ED Transfer Communication

USING DATA TO DRIVE IMPROVEMENT!

EDTC-6: Nurse Generated Information

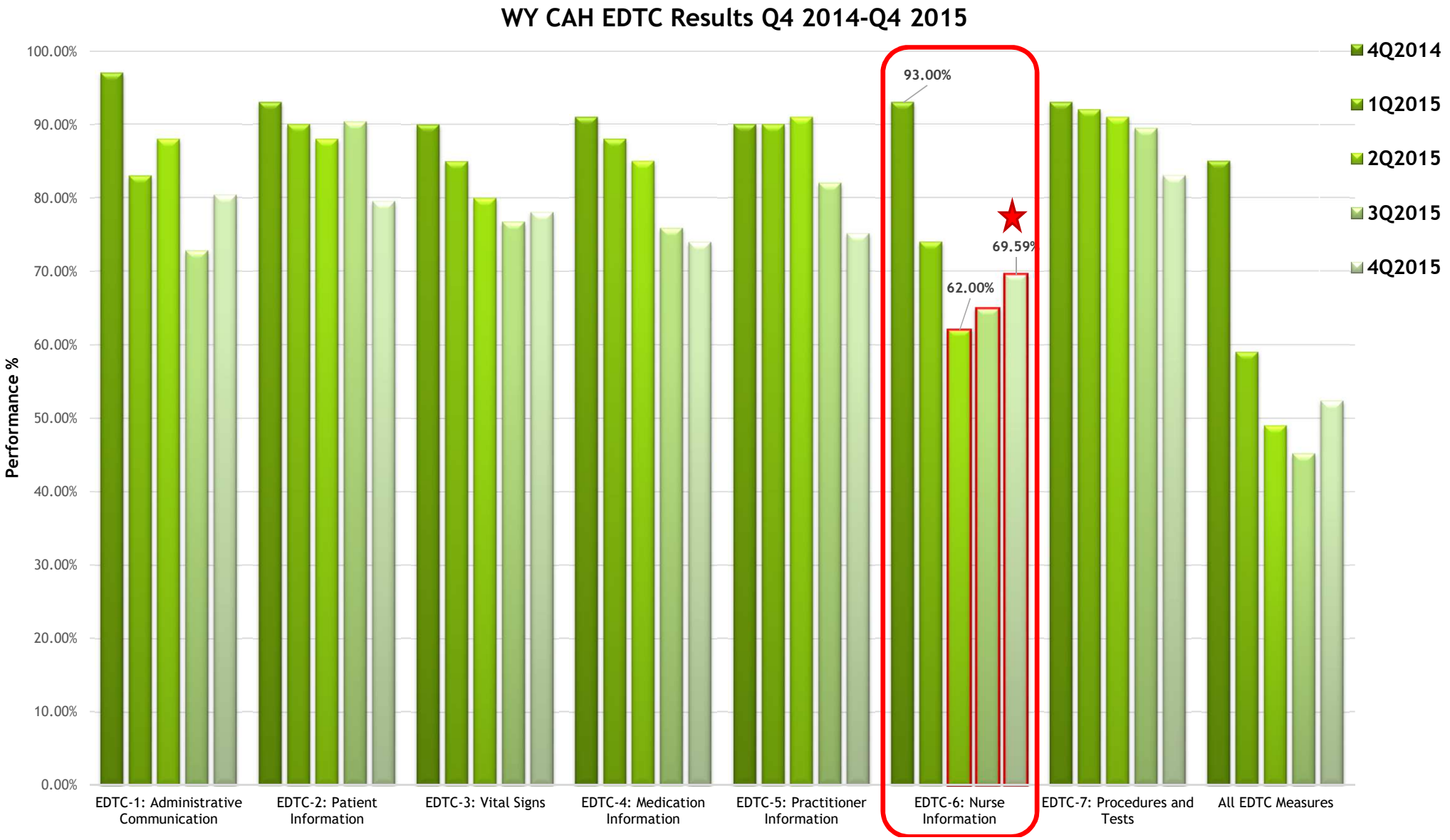
May 12th 2016

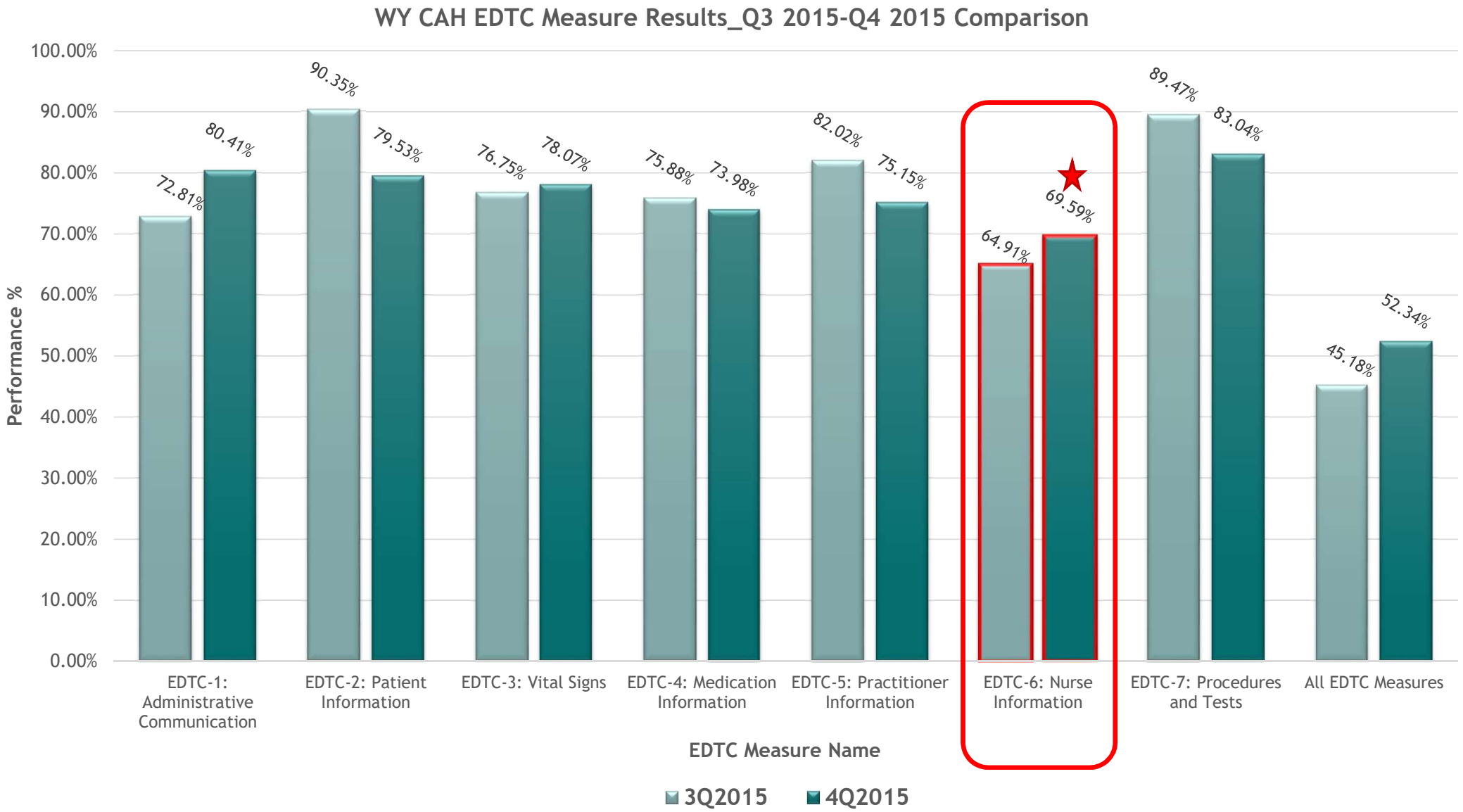
Presented By: Shanelle Van Dyke

Quality Reporting Services

Agenda

- EDT-6 Measure Overview
- Review of Data Results – Discussion amongst CAHs
- Review of Abstraction Guidelines *(If Necessary)*
- Interpretation of EDTC Reports (Q1 2016)
- Plan, Do, Study/Check, Act (PDSA/PDCA)
- Sample Checklists and Transfer Forms
- Develop and Implement an Action Plan
- Additional Resources (i.e. Nurse to Nurse Communication & Care Transitions)


WY CAH EDTC Results Q4 2014-Q4 2015
Performance %
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
4Q2014
1Q2015
2Q2015
3Q2015
4Q2015
93.00%
62.00%
69.59%
EDTC-1: Administrative Communication
EDTC-2: Patient Information
EDTC-3: Vital Signs
EDTC-4: Medication Information
EDTC-5: Practitioner Information
EDTC-6: Nurse Information
EDTC-7: Procedures and Tests
All EDTC Measures


WY CAH EDTC Measure Results_Q3 2015-Q4 2015 Comparison
Performance %
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
72.81%
80.41%
90.35%
79.53%
76.75%
78.07%
75.88%
73.98%
82.02%
75.15%
64.91%
69.59%
89.47%
83.04%
45.18%
52.34%
EDTC-1: Administrative Communication
EDTC-2: Patient Information
EDTC-3: Vital Signs
EDTC-4: Medication Information
EDTC-5: Practitioner Information
EDTC-6: Nurse Information
EDTC-7: Procedures and Tests
All EDTC Measures
EDTC Measure Name
3Q2015
4Q2015

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

Review of Data Results: *Discussion amongst CAHs*

- *Insert notes form discussion here…*

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

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

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

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

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

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

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

ED Transfer Comm. Data Collection Tool Demo

EDTC Report Interpretation

Hospital Report

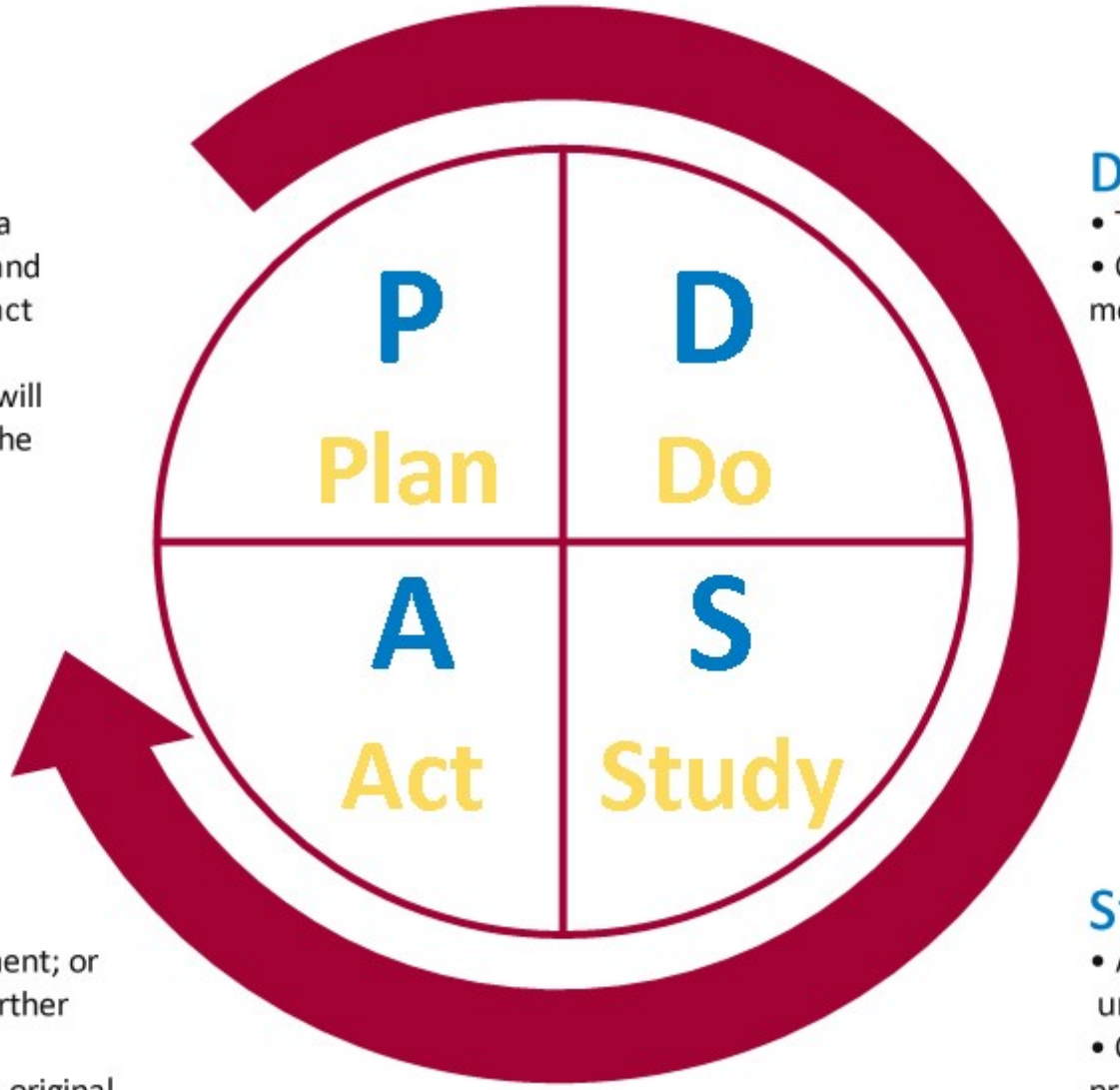
CMS Certified Number (CCN): 123456

Measures	Data Elements	Q1 2016 1/1/2016 Records Reviewed (N) = 5	Q2 2016 4/1/2016 Records Reviewed (N) =	Q3 2016 7/1/2016 Records Reviewed (N) =	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. Healthcare Facility to Healthcare Facility Communication	100.00% (n=5)	N/A	N/A	N/A
	2. Physician to Physician Communication	100.00% (n=5)	N/A	N/A	N/A
	All EDTC-1 Data Elements	100.00% (n=5)	N/A	N/A	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=5)	N/A	N/A	N/A
	2. Patient Address	100.00% (n=5)	N/A	N/A	N/A
	3. Patient Age	100.00% (n=5)	N/A	N/A	N/A
	4. Patient Gender	100.00% (n=5)	N/A	N/A	N/A
	5. Patient Contact Information	100.00% (n=5)	N/A	N/A	N/A
	6. Patient Insurance Information	100.00% (n=5)	N/A	N/A	N/A
	All EDTC-2 Data Elements	100.00% (n=5)	N/A	N/A	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=5)	N/A	N/A	N/A
	2. Respiratory Rate	100.00% (n=5)	N/A	N/A	N/A
	3. Blood Pressure	100.00% (n=5)	N/A	N/A	N/A
	4. Oxygen Saturation	100.00% (n=5)	N/A	N/A	N/A
	5. Temperature	100.00% (n=5)	N/A	N/A	N/A
	6. Neurological Assessment	100.00% (n=5)	N/A	N/A	N/A
	All EDTC-3 Data Elements	100.00% (n=5)	N/A	N/A	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=5)	N/A	N/A	N/A
	2. Allergies/Reactions	100.00% (n=5)	N/A	N/A	N/A
	3. Medication History	100.00% (n=5)	N/A	N/A	N/A
	All EDTC-4 Data Elements	100.00% (n=5)	N/A	N/A	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=5)	N/A	N/A	N/A
	2. Reason for Transfer/Plan of Care	100.00% (n=5)	N/A	N/A	N/A
	All EDTC-5 Data Elements	100.00% (n=5)	N/A	N/A	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	100.00% (n=5)	N/A	N/A	N/A
	2. Sensory Status (formerly Impairments)	100.00% (n=5)	N/A	N/A	N/A
★	3. Catheters/IV	20.00% (n=1)	N/A	N/A	N/A
	4. Immobilizations	100.00% (n=5)	N/A	N/A	N/A
	5. Respiratory Support	100.00% (n=5)	N/A	N/A	N/A
★	6. Oral Restrictions	20.00% (n=1)	N/A	N/A	N/A
★	**All EDTC-6 Data Elements**	20.00% (n=1)	N/A	N/A	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=5)	N/A	N/A	N/A
	2. Tests/Procedures Results	100.00% (n=5)	N/A	N/A	N/A
	All EDTC-7 Data Elements	100.00% (n=5)	N/A	N/A	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	20.00% (n=1)	N/A	N/A	N/A

Plan

- Capture the problem or idea
- Plan what you will change and predictions for what the impact will be
- Plan what information you will collect to measure whether the change has had an effect



Do

- Try out the change on a small scale
- Collect the information required to measure the change

Act

- Standardise your improvement; or
- Decide whether to make further change
- Plan how to improve on the original change made

Study

- Analyse the information collected to understand the impact of the change
- Compare your analysis with the predictions from the 'Plan' stage
- Summarise what you have learned

Complete PDSA Template

Sample Checklist

While some aspects of emergency department transfer communication may be unique, many of the communications concepts and ideas that have been developed for transitions of care or handoffs between settings along the continuum of care also apply. Below is a series of sample checklists that can be used, adapted, or provide suggestions on how to meet your hospital's and community's unique needs.

- **Safer Handoff: Patient Handoff Checklist**. *Emergency Nurses Association (ENA)*. Developed to highlight information that should be transferred to and from emergency departments and Long Term Care facilities/agencies.
- **Transfer Checklist and Feedback Form**. *Northeast Health Care Quality Foundation*. Checklist and feedback form for interfacility transfers. Allows receiving facility to provide feedback and suggestions if information was not received or is incomplete.
- **Acute Care Transfer Document Checklist**. *Interact. Florida Atlantic University*. Designed for long term care facilities to ensure appropriate documentation is sent with a resident to the Emergency Department. Could be adapted to address communication from the emergency department to other settings of care.

Transfer Checklist and Feedback

Sending Facility:_____ Receiving Facility: _____

Person & Phone Number of Receiving Facility Requesting Info: _____

Patient's Name_____ Date: __/__/__ Time: _ _:_ _ (military)

☐ **All** information necessary to treat the patient was **received**.
☐ The following information necessary to treat the patient was **not received or was incomplete**:

☐ Face sheet with demographic and insurance information	☐ Discharge Summary or discharge paperwork
☐ Medication list missing ☐ Medication list incomplete, missing: _____	☐ Treatment orders (wound care, nursing care, OT/PT/Speech therapy, lab orders)
☐ Reason for transfer	☐ H & P or Medical History
☐ Face to Face	☐ Verbal Report or Nurse to Nurse Report
☐ Advance Directives and/or Code Status	☐ Inadequate supplies for care
☐ Safety Concerns/Special Treatments:	☐ Other:

Please fax form **within 1 business day** to:
1. Contact person listed below *and*
2. NHCQF Fax

Form received on: ____/____/____ To be completed and resent **ONLY** if all information was not received.
RESPONSE: The following is now in place to prevent these deficiencies from occurring with future referrals:

_____
_____
_____
_____
_____
_____
_____

Person completing form: _____

*Please fax form **within 5 days** to Contact Person at Receiving Facility **and** NHCQF Contact*

Resident Name _____

Facility Name _____ **Tel** _____

Copies of Documents Sent with Resident *(check all that apply)*

Documents Recommended to Accompany Resident

_____ Resident Transfer Form

_____ Face Sheet

_____ Current Medication List or Current MAR

_____ SBAR and/or other Change in Condition Progress Note *(if completed)*

_____ Advance Directives *(Durable Power of Attorney for Health Care, Living Will)*

_____ Advance Care Orders *(POLST, MOLST, POST, others)*

Send These Documents *if indicated*:

_____ Most Recent History and Physical

_____ Recent Hospital Discharge Summary

_____ Recent MD/NP/PA and Specialist Orders

_____ Flow Sheets *(e.g. diabetic, wound care)*

_____ Relevant Lab Results *(from the last 1-3 months)*

_____ Relevant X-Rays and other Diagnostic Test Results

_____ Nursing Home Capabilities Checklist *(if not already at hospital)*

Emergency Department:

Please ensure that these documents are forwarded to the hospital unit if this resident is admitted. Thank you.

Sample Transfer Forms

Transfer forms are another tool used to improve transfer communications. In some states, minimum data standards have been set for all care transitions/transfers. Examples of what is required within the standard data sets established for all care transitions include:

- Principle diagnosis and problem list
- Reconciled medication list including over the counter/herbals, allergies and drug interactions
- Clearly identified medical home/transferring coordinating physician/provider/institution and their contact information
- Patient's cognitive status
- Test results/pending results ▫ Pertinent discharge instructions
- Follow up appointments
- Prognosis and goals of care
- Advance directives, power of attorney, consent
- Preferences, priorities, goals and values, including care limiting treatment orders (e.g., DNR) or other end-of-life or palliative care plans

Sample Transfer Forms

In addition, the “ideal” transfer record would also include:

- Emergency plan and contact number and person, Treatment and diagnostic plan, Planned interventions, durable medical equipment, wound care, etc., Assessment of caregiver status, and Patients and/or their family/caregivers must receive, understand and be encouraged to participate in the development of their transitions record which should take into consideration the patient’s health literacy, insurance status and be culturally sensitive

Following are sample transfer forms that can be adapted to meet your hospital emergency department and community needs, including:

- **Safer Handoff: Patient Handoff/Transfer Form**. *Emergency Nurses Association (ENA)*. ★
- **Universal Transfer Form.** *New Jersey Department of Health*.
- **Interact Hospital to Post Acute Care Transfer Form**. *Florida Atlantic University*. Designed for acute care discharges to post-acute facilities. Could be adapted for emergency department use.
- **Model Transfer Form: Nursing Facility to Emergency Department/Hospital**. *Virginia Department of Health*. Designed for nursing facility use, could be adapted or used as a tool with local nursing home partners.

High Performer
Sharing of Best Practices

Developing and Implementing an Action Plan

Establishing an ED Transfer Improvement Team

Step One: Gaining commitment of hospital leadership: This commitment includes supporting the project team towards accomplishing its goals, in particular, removing barriers identified through the improvement process.

Tips for gaining leadership commitment:

- Show them the data! The purpose of data collection on the Emergency Department Transfer Communication measures is to identify opportunities for improvement.
- Identify a realistic timeframe. Leaders and team members are more likely to offer support and input if they have an expectation of how long a particular improvement effort will take.
- Share how improvements in ED Transfer Communication align with other priority health care efforts.

Step Two: Establish an improvement team. The team will work to evaluate and improve the emergency department transfer communication process. It is important to involve those that work directly with transferring patients from the hospital emergency department to another hospital or care setting. As appropriate for your hospital the team should include:

- Team leader (often a QI coordinator/manager)
- Physician champion(s),
- Nurse leader(s),
- Case manager(s),
- Those responsible for maintaining patient information such as a unit coordinator and a medical records representative.
- IT representative that can help the team understand capabilities, and make adaptations to the electronic medical record if needed.
- Local EMS and transport organizations.

Teams should also consider including representation from facilities who will receive patients from the ED such as local nursing homes or a referring hospital.

Developing an Action Plan

Action plans are developed and used to move from a vision, to strategies, to meeting objectives. Each action step or change should include: what actions or changes will occur, who will carry out the changes, start and end dates for making the changes, resources needed to carry out the changes, and communication plans for the changes (who will know, receive, and participate in what). Action plans should be complete, clear, and current. This includes anticipating any new barriers or opportunities. Below is a list of items to consider when developing your action plan:

- Build in accountability.
- Engage key stakeholders.
- Design and standardize communications between sending and receiving health care organizations.
- Provide staff training.
- Consider revising standardized forms already in use (e.g., discharge summary document).
- Consolidate information when possible.
- Obtain buy-in from all users.
- Prioritize items that are actionable and address high priorities first.
- Create opportunities for care organizations to visit each other's care settings to observe patient care processes and the flow of information.

When process mapping and developing plans to address emergency department transfer communication, consider some of the common barriers that can impact care transitions:

- Lack of an integrated care system
- Lack of longitudinal responsibility across care settings
- Lack of standardized forms and processes
- Incompatible information systems
- Ineffective communication systems
- Ineffective communication
- Failure to recognize cultural, educational, or language differences
- Compensation and performance incentives not aligned with goal of maximizing care coordination and transitions
- Payment is for service rather than incentivized for outcomes
- Care providers do not learn care coordination and team-based approaches in school
- Lack of valid measures of the quality transition

When evaluating the outcomes of your action plan and the information communicated between providers, consider the timeliness, completeness, and accuracy of information transferred; the protocol of shared accountability in effective information transfer; and whether insurance requirements were met.

Definitions

Aim/Desired Outcome: This is what you're hoping to achieve by accomplishing your plan or your goal.

Barriers: These are problems, attitudes, and challenges that you should think about and address to achieve success.

Task(s): These are the steps/strategies needed to reach an aim/desired outcome.

Responsible Party(ies): These are the people who are assigned to the task.

Resources In-hand/ Resources Needed:
Resources in-hand: are people, time, materials, and know-how that already exist within your program and could be used to accomplish your tasks.

Resources needed: are people, time, materials, and know-how outside of your program needed to accomplish your tasks.

Measurement – How will the team know if the aim is achieved? - This is a simple way of keeping track of progress toward an aim/desired outcome. It should be easily tracked, and commonly understood. It data should be regularly checked to avoid wasting time on strategies that do not achieve your aim/desired outcome. Successful programs check in on average of every two weeks. For example, if you have a goal of increasing physical activity you need to:

1) Understand how many minutes of physical activity is currently happening on average throughout the program
2) Introduce your task/strategy for achieving your increased minutes of physical activity
3) Re-measure the amount of time of physical activity occurring in the program after your strategy has been rolled out
4) If your goal has not been reached, try a new strategy

Timeline/ Benchmarks- This is the time frame that programs assign to a task or aim. The benchmarks are the steps along the way that will let a program know they are on track toward achieving their aim/outcome.

Test of Plan
Is this plan worth doing? Answering yes to this means that you believe achieving your aim will have positive results for children, families, staff, or your business. Some plans that are REALLY worth doing have positive outcomes for all of those reasons.

Is this plan concrete, specific, and measurable? Answering yes to this means that when you/your program looks back at the goal, it will NOT be a matter of opinion if there is success or not. Instead you will be able to show clear results through your measurement.

Will the result of this plan improve outcomes? Answering yes to this means that there is a high likelihood that changes will be positive.

Quality Improvement Area	Aim/Desired Outcome	Barriers	Task(s)	Responsible Party(ies)	Resources In-hand/ Resources Needed	Measurement	Timeline/ Benchmarks	Test of Plan
								Worth doing? Yes No *Measureable?* Yes No *Improve outcomes?* Yes No
								Worth doing? Yes No *Measureable?* Yes No *Improve outcomes?* Yes No
								Worth doing? Yes No *Measureable?* Yes No *Improve outcomes?* Yes No

Implementing your Action Plan: Education & Training

An often forgotten component to quality improvement is educating and training staff on process improvement changes. This includes training staff at both ends of the care transfer/transition process and others in between (e.g., local EMS). Within the context of care transitions, there are different approaches that can be taken such as:

- *In-services for the staff* that include information on the following: importance/benefits of good transitions of care, components of an ideal transfer, baseline assessment findings (with specific examples), the newly created policy and procedures standardized transfer forms and/or patient resources
- *Mock patient transfer exercise* that highlights where breakdowns or failures may potentially occur (failure mode analysis exercise); allows for proactive consideration and considers implementing some actions to prevent failures from occurring
- *Joint educational sessions* with staff from health care facilities that send and receive transfers from your ED. Topics could include the importance of good care transitions for patients, especially those who are the most vulnerable, plus a “meet and greet” social function to help increase relationships with professionals sending and receiving patients to your facility
- *An article* about transitions of care in the local newspaper or a television news interview advertising the efforts by the hospital to improve transitions of care

Miscellaneous Reminders

- Next Q2 2016 EDTC Data Submission Deadline is July 31st 2016
- NEW! Quality Improvement Matters (QIM) website www.wyqim.com
- Quality Improvement Matters Newsletter: May version to go out the 17th
- New update to CMS Abstraction & Reporting Tool (CART) now available for Q4 2015 forward discharges and encounter
  - This new release contains the new ICD-10 codes. This version is required for Q4 2015 data submission, OQR due June 1st and IQR due May 15th

THANK YOU!

Questions ? ? ?

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Additional Resources

(i.e. Nurse to Nurse Communication & Care Transitions)

- **Appropriate Interhospital Patient Transfer**. *American College of Emergency Physicians*. This website includes policy statements and principles regarding patient transfers.
- **Care Transitions Program**. *Dr. Eric Coleman*. This website includes tools and resources to support care transitions, including those with Spanish and Russian translations.
- **Care Transitions: Strengthening Communication, Improving Outcomes**. *Oregon Patient Safety Commission*. Retrieved January 1, 2014. This website discusses care transitions between various health care settings and presents tools and resources to support improvements.
- **Got Transition.** *Center for Health Care Transition Improvement*. This toolkit focuses specifically on transitions related to young adults and children with special needs. It includes policies and procedures, action plans, and checklists.
- **Critical Care in the Emergency Department: Patient Transfer**. *Emergency Medical Journal*, January 2007, "This article reviews current recommendations for the transfer of critically ill patients, with a particular focus on pre-transfer stabilization, hazards during transport and the personnel, equipment and communications necessary throughout the transfer process."
- **Care Transitions Toolkit**. *Colorado Foundation for Medical Care*. This website includes a set of tools that supports organizations in beginning a quality improvement project through a series of steps such as root cause analysis, interventions, and measurement. The tool can be adapted and applied for most quality/process improvement needs. There are both online and PDF versions of the tool.
- **Transfer of Patient Care Between EMS Providers and Receiving Facilities.** *American College of Emergency Physicians*. This website includes policy statements and principles regarding patient transfers.

- **Implementation Guide to Improve Care Transitions**. *Project BOOST: Better Outcomes for Older Adults Through Safe Transitions, Society of Hospital Medicine*, retrieved January 19, 2014. "This guide is designed to facilitate the implementation, evaluation and maintenance of the BOOST toolkit and its adaptations. In addition to presenting BOOST interventions, the guide is filled with additional resources to manage, organize and document the efforts of your team."
- **Improving Nurse to Nurse Communication During Patient Transfers.** Reecha Madden, June 2012. This Powerpoint presentation describes the outcomes of the implementation of nurse to nurse communication tools.
- **INTERACT (Interventions to Reduce Acute Care Transfers).** This website includes tools and resources targeted at reducing transfers to hospitals, including care transitions between care settings, such as long term care, home health, and acute care.
- **National Transitions of Care Coalition Toolbox**. This website includes a series of tools, resources, and links to websites to support care transitions.
- **New Performance Improvement Coordinator Education.** *Montana Rural Healthcare Performance Improvement Network*. "This resource is specifically designed to provide new quality professionals with basic education about quality management and the tools used in implementing an effective, organization-wide quality program. The resources are designed for individual educational purposes as well as for the education and training of facility staff in the basic principles of quality management."
- **Patient Safety and Quality: An Evidenced-Based Handbook for Nurses.** *Agency for Healthcare Research and Policy*, April 2008. This handbook describes the handoff process in various care settings and presents strategies to improve handoff communications.