



# Data Collection Guide

## Emergency Department Transfer Communication Measures

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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.*

# Emergency Department Transfer Communication Measures

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# Emergency Department Transfer Communication Measures

## Emergency Department Transfer Communication Measure Specifications

### ED Transfer Communication QUALITY MEASURES Set

Measure ID #	Measure Short Name	NQF <sub>1</sub> Measure Number	NQMC <sub>2</sub> Measure Number
EDTC-SUB 1	Administrative communication	0291	7535
EDTC-SUB 2	Patient information	0291	7536
EDTC-SUB 3	Vital signs	0291	7537
EDTC-SUB 4	Medication information	0291	7538
EDTC-SUB 5	Physician or practitioner generated information	0291	7539
EDTC-SUB 6	Nurse generated information	0291	7540
EDTC-SUB 7	Procedures and tests	0291	7541
EDTC-Alt. All or None	Alternate all or none composite calculation	0291	

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 Measures

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 Minnesota, Utah, Nevada, Washington, Ohio, Pennsylvania, New York, and Hawaii; 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

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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](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 facilities. These measures are important for all health care facilities, but especially so for small rural hospitals that transfer a higher proportion of ED patients to other hospitals than larger urban facilities.

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 measures aim 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.

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# Emergency Department Transfer Communication Measures

## Population and Sampling

### ED Transfer Communication (EDTC) Initial Patient Population

(Update discharge codes with CMS changes as appropriate.)

The population of the EDTC measure set is defined by identifying patients admitted to the emergency department and transfers from the emergency department to these facilities:

3 Hospice –healthcare 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 (i.e. nursing homes, skilled nursing facilities, rehabilitation centers, swing beds; facilities with 24 hour nursing supervision.)

*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

2 Hospice-home

6 Expired

7 AMA (left against medical advice)

8 Not documented/unable to determine

### Sample Size Requirements

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. 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.

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### *Quarterly Sampling*

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

#### Quarterly Sample Size

Based on Initial Patient Population Size for the EDTC Measure Set

#### *Hospital's Measure*

Average Quarterly Initial Patient Population Size "N"	Minimum Required Sample Size "n"
≥ 45	45
1 - 44	No sampling; 100% Initial Patient Population required

### *Monthly Sampling*

Hospitals performing monthly sampling for EDTC must ensure that its Initial Patient Population and sample size meet the following conditions:

#### Monthly Sample Size

Based on Initial Patient Population Size for the EDTC Measure Set

<i>Hospital's Measure</i> Average Monthly Initial Patient Population Size "N"	Minimum Required Sample Size "n"
≥ 15	15
< 15	No sampling; 100% Initial Patient Population required

## Emergency Department Transfer Communication Measures

### Measure Calculation

Each of the seven SUB SECTIONS ARE calculated using an all-or-none approach. Data elements are identified for each SUBSECTION. If the data element is not appropriate for the patient, elements are scored as NA (not applicable) and 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) to pass the SUBSECTION. The subsections are used to identify areas with opportunity for improvement.

The all or none calculation approach for the subsections is in current use in two studies in nine states including almost 200 hospitals. This approach is under consideration for the Phase 3 of MBQIP. Maintaining the subsection scoring facilitates an EASY transition to the one measure approach and simplifies the transition to a reporting and payment measure.

The reporting measure is a sum of the subsection scores divided by the number of patients. The facility score is the average of the patients scores (range of 0-7) for each facility. This single score will provide an overview of the facility's communication performance for patients that are transferred from their Emergency Department to another healthcare facility.

**Alternate All or None Composite Measure Calculation:** Each of the seven sub-measures for EDTC has multiple data elements. In order for a given medical record to be counted as having met a sub-measure, it has to meet all of the data elements under that sub-measure. The overall EDTC Measure can be calculated the percentage of medical records that met every single data element in ALL of the sub-measures (27 data elements in total).

### 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 via fax, phone, or internet/Electronic Health Record.



# Emergency Department Transfer Communication Measures

## 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 have physician to physician communication and nurse to nurse 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 all of the elements were communicated to the receiving facility prior to transfer.

- Nurse to nurse 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: nurse to nurse 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.

# Emergency Department Transfer Communication Measures

## 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.

## Emergency Department Transfer Communication Measures

### 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.

# Emergency Department Transfer Communication Measures

## 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.

# Emergency Department Transfer Communication Measures

## 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 orders and plan

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
- 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.

## Emergency Department Transfer Communication Measures

### 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
- 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.

# Emergency Department Transfer Communication Measures

## 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

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.

## Emergency Department Transfer Communication Measures

### 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 with 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 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:

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

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

## Emergency Department Transfer Communication Measures

### Data Element Name:

#### *Nurse to Nurse Communication*

Collected For: Emergency Department Records: EDTC-SUB 1

Suggested Data Collection Question: Does the medical record documentation indicate that nurse-to-nurse 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 nurse communicating with the nursing staff of the receiving facility.

N (No) Select this option if there is no documentation of the ED nurse communicating with the nursing staff of the receiving facility.

#### Notes for Abstraction:

- Documentation must indicate that nurse to nurse communication occurred prior to transfer.
- Date and time of contact can be used to verify that communication occurred prior to transfer. If communication is given to a transfer coordinator at the receiving facility, the coordinator must be a nurse to select yes.
- House supervisor is assumed to be a nurse
- This does-not need to be full report. Acceptable communication includes assuring the availability of appropriate bed and staff for the patient.
- As small rural hospitals increasingly use staffing models which include paramedics and EMTs in ED roles, note that communication for this data element may occur between these staff (paramedics and EMTs) and nurses at the receiving facility.

#### Suggested Data Sources:

- Emergency Department record
- Transfer Summary document
- Nursing note

#### Inclusion Guidelines for Abstraction:

None

#### Exclusion Guidelines for Abstraction:

None

## Emergency Department Transfer Communication Measures

### 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.

#### Suggested Data Sources:

- Emergency Department record
- Transfer Summary document
- EMTALA form

#### Inclusion Guidelines for Abstraction:

None

#### Exclusion Guidelines for Abstraction:

None

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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



## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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 or 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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



## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### Data Element Name:

#### *History and Physical*

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 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 was done and sent to the receiving facility.

N (No) Select this option if there is no documentation that a history and physical 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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



## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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

## Emergency Department Transfer Communication Measures

### 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

#### Exclusion Guidelines for Abstraction:

None

## Emergency Department Transfer Communication Measures

### 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 shared medical record then tests and procedures done and results are considered sent – select yes  
If results not sent and no shared medical record then documentation must include a plan to communicate results – select yes

#### Suggested Data Sources:

- Emergency Department record
- Lab documentation
- Transfer Summary document

#### Inclusion Guidelines for Abstraction:

- Lab results
- X-ray results
- Procedure results

#### 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 Collection Guide 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. Nurse to Nurse Communication:

\_\_\_\_\_ Yes \_\_\_\_\_ No

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

\_\_\_\_\_ 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:**

\_\_\_\_\_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:**

\_\_\_\_\_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:**

\_\_\_\_\_Yes\_\_\_\_\_No \_\_\_\_\_N/A

# Appendix B: List of Data Elements

## Emergency Department Transfer Communication Measures 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
Nurse to Nurse 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](http://www.qualitynet.org) – Outpatient Reporting, Measure Resources, Discharge Code to Discharge Status Crosswalk

# Appendix C:

## Emergency Department Transfer Communication Measures: 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\\_SummaryCare.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_HospitalCore_12_SummaryCare.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 and the receiving 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