hospital or Children's Hospital
4d Acute Care Facility – Department of Defense or Veteran's Administration
5 Other Health Care Facility

Exclusions
Exclude patients with a discharge code of 1, 2, 6, 7, 8:

1 Home
2 Hospice - Home
6 Expired
7 Left Against Medical Advice/AMA

8 Not Documented or Unable to Determine (UTD)

Step 3: Data Collection

Tools for Data Collection and Data Entry

Data Collection Transfer Tool Form (optional)

A transfer tool was created for hospitals that would like to manually collect the data on paper as they are working to collect each element.

Data Collection Tool

This optional transfer tool was created for hospitals that would like to manually collect the data on paper as they are working to collect each element. This tool was prepared by the University of Minnesota Rural Health Center .

Patient's First Name: _____ **Patient's Last Name:** _____

1. **Does Medical Record documentation indicate that there was nurse to nurse communication that occurred prior to the patient's transfer from the ER to another facility?**

   _____ Yes

   _____ No

2. **Does Medical Record documentation indicate that there was practitioner/physician to practitioner/physician communication prior to the transfer of the patient from the ER to another facility?**

   _____ Yes

   _____ No

For questions 3 through 10, "sent" refers to medical record documentation that indicates information either went with the patient or was communicated to the receiving **facility** within 60 minutes of departure. Communication includes Fax, Internet and EHR availability or access within 60 minutes

3. **Does Medical Record documentation indicate that patient information including name, address, age, gender was sent with the patient?**

a. Name	Yes__	No__	NA__
b. Address	Yes__	No__	NA__
c. Age	Yes__	No__	NA__
d. Gender	Yes__	No__	

4. **Does Medical Record documentation indicate that contact information for significant other and/or family member was sent with the patient?**

e. Contact info	Yes__	No__	NA__

5. Does Medical Record documentation indicate that insurance information was sent with the patient?

f. Insurance	Yes__	No__	NA__

6. Does Medical Record documentation indicate that vital signs taken and were sent with the patient?

a. Pulse	Yes__	No__	
b. Resp	Yes__	No__	
c. BP	Yes__	No__	NA __
e. O2 Sat	Yes__	No__	
f. Temp	Yes__	No__	NA __

7. Does Medical Record documentation indicate that neuro assessments were done, as appropriate, and sent with the patient?

g. Glasgow Coma Scale or neuro flow sheet	Yes__	No__	NA__

8. Does Medical Record documentation indicate that the following practitioner/physician communications were sent with the patient?

a. History and Physical	Yes__	No__
b. Reason for transfer or Plan of care	Yes__	No__

9. Does Medical Record documentation indicate that the following nursing communications were sent with the patient?

a. Medication History	Yes__	No__	NA__
b. Allergies and reactions	Yes__	No__	NA__
c. Impairments	Yes__	No__	NA__
d. Comprehensive nurses notes	Yes__	No__	NA__

10. Does Medical Record documentation indicate that information was sent on the treatment provided in the originating hospital?

a. Medication Administration Record	Yes__	No__	NA__
b. Catheters	Yes__	No__	NA__
c. Oral restrictions (NPO etc)	Yes__	No__	NA__
d. Immobilizations	Yes__	No__	NA__
e. Respiratory support provided	Yes__	No__	NA__

For question 11 and 12, “sent” refers to medical record documentation that indicates information 1) went with the patient, 2) was communicated to the receiving facility within 60 minutes of departure, or 3) was sent when the information was available. Communication includes Fax, Internet and EHR availability or access within 60 minutes

11. Does Medical Record documentation indicate that information was sent on the tests and procedures that were done in the ER?

_____ Yes

_____ No

_____ NA

12. Does Medical Record documentation indicate that the results from completed tests and procedures were sent with the patient?

_____ Yes

_____ No

_____ NA