ED Transfer Communication

USING DATA TO DRIVE IMPROVEMENT!

EDTC-5: Physician/Practitioner Generated Information

November 17th 2016

Presented By: Shanelle Van Dyke

Quality Reporting Services

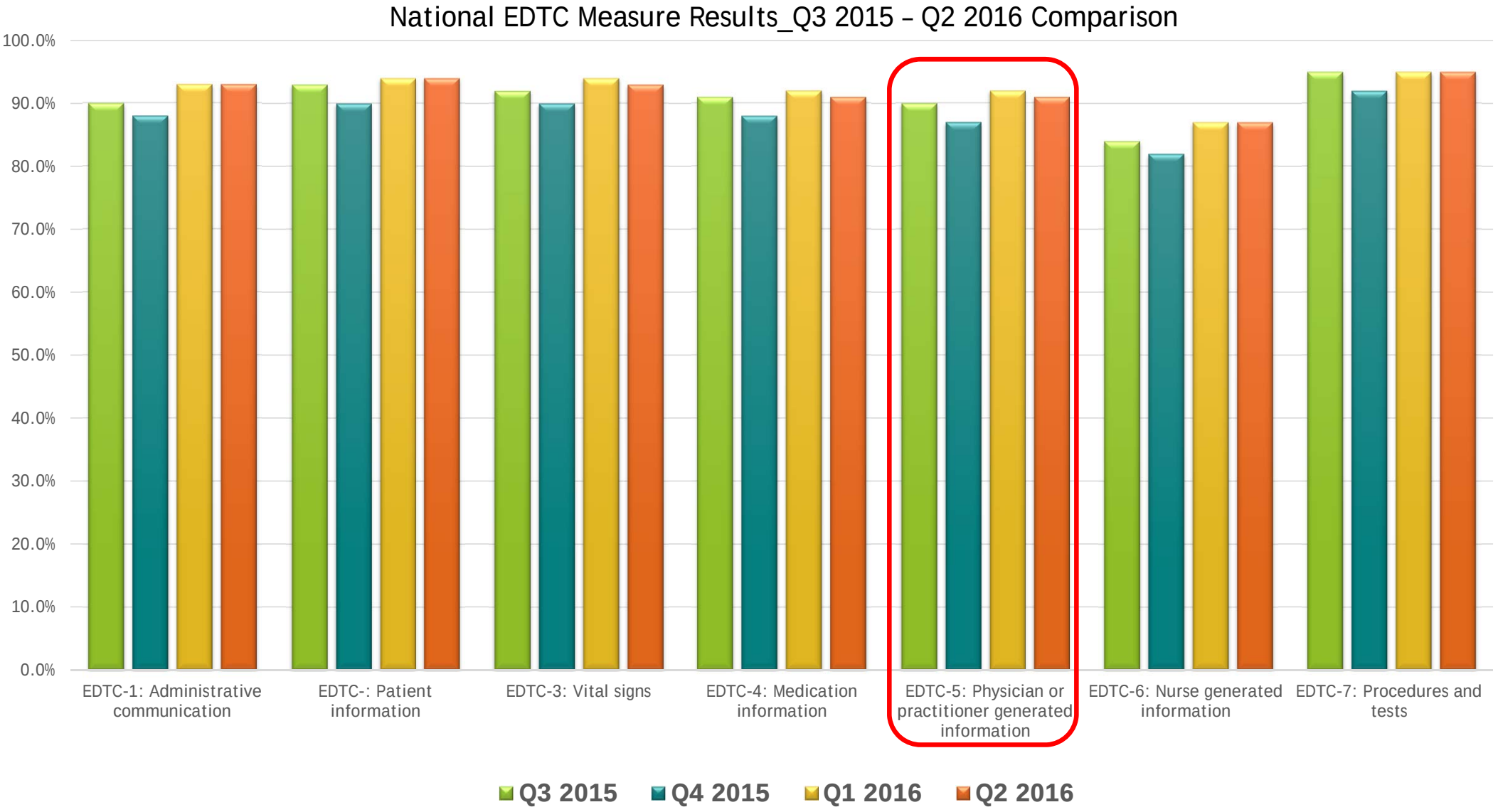
Agenda

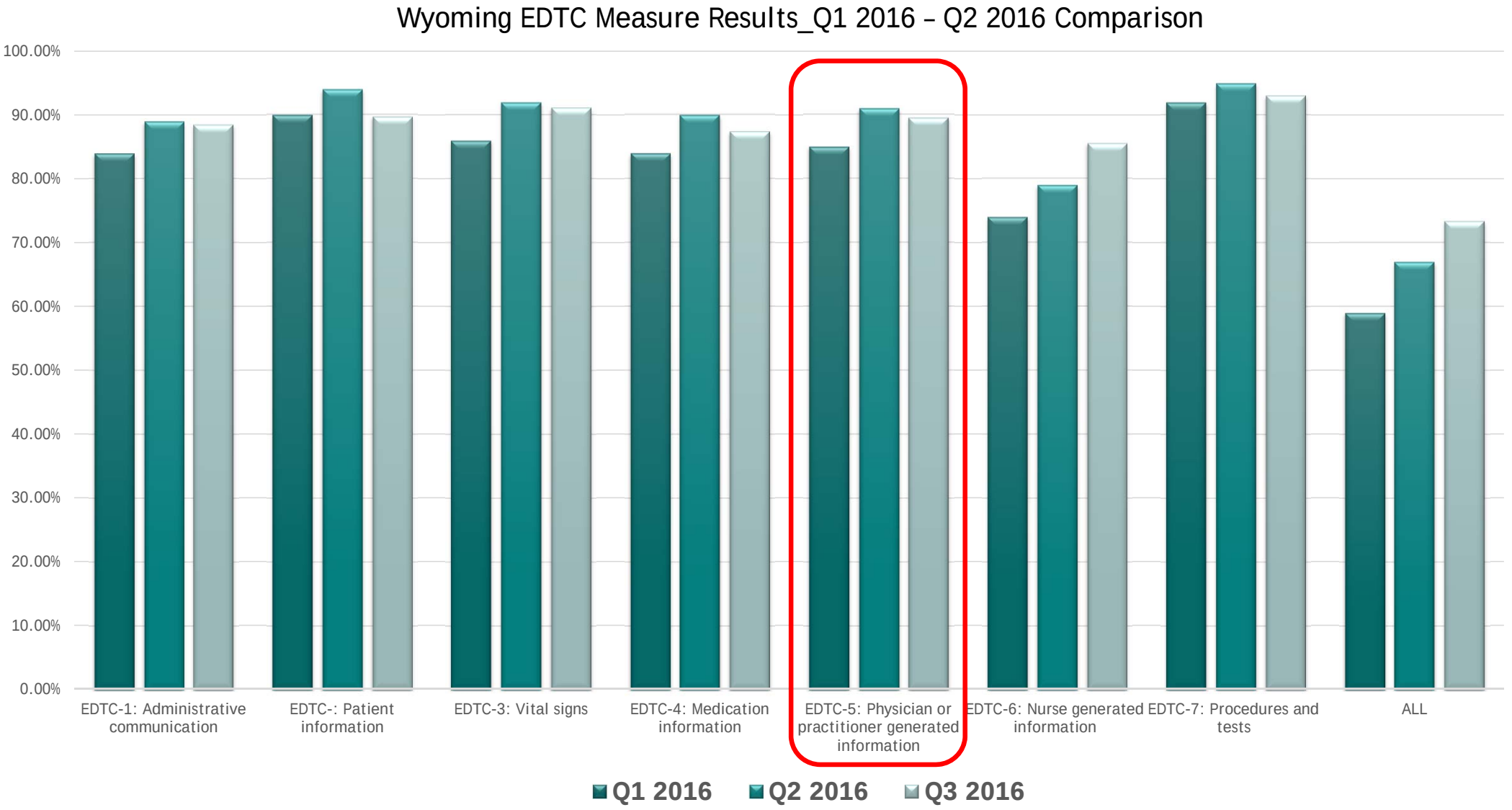
- EDTC–5 Measure Overview
- Review of Data Results – Discussion among CAHs
- Review of EDTC-5 Abstraction Guidelines *(If Necessary)*
  - *Roles and Responsibilities*
- Sample forms, tools, techniques, etc.
- Interpretation of EDTC-5 Reports (Q3 2016)
- Quality Improvement Methods
  - *Root Cause Analysis (RCA) & Plan, Do, Study/Check, Act (PDSA/PDCA)*
- Sharing of Best Practices
- Additional resources

Measure Overview

ED Transfer Communication Measures

Category
Pre-Transfer Communication Information
Nurse communication with receiving hospital
Physician communication with receiving physician
Patient Identification
Name
Address
Age
Gender
Significant others contact information
Insurance
Vital Signs
Pulse
Respiratory Rate
Blood Pressure
Oxygen Saturation
Temperature
Glasgow score (trauma or neuro patients)
Medication-related Information
Medications Given
Allergies
Medications from home
Practitioner generated information (History and Physical)
Physical exam, history of current event, chronic conditions
Physician orders and plan
Nurse generated information
Nurse documentation includes:
Assessment/interventions/response
Impairments
Catheters
Immobilizations
Respiratory support
Oral limitations
Procedures and tests
Tests and procedures done
Tests and procedure results sent


National EDTC Measure Results_Q3 2015 – Q2 2016 Comparison
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
EDTC-1: Administrative communication
EDTC-: Patient information
EDTC-3: Vital signs
EDTC-4: Medication information
EDTC-5: Physician or practitioner generated information
EDTC-6: Nurse generated information
EDTC-7: Procedures and tests
Q3 2015
Q4 2015
Q1 2016
Q2 2016


Wyoming EDTC Measure Results_Q1 2016 – Q2 2016 Comparison
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
EDTC-1: Administrative communication
EDTC-: Patient information
EDTC-3: Vital signs
EDTC-4: Medication information
EDTC-5: Physician or practitioner generated information
EDTC-6: Nurse generated information
EDTC-7: Procedures and tests
ALL
Q1 2016
Q2 2016
Q3 2016

Measure Information EDTC-5

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.

Data Element Information EDTC-5

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

Data Element Information EDTC-5

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

Importance of detailed/complete H & P

- Often the history alone does/can reveal a diagnosis.
  - A basis for selecting relevant diagnostic testing.
- Provides pertinent information regarding the patient's current condition.

Importance for Improving Physician/Practitioner Documentation

- Without effective, timely communication between physicians, both the quality of care and the patient experience can suffer.
- Documentation issues can cost hospitals millions of dollars per year.
- Improving physicians' clinical documentation skills is critical for any healthcare organization to survive in a value-based, post healthcare reform environment.
  - It will help sustain and maximize reimbursements, the data it provides will help reduce compliance risk, minimize your vulnerability during external audits, and will allow you to troubleshoot quality of care issues.
- Engaging physicians.

Importance for Improving Physician/Practitioner Documentation

Clinical documentation improvement (CDI):

- CMS has taken note of the documentation/quality connection and is moving toward payment models based on outcomes and quality measures, not volume of how much care was provided.
  - We all know, that CMS has mandated incentivizing or penalizing hospitals by using quality-based programs and measures such as value-based purchasing (VBP), readmissions reduction program (RRP), and hospital-acquired conditions (HAC).

- The quality of the documentation in the medical records has significantly increased, making it a much better record whether for Inpatient, Outpatient, and/or transfers. Studies show a positive link between strong documentation and higher quality.
  - Patients treated at hospitals with better medical records quality have significantly lower mortality and readmission rates… (and) the relationship between better medical charting and better medical care could lead to new ways to monitor and improve the quality of medical care.

Improving Physician/Practitioner Documentation

Using a physician-first technique at the point of care to help providers ensure financial integrity, reduce risk, and improve patient outcomes.

- Determine which physicians will benefit the most.
- Make a compelling case to physicians using evidence-based reasoning.
- Educate through a documentation training session.
- Provide ongoing progress and performance monitoring and support.
- Involve executives/leadership.

Improving Physician/Practitioner Documentation

Documentation Review Self-Assessment:

- Physicians are encouraged to periodically review a selection of their own medical records to assess and maintain the quality of their documentation.
  - Better documentation can also have a significant positive impact on the quality measures of Severity of Illness (SOI) and Risk of Mortality (ROM). These measurements don't just affect hospitals, they are also used to reflect the quality of physicians when compared to their peers and are featured on public websites like healthgrades.com and Medicare's Physician Compare. Through solid documentation, physicians have a means to positively impact the way the care they deliver is perceived and measured.

View Sample 'Documentation Review Self-Assessment' Form

Improving Physician-to-Physician Communication

- Fostering organizational culture change:
  - A strongly hierarchical culture is less conducive to provide communication. To have a high reliability organization, the hierarchy must break down in safety-critical activities.
  - Providers in a strongly patient-centric culture may be more likely to contact each other regarding patient care issues compared with those in one that is less patient-focused.
  - Physician leaders also can set expectations for physician-to-physician communication through policy development and peer review feedback.
- Building a supportive infrastructure:
  - Fostering the development of processes to better coordinate care and ensuring the availability of technology that streamlines communication.
  - Physician leaders also can support physician-to-physician communication by ensuring that health care providers have easy access to effective, streamlined channels for communication.

Improving Physician-to-Physician Communication

- Supporting initiatives to standardize communication across their organizations:
  - Distribution of guidelines with structured transfer sheets (e.g., checklists to be completed at the time of transfer and standard forms) has been shown to improve communication between providers.
  - Communication tools like SBAR (Situation-Background-Assessment Recommendation), which has primarily been applied to nurse-physician communication, could be used to standardize and improve physician-to-physician communication.
    - **SBAR** - is an acronym for **Situation, Background, Assessment, Recommendation**; a technique that can be used to facilitate prompt and appropriate communication. SBAR promotes quality and patient safety, primarily because it helps individuals communicate with each other with a shared set of expectations. Staff and physicians use SBAR to share patient information in a clear, complete, concise and structured format; improving communication efficiency and accuracy.

Tips for Taking History & Physical

General framework for history taking is as follows:

- Presenting complaint.
- History of presenting complaint, including investigations, treatment and referrals already arranged and provided.
- Past medical history: significant past diseases/illnesses, surgery, including complications, trauma.
- Drug history: now and past, prescribed and over-the-counter, allergies.
- Family history: especially parents, siblings and children.
- Social history: smoking, alcohol, drugs, accommodation and living arrangements, marital status, baseline functioning, occupation, pets and hobbies.
- Systems review: cardiovascular system, respiratory system, gastrointestinal system, nervous system, musculoskeletal system, genitourinary system.

Tips for Taking History & Physical

- Let the patient tell you his/her story - This can be encouraged by active listening.
- **Open questions –** These are seen as the gold standard of historical inquiry. They do not suggest a 'right' answer to the patient and give them a chance to express what is on their mind.
- **Questions with options –** Sometimes it is necessary to 'pin down' exactly what a patient means by a particular statement. In this case, if the information you are after cannot be obtained through open questioning then give the patient some options to indicate what information you need.
- **Leading questions –** These are best avoided if at all possible. They tend to lead the patient down an avenue that is framed by your own assumptions.
- **Summarizing –** After taking the history, it's useful to give the patient a run-down of what they've told you as you understand it.
- **Sharing understanding –** It's always a good idea to ask the patient if there's anything they want to ask you at the end of a consultation.

History & Physical
SAMPLES

Reason for Transfer and/or Plan of Care Form
SAMPLES

Patient H & P Questionnaires

Many medical practices ask patients to complete a questionnaire that documents information about past medical and surgical history, family medical history, and personal habits.

- These can be helpful forms as they provide the physician with useful information; as evidence that the physician has reviewed questionnaires and history forms.
- The doctor should initial the forms.
- On a questionnaire, patients may leave spaces blank (for multiple reasons) Fill in or void all spaces for information on forms; ask office staff to review forms patients fill in to ensure the forms are complete.

View Sample ‘H & P Questionnaire’

ED Transfer Comm. Data Collection Tool

EDTC Report Interpretation

Emergency Department Transfer Communication
Hospital Report

CMS Certified Number (CCN): 123456

Measures	Data Elements	Q1 2016 1/1/2016 Records Reviewed (N) = 10	Q2 2016 4/1/2016 Records Reviewed (N) = 2	Q3 2016 7/1/2016 Records Reviewed (N) = 5	Q4 2016 10/1/2016 Records Reviewed (N) =
EDTC-1: Administrative Communication	Percentage of medical records that indicated the following occurred prior to patient departure from ED:				
	1. Nurse to Nurse Communication	60.00% (n=6)	100.00% (n=2)	100.00% (n=5)	N/A
	2. Physician to Physician Communication	60.00% (n=6)	100.00% (n=2)	100.00% (n=5)	N/A
	All EDTC-1 Data Elements	60.00% (n=6)	100.00% (n=2)	100.00% (n=5)	N/A
EDTC - 2 Patient Information	Percentage of medical records that indicated the communication of following patient information within 60 minutes of patient's departure from ED:				
	1. Patient Name	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	2. Patient Address	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	3. Patient Age	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	4. Patient Gender	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	5. Patient Contact Information	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	6. Patient Insurance Information	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	All EDTC-2 Data Elements	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
EDTC - 3 Vital Signs	Percentage of medical records that indicated the communication of following patient's vital signs information within 60 minutes of patient's departure from ED:				
	1. Pulse	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	2. Respiratory Rate	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	3. Blood Pressure	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	4. Oxygen Saturation	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	5. Temperature	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	6. Neurological Assessment	80.00% (n=8)	100.00% (n=2)	100.00% (n=5)	N/A
	All EDTC-3 Data Elements	80.00% (n=8)	100.00% (n=2)	100.00% (n=5)	N/A

EDTC - 4 Medication Information	Percentage of medical records that indicated the communication of following patient's medication information within 60 minutes of patient's departure from ED:				
	1. Medication Given in ED	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	2. Allergies/Reactions	90.00% (n=9)	100.00% (n=2)	100.00% (n=5)	N/A
	3. Medication History	80.00% (n=8)	100.00% (n=2)	100.00% (n=5)	N/A
	All EDTC-4 Data Elements	80.00% (n=8)	100.00% (n=2)	100.00% (n=5)	N/A
EDTC - 5: Physician or Practitioner Generated Information	Percentage of medical records that indicated the communication of following physician generated information within 60 minutes of patient's departure from ED:				
	1. History and Physical	100.00% (n=10)	100.00% (n=2)	80.00% (n=4)	N/A
	2. Reason for Transfer/Plan of Care	100.00% (n=10)	100.00% (n=2)	80.00% (n=4)	N/A
	All EDTC-5 Data Elements	100.00% (n=10)	100.00% (n=2)	80.00% (n=4)	N/A
EDTC - 6 Nurse Generated Information	Percentage of medical records that indicated the communication of following nurse generated information within 60 minutes of patient's departure from ED:				
	1. Nursing Notes	90.00% (n=9)	100.00% (n=2)	100.00% (n=5)	N/A
	2. Sensory Status (formerly Impairments)	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	3. Catheters/IV	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	4. Immobilizations	90.00% (n=9)	100.00% (n=2)	100.00% (n=5)	N/A
	5. Respiratory Support	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	6. Oral Restrictions	90.00% (n=9)	100.00% (n=2)	100.00% (n=5)	N/A
	All EDTC-6 Data Elements	90.00% (n=9)	100.00% (n=2)	100.00% (n=5)	N/A
EDTC - 7 Procedures and Tests	Percentage of medical records that indicated the communication of following procedures and tests information within 60 minutes of patient's departure from ED:				
	1. Tests/Procedures Performed	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	2. Tests/Procedures Results	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
	All EDTC-7 Data Elements	100.00% (n=10)	100.00% (n=2)	100.00% (n=5)	N/A
All EDTC Measures	Percentage of medical records that indicated the communication of all necessary patient's data upon patient's departure from ED:				
	All EDTC Measures	40.00% (n=4)	100.00% (n=2)	80.00% (n=4)	N/A

Improvement Techniques

Principles of Improving:

- Know why you need to improve a system and/or process.
- Have a way to obtain feedback to let you know if improvement is occurring.
- Develop a change that you think will result in improvement.
- Test a change before implementing.
- Implement a change.

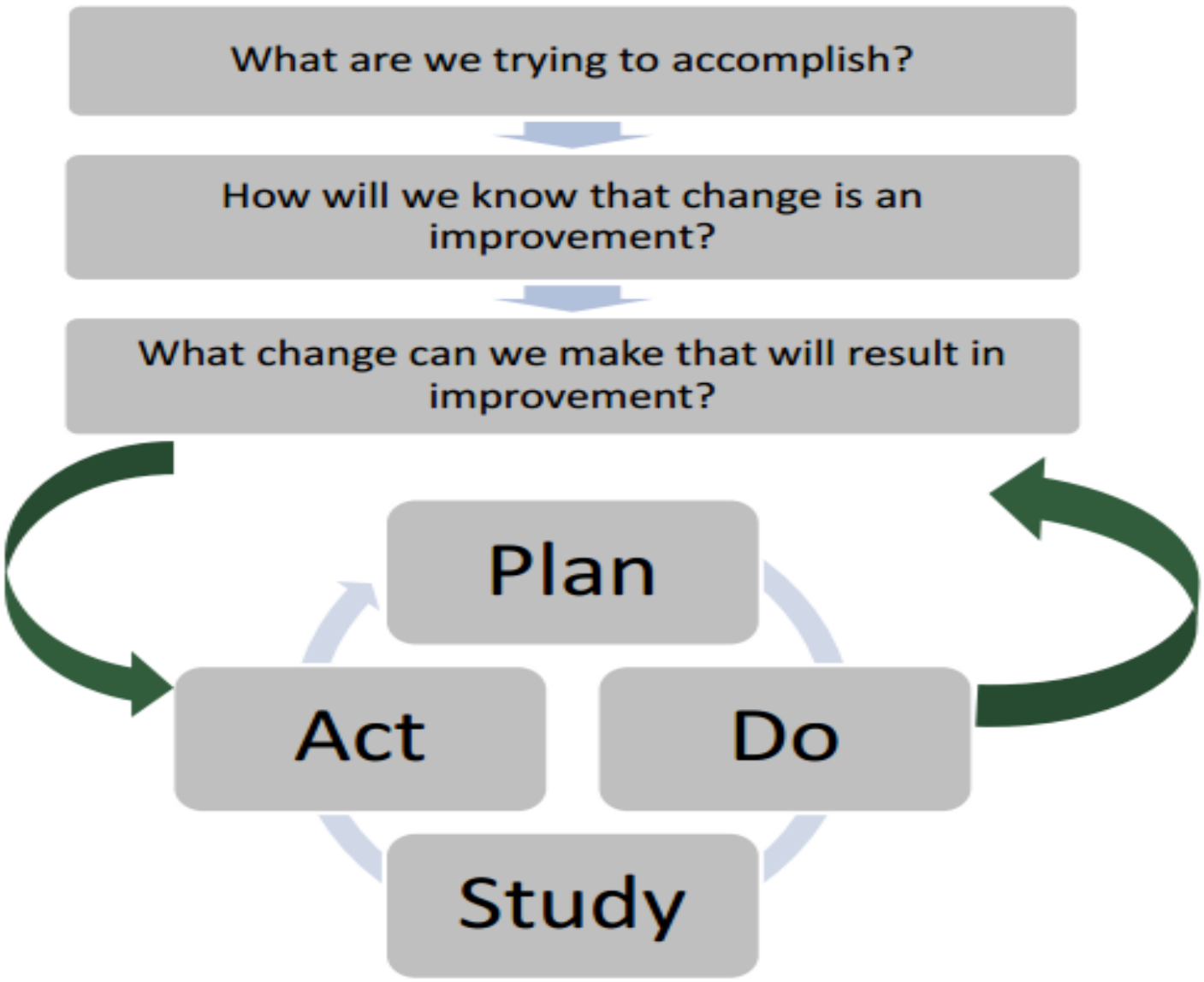
Quality Improvement Tools

Root Cause Analysis & Plan, Do, Study/Check, Act:

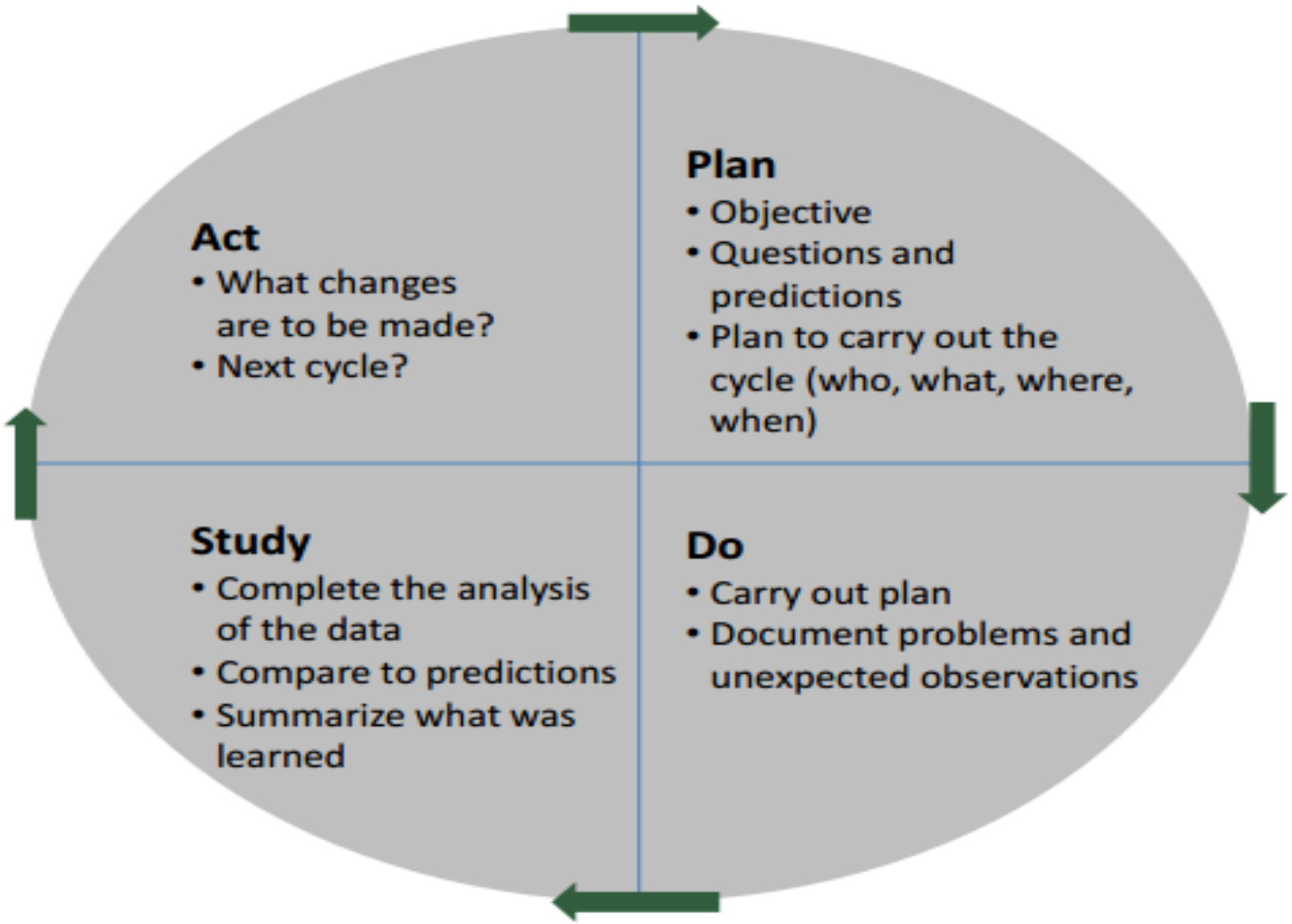
- **Root cause analysis (RCA)** is a systematic process for identifying "root causes" of problems or events and an approach for responding to them. RCA is based on the basic idea that effective management requires more than merely "putting out fires" for problems that develop, but finding a way to prevent them.

- **Plan, Do, Study, Act (PDSA)** cycles to test an idea by temporarily trialing a change and assessing its impact. This approach is unusual in a healthcare setting because traditionally, new ideas are often introduced without sufficient testing.

RCA Template Review
SAMPLE


What are we trying to accomplish?
How will we know that change is an improvement?
What change can we make that will result in improvement?
Plan
Do
Study
Act

PLAN-DO-STUDY-ACT



Sharing of Best Practices

Miscellaneous Reminders

- Next Q4 2016 EDTC Data Submission Deadline is January 31st 2017.
- NEW! Quality Improvement Matters (QIM) website www.wyqim.com.
- MBQIP Deadline Reminders:
  - Q3 2016 Outpatient Core Measures due February 1st 2017.
  - Q2 2016 Inpatient Core Measures due November 15th 2016.
    - Q3 2016 Inpatient Core Measures due February 15th 2017.
  - Q3 2016 Inpatient & Outpatient Population & Sampling due February 1st 2017.

THANK YOU!

Questions ? ? ?

Shanelle Van Dyke
1.406.459.8420
Shanelle.VanDyke@QualityReportingServices.com

Quality Reporting Services

Kyle Cameron—Wyoming Flex
Flex-Office of Rural Health
1.307.777.8902
Kyle.Cameron@wyo.gov

Wyoming ORH
Your Partner in Rural Health

Rochelle Spinarski—Rural Health Solutions
1.651.731.5211
Rspinarski@rhsnow.com

Rural Health Solutions

Additional Resources

(i.e. Communication & Patient Handoff tools, Care Transitions, etc.)

10 patient handoff communications tools

1. **Sign-out software.** Kolkin Corp, a healthcare information technology company in Newport Beach, Calif., offers free sign out software for download. The software addresses HIPAA and The Joint Commission's National Patient Safety Goal 2E, and it includes a secure physician case list, real-time patient handoff capabilities, team instant messaging and a clinical article editor. The software can be downloaded on to any computer or wireless device.

2. **Safer sign-out form for patient handoffs.** The Emergency Medicine Patient Safety Foundation offers a free Safer Sign Out form to improve the safety of patient handoffs at the end of a shift. The protocol involves five key components: record, review, round together, relay to the team and receive feedback.

3. **Pocket card for safe clinic handoffs.** A free pocket card with patient handoff tips was developed by University of Chicago Medical Center researchers and is available from the Picker Institute.

4. **Medical transitions and clinical handoffs toolkit.** The Agency for Healthcare Research and Quality has released a toolkit designed to help hospitals improve medication safety. It provides step-by-step instructions on how to improve medication reconciliation, from planning — including how to get leadership support — to pilot testing, implementation and evaluation. The toolkit also includes a workbook to help users implement the toolkit.

5. **Patient handover toolkit from the Royal College of Physicians.** The Royal College of Physicians, based in London, has published a free, downloadable toolkit focusing on patient handovers. The toolkit provides "a framework for standardization of clinical handover practice, audit and monitoring of the process and defining accountability and responsibilities in the process."

6. **Patient handoff policy and form from Morehouse School of Medicine.** The Morehouse School of Medicine in Atlanta, as part of its graduate medical education policies and procedures, provides a downloadable patient handoff policy and sample form. The three-page policy includes a purpose statement, background information, characteristics of a high-quality handoff and handoff procedures.

7. **SBAR (Situation, Background, Assessment, Recommendation) handoff tool.** The American Association of Critical-Care Nurses offers a free, downloadable communication tool designed to aid in safe patient hand-offs. This document also outlines AACN standards for health work environments, including skilled communications, collaboration, appropriate staffing, effective decision making, meaningful recognition and leadership.

8. **AORN perioperative patient hand-off tool kit.** AORN, in the "Perioperative Patient 'Hand-Off' Tool Kit" developed by AORN and the U.S. Department of Defence Patient Safety Program, provides 10 sample patient handoff tools gathered from organizations around the country. The tools include forms, posters, worksheets and a button design.

9. **Improving transitions of care: Hand-off communications.** From AHRQ, this tool describes factors that contribute to incomplete handoffs and recommends tactics improve handoff communication.

10. **Handoff communications video: Improving transitions of care.** The Joint Commission's Center for Transforming Healthcare offers the Hand-off Communications Targeted Solutions Tool™, or TST, to organizations improving their handoff process.