Emergency Department Transfer Communication (EDTC)
Frequently Asked Questions

Q: If a hospital is doing monthly sampling and the total transfers were less than 15 for the first month do they need to make up for this with the next month’s abstractions if the available population is greater than 15? Would they sample more than 15 cases for the following months in attempts to reach the 45 abstractions in the quarter?
A: Yes, if a CAH has less than 15 cases in one month and can make it up in another, they are encouraged to review 45 cases per quarter if possible.

Q: We would like to abstract all our ED cases that fit the population requirements, must we only do 45?
A: A hospital doesn’t have to sample, they can do all their cases. 45 is the minimum required if the hospital choses to sample. If a hospital has less than 45 cases per quarter, they are required to do them all.

Q: Is the patient who arrives at the ED from a Skilled Nursing Facility and then is transferred back to their SNF included? Or would this be considered a discharge “home” since they live at the SNF?
A: Even though these patients are being transferred back to where they currently reside, it is a Skilled Nursing Facility and should not be considered as a transfer/discharge home. The discharge code should be 5, other health care facility so they should be included in the EDTC population.

Q: The patient was transferred from our ED to jail. Should this patient be included in the EDTC population?
A: Transfers/discharges to jail, detention facilities, prisons would fit under the value of home, so those patients would not be included in the EDTC population.

Q: The patient was discharged back to the Long Term Care facility where she lives. Isn’t that considered as a discharge home?
A: For this EDTC abstraction, the patient would be considered as being transferred to an “other health care facility” and should be included in the population.
**Q:** Our patient is being transferred from the ED to an assisted living facility. How do we know if it is a state designated assisted living facility or a non-state designated assisted living facility?

**A:** For EDTC abstraction, the instructions don’t differentiate different types of assisted living facilities. If the documentation states the patient is being discharged to an assisted living facility, that is considered “home” for EDTC abstraction and the patient would not be in the population.

**Q:** Our patient was transferred to another healthcare facility but went via private vehicle. Would they be included in the EDTC population?

**A:** Yes, the mode of transportation doesn’t matter. The population for the EDTC measure is based on the facility the patient is transferred to.

**Q:** Are ED patients admitted to Observation and then transferred to another healthcare facility kept in the EDTC measure population, or are they excluded?

**A:** They would be kept in the population because they were never made an inpatient.

**Q:** On our transfer form, there is a box to check in front of the documentation "ER record copied and sent". Would you say that is acceptable to infer that the entire ER record was sent? My thought is that would include the labs, medications, face sheet, ER notes, etc.

**A:** If there was a check in front of the ER record copied and sent, you would take this to mean that the entire ER record was sent and that it would include all ER documentation. Although this indicates the ER record was sent, you still need to check and make sure all the required data elements were documented.

**Q:** If the EMTALA form has a check box stating Copies Sent: ER record and it is checked, is that acceptable to say yes? What if it isn’t checked, would they fail every measure?

**A:** If the box is checked, you could take that to mean that the entire ER record was sent. However, you would still need to check and see if each data element required was in the record. If it isn’t checked, then we would take that to mean no ER record was sent unless there was some other documentation to indicate that it was. If not, the only data elements you may be able to answer yes for are the nurse to nurse and physician to physician communication.

**Q:** Can we assume that the “Transfer Record” “Medical Necessity Certificate” and “Transfer Summary” gets sent to the receiving hospital?

**A:** No. If you are using these forms as documentation that certain data elements were sent, then you would need to see documentation that the form was sent.
Q: If a facility has an ED packet that is sent with the patient and EMS (flight crew/ambulance/etc..) and in the medical record they have the ability to document/check what items were sent – will this fulfill the requirement? What if all they do is check that the packet was sent?

A: There needs to be documentation that all the data elements required were either being sent with the patient, or available in the electronic health record within 60 minutes of the patient’s transfer. So for this question, you would need to see documentation in the record that the packet was sent, and what was contained in it. If the packet contains the required data elements and there was indication it was sent, then you could say yes to those elements being sent. If we don’t know what was in the packet and all you had was documentation indicating that it was sent, then there is no way to know which, if any of the required data elements were sent.

Q: Our transfer forms have a checkbox in front of the statement “pertinent records sent”. If this box is checked can we say yes to the data elements being sent?

A: No, because you don’t know what actually was sent. Pertinent might not mean the same thing to everyone. You need to have documentation that each of the data elements were sent.

Q: If the CAH shares electronic health records with the hospital the patient is being transferred to, can we approve all records being sent even though they only checked ER/OP/Transfer form, Transfer consent and facesheet as being sent?

A: If the facilities have a shared EHR (Electronic Health Record), you can give credit for all documentation being sent if the info was available within 60 minutes of discharge. You just have to look and make sure all the data elements were documented in the record.

Q: Can the ambulance transfer form be used for abstracting?

A: No, the measure focuses on information communicated from the Emergency Department.

Q: Would you consider the face sheet to be part of the ER record?

A: Yes, any documentation that occurs while the patient is being seen in the ER is considered part of the ER record.

Q: Our nurses don’t call the transferring hospital to give report until after the patient has left our facility and is on route to the receiving hospital. They are too busy taking care of the patient to do this until the patient has left. It doesn’t seem right that we should be failing the nursing communication data element.

A: We heard from many CAH’s that this was happening, that is why that data element was renamed Healthcare Facility to Healthcare Facility Communication. This data element does
not say that the communication must be a full report on the patient’s condition. There must be documentation that communication occurred between the two facilities prior to the patient’s transfer but it may be done by any ED staff. It also doesn’t have to be a full report, communication regarding bed availability and appropriate services is acceptable. Please be sure you are referring to the current version of the EDTC Manual, updated June 2017.

Q: At times the transfer of the patient from the ED to the receiving site is longer than 60 minutes. Many times the face sheet is the only document faxed, with the remaining medical record being sent with patient and EMS which makes many of the data elements unavailable within 60 minutes. Please advise on how to capture these timely elements.
A: If the information gets sent along with the patient the time isn’t an issue, it is available to the receiving facility when the patient arrives. The within 60 minutes is for those sites using shared electronic medical records, or communicating the information via fax or phone.

Q: Our providers don’t do H&P’s on patients seen in the ED. There are notes from the visit but no formal H&P so do we always have to say no for the data element History and Physical?
A: No, the intent of this data element was more about the content rather than the name. It doesn’t matter if it is called an H&P or it is just a provider note, the documentation must minimally include a history of the current ED episode, a focused physical exam and any relevant chronic conditions. To make this clearer, the data element name has been changed to History and Physical/ED Provider Note.

Q: When it is obvious there is physician-to-physician communication prior to transfer, is it necessary to have a time? For instance, the physician-to-physician communication is documented on the H&P which was dictated prior to transfer.
A: If the H&P was dictated prior to transfer and documentation indicated there was physician-to-physician communication that would be acceptable. Documentation needs to indicate the communication occurred prior to the transfer.

Q: If there is documentation of an allergy, does it have to include the reaction?
A: No

Q: For the data elements Allergies/Reactions and Home Medications, if there is no documentation in the ED encounter, can we assume that the patient did not have allergies or was on no medications prior to the ED visit?
A: No, you can’t assume that if nothing about allergies or home meds was documented that the patient doesn’t have or wasn’t on any. It could mean that there was no discussion about those at all. There needs to be documentation of any allergies the patient may have or home
meds they may be on. If the patient has no allergies or isn’t on any home meds, then that must be documented to be able to answer yes for those data elements.

**Q:** Does the “within 60 minutes” mean prior to transfer or after transfer or both? Some of my CAH’s send test results after transfer, especially on complicated tests. They send the results later and this assures the patient gets care quickly.

**A:** The data should be available to the receiving hospital within 60 minutes after the patient’s discharge/transfer. If the question is specifically about test results, there needs to be documentation indicating what tests were completed, along with the plan as to how they will get communicated to the receiving facility when the test results are available.

**Q:** If test results are not ready at the time of the transfer and the transfer documentation does NOT mention a plan for communicating them when complete, is that a Yes or No for Test/Procedure Results?

**A:** For the data element Tests/Procedure Results, the answer would be no. Unless the facilities share an electronic health record, there needs to be a plan on how the results will be communicated. If there is a shared electronic medical record then the results would be considered sent since the receiving facility would have access.

**Q:** How do I know which version of the Excel data entry tool I should be using?

**A:** If you are using the Excel data entry tool, the version that is currently found on the EDTC Resources site is the version that should be used.

[http://www.stratishealth.org/providers/ED_Transfer_Resources.html](http://www.stratishealth.org/providers/ED_Transfer_Resources.html)

The tool was not updated for 2017 since there were no measure changes. However, be sure to reference the EDTC Data Specifications Manual for updated clarifications on how to abstract your ED cases.

**Q:** I am trying to enter a patient who has been seen in our ED more than once but the EXCEL tool won’t let me enter the patient, it says the record already exist, even though this is a different encounter date. The message asks me if I want to overwrite the existing record. What do I do?

**A:** Say no to overwriting, you don’t want to lose the encounter you have already entered. Sometimes it won’t accept the patient again because you are entering the same medical record number. For the second encounter put an “a” behind the number. If there is another encounter use a “b” and so on. We aren’t sure why this sometimes happens. The medical record number is only there for your use, so it won’t matter in the reporting.