Data Collection Guide
Emergency Department Transfer Communication Measures
(07/01/2012 to 06/30/2013 Dates of Service)

Minnesota Statewide Quality Reporting and Measurement System
2013 Hospital Measures

February 12, 2013
Prepared by Stratis Health, under contract with MN Community Measurement, funded by the Minnesota Department of Health

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Emergency Department Transfer Communication 2013
(07/01/2012 to 06/30/2013 Dates of Service)

Measure Specifications
### Summary of Change

No changes.

### Description

Percent of charts that had medical record documentation indicating that the following patient care elements were sent with the patient or within 60 minutes of departure. Measurement collection is done by the sending hospital. This measure assesses the sending hospital’s completeness of communication to a receiving facility. The elements are separated into seven subcategories to facilitate improvement.

### Methodology

Sources used for development of measure: Coordination of Care Record (CCR), EMTALA.

### Measurement Period

Data will be submitted on a quarterly basis on the following schedule for the 12 month measurement period:

<table>
<thead>
<tr>
<th>Discharge Dates</th>
<th>Data Submission Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third Quarter, 2012: July 1 – September 30</td>
<td>02/15/2013</td>
</tr>
<tr>
<td>Fourth Quarter, 2012: October 1 – December 31</td>
<td>05/15/2013</td>
</tr>
<tr>
<td>First Quarter, 2013: January 1 – March 31</td>
<td>08/15/2013</td>
</tr>
<tr>
<td>Second Quarter, 2013: April 1 – June 30</td>
<td>11/15/2013</td>
</tr>
</tbody>
</table>

### Denominator

All patients who are transferred to another acute care facility. This is for all seven of the subcategories.

Include patients with a discharge status code of 02, 05, and 43.

- 02 = Discharged/Transferred to another short term general hospital for inpatient care
- 05 = Discharged/Transferred to a designate cancer center or children’s hospital
- 43 = Discharged/Transferred to a federal health care facility

### Allowable Exclusions

Exclude patients with a discharge code of 01, 03, 04, 06, 07, 08, 09, 20, and 41.

- 01 = Discharged to home care or self-care (routine discharge)
- 03 = Discharged/Transferred to a skilled nursing facility (SNF) with Medicare certification
- 04 = Discharged/Transferred to an intermediate care facility (ICF)
- 06 = Discharged/Transferred to home under the care of organized home health service
- 07 = Left against medical advice or discontinued care
- 08 = Discharged/Transferred to home under care of home IV provider
- 09 = Admitted as an inpatient to this hospital
- 20 = Expired
- 41 = Hospice patients who expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice
Emergency Department Transfer Communication 2013
Measure Specifications

Numerator
The elements are separated into seven subcategories.

**Administrative (i.e., pre-transfer) communication**
Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of departure.
Total of 2 elements:
- Nurse communication with receiving hospital
- Physician communication with receiving physician

**Patient information**
Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of departure.
Total of 6 elements:
- Name
- Address
- Age
- Gender
- Significant others contact information
- Insurance

**Vital signs**
Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of departure.
Total of 6 elements:
- Pulse
- Respiratory rate
- Blood pressure
- Oxygen saturation
- Temperature
- Glasgow score or other neuro assessment (trauma, cognitively altered or neuro patients only)

**Medication information**
Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of departure.
Total of 3 elements:
- Medications given
- Allergies
- Medications from home
### Emergency Department Transfer Communication 2013

#### Measure Specifications

<table>
<thead>
<tr>
<th>Numerator (cont.)</th>
<th><strong>Physician or practitioner generated information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of departure.</td>
</tr>
<tr>
<td></td>
<td>Total of 2 elements:</td>
</tr>
<tr>
<td></td>
<td>• History and physical: Physical exam, history of current event, chronic conditions</td>
</tr>
<tr>
<td></td>
<td>• Physician or practitioner orders and plan</td>
</tr>
</tbody>
</table>

**Nurse generated information**

Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of departure

Total of 6 elements:

- Nurse documentation includes:
  - Assessment/interventions/response
  - Impairments
  - Catheters
  - Immobilizations
  - Respiratory support
  - Oral limitations

**Procedures and tests**

Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the applicable elements were communicated to the receiving hospital within 60 minutes of departure, or were sent when available.

Total of 2 elements:

- Tests and procedures done
- Tests and procedure results sent
Emergency Department Transfer Communication 2013
(07/01/2012 to 06/30/2013 Dates of Service)

Data Abstraction Definitions
Emergency Department Transfer Communication 2013  
Data Abstraction Definitions  
Each of the seven sub-categories listed below is calculated using an all-or-none approach. Each element included in each sub category must be documented in the medical record for every patient transferred to another acute care hospital to be included in the numerator for that sub category.

For hospital systems with shared electronic medical records, documentation must indicate that data elements had been entered into the data system and were available to the receiving hospital within 60 minutes of departure. Test and procedure results that become available after the 60-minute timeframe are assumed to be entered into the data system and available to the receiving hospitals when the tests are completed.

Items scored as NA (not applicable) are counted in the measure as a positive, or ‘yes,’ response. Please see the Step by Step Guide to Data Collection and Submission section found on page 19 for more detailed instructions.

For questions 3A through 9, “sent” means that medical record documentation indicates the information went with the patient or was communicated via fax or phone within 60 minutes of the patient’s departure.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>INSTRUCTIONS</th>
<th>RECOMMENDED LOCATIONS</th>
<th>NUMERATOR CATEGORY</th>
</tr>
</thead>
</table>
| Question 1: Does the medical record documentation indicate that nurse-to-nurse communication occurred prior to the transfer of the patient from the ER to another facility? | **Yes** = Select this option if there is documentation of the ER nurse giving report to the nursing staff of the receiving facility. Must include minimally the date and time report was given, and the communication means (i.e., phone, fax, other).  
**No** = Select this option if there is no documentation of the ER nurse giving report to the nursing staff of the receiving facility, or the minimum documentation is not met; including date and time report was given, and the communication means (i.e., phone, fax, other). Giving report to a transfer coordinator, who is not a nurse, is not adequate. | - Nursing note  
- Transfer summary document | Administrative (i.e., pre-transfer) communication |
### Emergency Department Transfer Communication 2013

**Data Abstraction Definitions**

<table>
<thead>
<tr>
<th>QUESTION</th>
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</table>
| **Question 2:** Does the medical record documentation indicate that physician-to-physician communication occurred prior to the transfer of the patient from the ER to another facility? | **Yes** = Select this option if there is documentation of the ER physician’s or mid-level practitioner’s discussion of the patient’s condition with physician or mid-level staff at the receiving facility. Must include minimally the names of the two providers, the date and time of communication, and the communication means (i.e., phone, fax, other).<br><br>**No** = Select this option if there is no documentation of the ER physician’s or mid-level practitioner’s discussion of the patient’s condition with physician or mid-level staff at the receiving facility, or the minimum documentation is not met; including the names of the two providers, the date and time of communication, and the communication means (i.e., phone, fax, other). | - Physician’s note  
- Transfer summary document  
- Physician’s orders | Administrative (i.e., pre-transfer) communication |
<p>| <strong>Question 3A-3C:</strong> Does the medical record documentation indicate that patient information, including name, address, and age was sent? | <strong>Yes</strong> = Select this option for each of the 3 elements sent: name, address, age.&lt;br&gt;&lt;br&gt;<strong>No</strong> = Select this option for each of the 3 elements not sent: name, address, age.&lt;br&gt;&lt;br&gt;<strong>NA</strong> = Select this option if patient is a John/Jane Doe, and/or is altered neurologically, or has potential brain/head injury, or if the patient refuses to answer the question. | - Face sheet | Patient information |
| <strong>Question 3D:</strong> Does the medical record documentation indicate that patient gender was sent? | <strong>Yes</strong> = Select this option if gender was sent.&lt;br&gt;&lt;br&gt;<strong>No</strong> = Select this option if gender was not sent. | - Face sheet | Patient information |</p>
<table>
<thead>
<tr>
<th>QUESTION</th>
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</tr>
</thead>
</table>
| **Question 3E:** Does the medical record documentation indicate that contact information for significant others and family members was sent? | **Yes** = Select this option if the name and phone number for at least one of the patient’s family or friends was sent.  
**No** = Select this option if the name and phone number for at least one of the patient’s family or friends was not sent.  
**NA** = Select this option if patient is a John/Jane Doe, and/or is altered neurologically, or has potential brain/head injury, or if the patient refuses to answer the question. | ● Face Sheet  
● Nursing notes | Patient information |
| **Question 3F:** Does the medical record documentation indicate that insurance information was sent? | **Yes** = Select this option if insurance company and number were sent.  
**No** = Select this option if insurance company and number were not sent.  
**NA** = Select this option if patient is a John/Jane Doe, and/or is altered neurologically, or has potential brain/head injury, or if the patient refuses to answer the question. | ● Face Sheet  
● Copy of insurance card | Patient information |
| **Question 4A – 4E:** Does the medical record documentation indicate that vital signs were taken and sent? | **Yes** = Select this option if vital signs documented as sent include: pulse, respiratory rate, blood pressure*, oxygen saturation, temperature. **  
**No** = Select this option if vital signs documented as sent do not include: pulse, respiratory rate, blood pressure, oxygen saturation, temperature.*  
*If patient is less than or equal to 2 years of age, select **NA** for blood pressure.  
**If infection, hypothermia, or heat disorder is suspected from the physician notes, a temperature is required. Otherwise answer for temperature is **NA**. | ● ER flow sheet  
● Nursing notes | Vital signs |
**Emergency Department Transfer Communication 2013**  
**Data Abstraction Definitions**

<table>
<thead>
<tr>
<th>QUESTION</th>
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</tr>
</thead>
</table>
| **Question 4F:** Does the medical record documentation indicate that appropriate neuro assessments were done and sent? | **Yes** = Select this option if vital signs documented as sent include:  
   a. Glasgow coma scale or neuro flow sheet if patient has altered consciousness. (This is required for trauma, cognitively altered, or neuro patients only.)  
   **No** = Select this option if vital signs documented as sent do not include:  
   a. Glasgow coma scale or neuro flow sheet if patient has altered consciousness.  
   **NA** = If patient is not at risk for altered consciousness. |  
   - Flow sheets  
   - Nursing notes  
   - MD notes  
   - Flow sheets  
   - Nursing notes  
   - MD notes  
   - Birth or delivery record | Vital signs |

Please note: This question only needs to be answered for patients with altered consciousness levels or with possible brain/ head injury; post seizure and all trauma patients.
## Emergency Department Transfer Communication 2013
### Data Abstraction Definitions

<table>
<thead>
<tr>
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<th>RECOMMENDED LOCATIONS</th>
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</tr>
</thead>
</table>
| **Question 5A – 5B:** Does the medical record documentation indicate that physician communication was sent? | **Yes** = Select this option if information documented as sent includes minimally:  
   a. History and Physical (includes focused physical exam, history of current ER episode, and relevant chronic conditions). Chronic conditions may be excluded if patient is neurologically altered.  
   b. Reason for the transfer and/or a plan of care (may include suggestions for care to be received at the receiving hospital). | • MD notes  
   • Transfer summary | Physician or practitioner generated information |
## Emergency Department Transfer Communication 2013

### Data Abstraction Definitions

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>INSTRUCTIONS</th>
<th>RECOMMENDED LOCATIONS</th>
<th>NUMERATOR CATEGORY</th>
</tr>
</thead>
</table>
| **Question 6A – 6D:** Does the medical record documentation indicate that nursing communication was sent? | **Yes** = Select this option if information documented as sent includes minimally:  
  a. Medication history (including complimentary medications, OTC medications and oxygen). This may be not available (NA) if patient is neurologically altered.  
  b. Allergies (food, medication, other), reactions. This may be not available (NA) if patient is neurologically altered.  
  c. Impairments (mental, speech, hearing, vision, sensation).  
  d. Nurse notes. For example: nurse assessment / intervention / response or SOAP.  
 **No** = Select this option if information documented as sent does not include minimally:  
  a. Medication history (including complimentary medications, OTC medications and oxygen). This may be not available (NA) if patient is neurologically altered.  
  b. Allergies (food, medication, other) reactions. This may be not available (NA) if patient is neurologically altered.  
  c. Impairments (mental, speech, hearing, vision, sensation).  
  d. Nurse notes. For example: nurse assessment / intervention / response or SOAP. | • Nurse notes  
• Flow sheets  
• MD notes | Medication information AND Nurse generated information |
**Question 7A – 7E:**
Does the medical record documentation indicate that information on the treatment provided in the originating hospital was sent?

**Yes** = Select this option if information documented as sent includes minimally:
- a. Medication administration record (MAR).
- b. Catheters (IV, IT, Urinary).
- c. Oral restrictions (NPO, clear liquids, etc.).
- d. Immobilizations (splints, neck brace, back board, etc.).
- e. Respiratory support provided (ventilator support, intubations, bronchial drainage, etc.).

**No** = Select this option if information documented as sent does not include minimally:
- b. Catheters (IV, IT, Urinary).
- c. Oral restrictions (NPO, clear liquids, etc.).
- d. Immobilizations (splints, neck brace, back board, etc.).
- e. Respiratory support provided (ventilator support, intubations, bronchial drainage, etc.).

**NA** = Select this option if no treatment provided in the originating ER.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>INSTRUCTIONS</th>
<th>RECOMMENDED LOCATIONS</th>
<th>NUMERATOR CATEGORY</th>
</tr>
</thead>
</table>
| **Yes**  | **Select this option if information documented as sent includes minimally:** | • Nursing notes  
• Flow sheets  
• MAR | Nurse generated information |
<p>| <strong>No</strong>   | <strong>Select this option if information documented as sent does not include minimally:</strong> | | |
| <strong>NA</strong>   | <strong>Select this option if no treatment provided in the originating ER.</strong> | | |</p>
<table>
<thead>
<tr>
<th>QUESTION</th>
<th>INSTRUCTIONS</th>
<th>RECOMMENDED LOCATIONS</th>
<th>NUMERATOR CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question 8:</strong></td>
<td></td>
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</tr>
<tr>
<td>Does the medical record documentation indicate that information on the tests and procedures that were done in the ER (and are pertinent to the emergency condition) were sent?</td>
<td><strong>Yes</strong> = Select this option if information documented as sent includes minimally: List of labs, X-rays and procedures completed in the ER prior to transfer.</td>
<td>• MD orders and notes  • Nursing notes  • Flow sheets  • Lab documentation</td>
<td>Procedures and tests</td>
</tr>
<tr>
<td></td>
<td><strong>No</strong> = Select this option if information documented as sent does not include minimally: List of labs, X-rays and procedures completed in the ER prior to transfer.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>NA</strong> = Select this option if no tests, X-rays, or procedures were performed.</td>
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<td></td>
</tr>
<tr>
<td><strong>Question 9:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the medical record documentation indicate that results from the completed tests and procedures that are done in the ER (and are pertinent to the emergency condition) were sent?</td>
<td><strong>Yes</strong> = Select this option if information documented as sent includes minimally: Documentation of the results being sent either with the patient or communicated when available.</td>
<td>• MD orders and notes  • Nursing notes  • Flow sheets  • Lab documentation</td>
<td>Procedures and tests</td>
</tr>
<tr>
<td></td>
<td><strong>No</strong> = Select this option if information documented as sent does not include minimally: Documentation of the results being sent either with the patient or communicated when available.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>NA</strong> = Select this option if no tests, X-rays or procedures were performed.</td>
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</tr>
</tbody>
</table>
Emergency Department Transfer Communication 2013
(07/01/2012 to 06/30/2013 Dates of Service)

Data Submission Instructions
Getting Started

Overview

Minnesota’s 2008 Health Reform Law requires the Commissioner of Health to establish a standardized set of quality measures for health care providers across the state (Minnesota Statutes 62U.02). The goal is to create a uniform approach to quality measurement in Minnesota to enhance market transparency and improve health care quality. To implement the collection and reporting of quality measurement data, the Minnesota Department of Health (MDH) has developed the Minnesota Statewide Quality Reporting and Measurement System (SQRMS; created through Minnesota Rules, Chapter 4654). MDH is required to annually evaluate the measures required for reporting in the Statewide Quality Reporting and Measurement System. The Department utilizes community-driven stakeholder recommendation processes to conduct this annual review. With a goal of including measures that are specifically appropriate for rural hospitals, MDH added the following seven National Quality Forum (NQF)-endorsed emergency department (ED) transfer communication measures for critical access hospitals for reporting beginning in 2012:

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

Background of the Measures

In 2003, an expert panel convened by the University of Minnesota Rural Health Research Center identified ED care as an important quality assessment measurement category for rural hospitals. While emergency care is important in all hospitals, it is particularly critical in rural hospitals where the size of the hospital and geographic realities make organizing triage, stabilization, and transfer of patients more important. Communication between providers promotes continuity of care and may lead to improved patient outcomes. These measures were piloted by some rural Minnesota hospitals in a project that took place from October 2005 through March 2006. Results of the pilot project indicated room for improvement in ED care and transfer communication.
Emergency Department Transfer Communications 2013
Data Submission Instructions

**Timelines**

Each critical access hospital must submit the data described in the measure specifications found on page 4 through 6 of this guide according to the following schedule:

<table>
<thead>
<tr>
<th>Discharge quarter</th>
<th>Dates of discharge</th>
<th>Data submission deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third Quarter</td>
<td>07/01/2012 to 09/30/2012</td>
<td>02/15/2013</td>
</tr>
<tr>
<td>Fourth Quarter</td>
<td>10/01/2012 to 12/31/2012</td>
<td>05/15/2013</td>
</tr>
<tr>
<td>First Quarter</td>
<td>01/01/2013 to 03/31/2013</td>
<td>08/15/2013</td>
</tr>
<tr>
<td>Second Quarter</td>
<td>04/01/2013 to 06/30/2013</td>
<td>11/15/2013</td>
</tr>
</tbody>
</table>

**Become a Registered User of Minnesota Hospital Association’s Reporting Tool**

Hospitals will need to become a registered user of the Minnesota Hospital Association’s (MHA) reporting tool for ED Transfer Communication data submission.

Go to [https://edtransfercommunication.mnhospitals.org](https://edtransfercommunication.mnhospitals.org) and click on the link to register. After the hospital has entered its information, an email will be sent to MHA to approve the hospital’s access. When access has been approved by MHA, a notification email will be sent to the hospital.
Step by Step Guide to Data Collection and Submission

Step 1: Review the Measure Specifications

Measure specifications are provided on pages 4 through 6 of this document.

Step 2: Identify the Patient Population (Denominator)

All patients who are transferred to another acute care hospital are included in the measure for all seven subcategories.

Include patients with a discharge status code of 02, 05, and 43.

- 02 = Discharged/transferred to another short term general hospital for inpatient care
- 05 = Discharged/transferred to a designate cancer center or children’s hospital
- 43 = Discharged/transferred to a federal health care facility (i.e., VA hospital)

Exclude patients with a discharge code of 01, 06, 07, 08, 09, 20, and 41.

- 01 = Discharged to home care or self-care (routine discharge)
- 06 = Discharged/transferred to home under the care of organized home health service
- 07 = Left against medical advice or discontinued care
- 08 = Discharged/transferred to home under care of home IV provider
- 09 = Admitted as an inpatient to this hospital
- 20 = Expired
- 41 = Hospice patients who expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice

Step 3: Data Collection

Select tools for data collection and data entry

- Data Collection Transfer Tool Form (optional)
  A transfer tool was created for hospitals that would like to manually collect the data on paper while working to collect each element. Data collected on these forms must also be entered into the Excel spreadsheet file described below. To download the transfer tool form, click here.

- Excel Spreadsheet File (required)
  The Excel spreadsheet was created to ensure all necessary data elements are collected for these measures and to assist with calculating the summary data results required for reporting. The Excel spreadsheet contains all of the necessary fields according to the measure specifications. To download the Excel spreadsheet, click here.

Step 4: Data Submission

Before proceeding with the data submission, be sure to complete all data collection and data entry in the Excel spreadsheet.
Data Submission Instructions

To submit the information calculated using the Excel spreadsheet, login at https://edtransfercommunication.mnhospitals.org. The reporting tool has eight fields to report per time period.

The denominator used for all measures is the number of patients; this is counted by the number of rows for which the data has been collected in the spreadsheet.

To report the numerators, add up all the records that have a “1” in the “Met?” column for each of the seven topics. For example, if there are five records that have a “1” in the “Met?” column for the “Pre-Transfer Communication Information” topic in the Excel spreadsheet, then report a five in the field for “Pre-Transfer Communication Information” in the reporting tool. A simple way to do this is to calculate a sum for each of the “Met?” columns in the spreadsheet.

Hospitals will repeat this process each quarter.
**Frequently Asked Questions**

**What if there were no ED transfer cases to report in a quarter?**

Even if there were no cases, the hospital will need to log in and report zero cases. Missing data cannot be assumed to mean zero cases.