Robyn Carlson:

Hey everyone, this is Robyn Carlson from Stratis Health, which serves as the Rural Quality Improvement Technical Assistance Provider with the Federal office of Rural Health Policy.

During this recording I will be highlighting sections of the data specifications manual for the Emergency Department Transfer Communication Measure. We will start with how to determine which emergency department encounters to include in this abstraction and then go over the data elements that you will be looking for in those records.

If you have a copy of the data specifications manual in front of you, it would be on page 6 that has the information about population and sampling. So again, population are the records that you’re going to choose, the records that we want you to use for this abstraction. The population of the EDTC measure set is defined by identifying patients admitted to the emergency department and transferred from your emergency department to these facilities. These listing of facilities are the same ones that are used for the CMS outpatient abstraction so that’s where we got these values from.

- Value 3 – which is Hospice, so another healthcare facility hospice.
- Value 4A - acute care facility general and patient care, they were transferred to another acute care hospital and that would be including the emergency room of another hospital.
- Value 4B - is an acute care facility critical access hospital, so that would be if they were transferred from your ED to another critical access hospital, again including emergency department.
- Value 4C - another acute care facility, cancer hospital or children’s hospital, again including an emergency department of those two facilities.
- Value 4D - acute care facility Department of Defense or Veterans Administration, again including an emergency department.
- Value 5 - is the value of healthcare facility. This would be someone who was seen in your ED and transferred to a nursing home, skilled nursing facility, a rehab center, a psych facility, to a swing bed, any other healthcare facility.

There’s a note that says ED patients that have been put in observation status and are then transferred to another hospital or healthcare facility should be included. So if they’re in your ED you admit them in observation and then they are transferred out to any of those facilities that I just mentioned, which should be included.

You have some exclusions… anyone who was in your ED and was transferred home is excluded… and let me note that there are issues around home. If you have a patient who comes into your ED from a nursing home and that’s where they live. So they’re in the nursing home, they come to the ED,
they go back to the nursing home. For this abstraction that is not considered home that is considered they are transferred to another healthcare facility, so that person should be included. So home is if they go back to their home, not another healthcare facility.

If they go to a hospice in their home that would be excluded. If they’re expired that’s excluded. If they left AMA that’s excluded. Or, if you’re not able to determine value 8 that’s excluded. So that’s the population and that’s how you determine which case is seen in your ED that you’re going to abstract.

The next part on page six is **sampling** and a hospital can choose to sample if they don’t want to do all of their ED cases. They can sample quarterly or monthly. Page seven is the size requirements. If you have at least 45 encounters for that quarter then you need to do 45. You can do more if you would like but you must do at least 45. If you have between one and forty-four, there’s no sampling you need to do 100% of your population. So, you can pick 45 for the quarter or you can do it monthly by doing 15, that’s up to you how you choose to do that. You just want to make sure you do a random sample.

Now we’re going to move on to the next pages of the manual talking about the measures, but we’re going to focus now on the **data elements** and what I mean is that that’s what you’re looking for in those records that are part of your population.

The first data element you’re going to be looking for is called healthcare facility to healthcare facility communication.

What we’re looking for is indicating that bed and services are available at the receiving facility. If you’ve done this EDTC abstraction before this is the data element that used to be called nurse to nurse communication. In doing these abstractions and listening to the critical access hospitals we found out that it isn’t always the nurse that’s doing the communication and it’s not a full report. We were having people who were really getting mixed up with this data element, so we’ve changed it to healthcare facility to healthcare facility communication.

If you’re looking on page 18 in the manual the suggested data collection question is… does the medical record documentation indicate that healthcare facility to healthcare facility communication occurred prior to discharge of the patient from the ED to another healthcare facility? So we’re looking at the two facilities communicated prior to the patient being discharged. You’re going to say yes if there was documentation of communication. No, if there was not.

There are notes for abstraction and this is how we’ve set up the specifications manual, similar to the pages in the CMS outpatient manual if you’re familiar with that. We have notes for abstraction and this is just helpful guides for how to abstract.

It says, documentation must indicate that healthcare facility to healthcare facility communication occurred prior to the transfer, that’s the same as how this communication was before. It doesn’t need to be full report. Acceptable communication includes assuring the availability of appropriate bed and services for the patient. So again, notes for abstraction just to help you with a little more information about what we’re looking for.

Suggested data sources – you’ll note that all these data elements have suggested sources where you might find this information. It’s just suggested you don’t have to find it here, but this is where you would usually find it.

Inclusion– there aren’t any.
Exclusions– there aren’t any.

So inclusions would be things that are acceptable and exclusions would be things that aren’t acceptable.
The next element is on page 19 – **physician to physician communication**.

In this one we’re looking that the medical record documentation, your ED encounter documentation indicates that a physician or advanced practice nurse or physician’s assistant to physician advanced practice nurse physician’s assistant communication occurred prior to the transfer of the patient from your ED to another healthcare facility.

Yes, would be if there was documentation of communication. No, if there was no documentation of communication. N/A, you could record not-applicable if the transfer is to a non-acute healthcare facility. Because, right now in this iteration of the manual we’re feeling that a lot of times in other healthcare facilities there might not be a physician there to accept that communication, so again, if you’re putting that this patient, the discharge source was other healthcare facility then you could put a N/A for this physician to physician communication.

Notes for abstraction again, just to give you a little guideline has to occur prior to transfer and suggested data sources where you might find this information.

The next elements are pretty demographic, so I won’t spend a lot of time on those, **patient information**.

On page 20 – patient name – we want to know if the patient’s name was available. Did the documentation indicate that the patient’s name was sent to the receiving facility?

One thing I would like to mention if you’re following along with me in the manual is in the definition on page 20, where it says for this question sent. For all of these data elements coming up it says, does the medical record documentation indicate that this information was sent to the receiving facility? Sent means medical record documentation that indicates information went with the patient or was communicated via fax or phone or Internet or electronic health record connection was available within 60 minutes of the patient’s discharge. This is what we mean by sent and this is listed on every data element page.

So, it either needs to go with the patient or it was communicated via fax, phone or if you have an EHR that availability happened within 60 minutes of the patient’s discharge. The patient’s name, yes if there’s documentation it was sent. No, if there’s documentation it wasn’t and N/A would be if this information was not available.

The notes for abstraction explain what we would mean for not available. If the patient was a Jane or John Doe and they were altered neurologically. If they had a potential brain or head injury, so they can’t answer the question or if the patient refuses to answer, you can select N/A.

When we’re abstracting here an N/A is the same as like being a positive value, so it’s not as if when you put N/A you would fail this data element. N/A is the same as a yes.

Patients address is basically the same situation. The values yes or no or N/A and the reasons why.

Patient age
Patient gender
Patient contact information

Notes for abstraction for this one, patients contact can be a family member, significant other or friend. Contact information must include a name and phone number. You can have more than one contact, but you must have at least one.

Patient’s insurance information – read the notes for abstraction for what’s allowable there.

On page 26 we’re looking for more clinical data and the data element here is **pulse**.
Does the medical record documentation indicate that the patient’s pulse was taken and sent to the receiving facility? Yes, would be that the pulse was taken and sent. No, would be if there’s no documentation that the patient’s pulse was taken and/or sent to the facility.

There aren’t really any notes for abstraction because the pulse is the pulse. And then there are some suggested data sources where you might find that data.

As I’m thinking about it, let me just add, all of this information, we’re talking about medical record documentation, so there has to be documentation in the medical record that these things were sent. It can’t just be because you just know that these things always get sent or this is our protocol that things get sent. There needs to be documentation in the record that these elements were sent.

Page 27 data element is **respiratory rate**.

Again it’s, was there documentation that the patient’s respiratory rate was taken and sent to the facility, yes or no?

Blood pressure, same thing. I will say that for the allowable values there’s an N/A, so select this option if the patient is less than or equal to three years of age. Also, you can select N/A if a blood pressure is unable to be assessed due to the patient’s behavior or mental status.

Page 29 is **oxygen saturation**.

Page 30 is **temperature**.

We do have an N/A for this. The allowable value for that is, select the option if the temperature is not required. It says see notes for abstraction.

The notes for abstraction say, temperature is required for patients with physician APN or PA documentation of suspected infection, hypothermia or heat disorder. So if you have a record and the physician has documented that the patient has any one of those conditions then a temperature would be required. If not, then you can put N/A, if it’s not one of those conditions.

Page 31 is **neurological assessment**.

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? So you have yes it was done and sent; no it wasn’t done or sent and then N/A, which you would use if you have a patient that it’s not required to do a neurologic assessment if there’s no documentation of altered consciousness, a possible brain or head injury, trauma, post seizure, stroke or TIA condition. So there are only certain conditions where you would need to do a neurological assessment. They are listed under the notes for abstraction.

Page 32 is **medications administered in the ED**.

Does the medical record documentation indicate that the list of medications administered or that no medications were administered in the ED was sent to the receiving facility? There’s only a yes or no option for this.

The notes for abstraction say, if no medications were given during the ED visit, documentation must state that there were no medications given to select yes. There can’t just be no documentation about any medications or nothing. You can’t just make that decision that none were given. You need to see documentation that none were given, to be able to say yes.

Page 33 are **allergies and reactions**.
Was there documentation that the patient’s allergy history was sent to the receiving facility? Yes, if it was sent and no if it wasn’t.

For the notes for abstraction it says, if documentation is sent that allergies are unknown, that would be a yes because there is documentation about allergies, it’s the fact that they’re unknown but there’s still documentation that that was assessed.

Inclusion guidelines – say we’re looking for food allergies or if there are any medication reactions any other allergies or reaction types as well and if that was documentation and/or sent. If there’s nothing at all about allergies in your medical record and it’s not mentioned. That would be a no.

Page 34 is home medications.

Does the medical record documentation indicate that the patient’s medication history was sent to the receiving facility? Yes if there was documentation sent. No if there’s no documentation sent.

Notes for abstraction… if the documentation indicates patient is not on any home medication that would be yes, because it’s being assessed. If documentation is sent that home medications are unknown again you can select yes, because it’s being assessed.

The inclusion guidelines– any over the counter medications, any complementary medications, anything they were on at home.

Page 35 is history and physical.

Was there medical record documentation to indicate that a history and physical was done and sent to the receiving facility, yes or no?

You can read the notes for abstraction as to what that history and physical needs to, at least, include.

Page 36 is a reason for transfer or plan of care

Was there documentation that indicates a reason for a transfer and/or a plan of care documented and then sent to the receiving facility?

Page 37 is nursing notes.

Did the medical record documentation indicate that the nursing notes were sent to the receiving facility?

Page 38 is sensory status.

If you’ve been doing this for a while and have been doing ED transfer communication abstraction before, it used to be called impairments. But, does the medical record documentation indicate that the patient was assessed for impairments? What you’re looking for are some of the notes for abstraction…was there indication that the patient was unresponsive? Is there documentation that includes the patient being assessed for mental status, speech, hearing and vision?

A history or physical oftentimes will have that information or nursing notes, who might assess seeing if the patient wears glasses or has a hearing aid? That would all be part of sensory status assessment.

Page 39 is catheters or IVs.

Does the medical record documentation indicate that treatment with an IV or any catheter was provided to the patient and sent to the receiving facility? For this one there’s an N/A because if there’s no catheter were placed you can record N/A.
The inclusion guidelines say—what kinds of catheters you might find and they would be included.

Page 40 is **immobilizations**.

Was there any information regarding immobilizations sent? There’s an N/A if there’s no immobilizations that were done.

Look at your inclusions to see what’s included here.

Page 41 is **respiratory support**.

Does the medical record documentation indicate that any respiratory support was provided to the patient? Yes or no and N/A, if no respiratory support was provided.

The things you’re looking for under inclusions says—was there bronchial drainage, intubations where they give oxygen, ventilator support? That’s what you’re looking for there.

Page 42 is **oral restrictions**.

Does the medical record documentation indicate information was sent regarding any oral restrictions? Yes if it was and sent. No, if it wasn’t. N/A if no oral restrictions were in place.

What you’d be looking for in the inclusions gives you some suggestions. Did they say the patient was NPO? Are they on clear liquids, a soft diet, any kind of special diet? That’s what we’re looking for there.

Page 43 is **were there any tests or procedures performed?**

Yes, if there was documentation that on all the tests and procedures completed in the ED prior to transfer were sent to the receiving facility. No, if there’s no documentation of that information on all tests and procedures completed in the Ed prior to transfer were sent to the receiving facility. N/A in this instance, if no tests or procedures were done. We’re talking about lab work, x-rays, any procedures that were performed.

Page 44 is **test or procedures results**.

Does the medical record documentation indicate that a results were sent from completed tests and procedures done in the ED?

Some of the tests that were done, the results might not be ready by the time the patient left, so this is the data element addressing that. So select yes if there’s documentation of results being sent with the patient or communicated to the receiving facility when available. No, would be if there’s no documentation of results being sent with the patient or communicated to the receiving facility when available. N/A can be selected if no tests or procedures were done.

So, if you have a shared medical record, if you’re sending it to another hospital in your system, then tests and procedures done and results are considered sent, so you can select yes. If results not sent and you don’t have a shared medical record, then the documentation must include a plan to communicate results, and if there is a plan then you can select yes.

Those are the data elements. The last part is an ED paper tool and that’s provided in case there are some who like to enter data on a tool before they have to submit it or do however you submit your ED department transfer communication and that’s what that paper tool is for.
That concludes this recording today and if you have any questions about what was covered, please contact your State Flex Coordinator and they will forward the questions on.

Thank you.

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