PIN Quality Improvement Study
ED Transfer Communication

Performance Improvement Discussion

May 1, 2017

Agenda:

- Q4 2016 Performance Summary
- Survey Results
- Why: EDTC & EMTALA: Required documentation
- Tool Development & Recommendations

Q4 2016 Performance Summary

- 40 facilities reporting
- 2 facilities with 100% on all measures & All Communications Composite (5%)
- 5 facilities scoring >90% on All Communications Composite (12.5%)
- 9 facilities scoring >90% on all measures (22.5%)
- State average on All Communications Composite (58.6%)
  - *Many facilities only missed one or 2 elements, but missed it on a large % of patients- hopefully creates some low hanging fruit for improvement ideas (such as, definition of sensory status)*
- Most frequently missed measures:
  1. Sensory Status (by far)
  2. Oral Restrictions
  3. H&P
  4. Nursing Notes
  5. Medication History/Home Medications
  6. Patient Contact

Survey Findings (27 facilities responded!): main reasons the lowest scoring measures were missed

1. Sensory Status:
   - abstractor not being able to find the documentation that an assessment of sensory status was done and sent to the receiving facility
2. Oral Restrictions:
   - not having the documentation to support an N/A response (no place to indicate "no oral restrictions")
3. H&P:
   - abstractor not being able to find the documentation that an H&P containing the appropriate content was sent to the receiving facility
4. Nursing Notes:
   - abstractor not being able to find the documentation that nursing notes containing the appropriate content were sent to the receiving facility
5. Medication History/Home Medications:
   a. There was no documentation of home medications being sent to the receiving facility
   b. No Place to document home medications are "UNKNOWN"
6. Patient Contact:
   - abstractor not being able to find the documentation that the patient contact information was sent to the receiving facility

POLL QUESTIONS

1. Why is an assessment of Sensory Status difficult to find in the patient record?

2. Please type in recommendations for making it easier to identify and abstract Sensory Status from the patient record

Sensory Status Abstraction Notes

- Select "Yes" if there is documentation that assessment of sensory status was done and information was sent to the receiving facility
- Select "No" if there is no documentation that assessment of sensory status was done and information was sent to the receiving facility
- 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:

- 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

POLL QUESTIONS

3. Why are Oral Restrictions difficult to find in the patient record?

4. Please type in recommendations for making it easier to identify and abstract Oral Restrictions from the patient record

Oral Restrictions Abstraction Notes

- Select "Yes" if there is documentation that oral restriction were placed and information was sent to the receiving facility
- Select "No" if there is documentation that oral restrictions were placed and information was not sent to the receiving facility
- Select "N/A" if no oral restrictions were placed

Inclusion Guidelines for Abstraction:

- NPO
- Clear liquids
- Soft diet
- Low NA diet

Survey Findings: Practices used to consistently document communications

Facility 1:

1. Clinical Review Analyst abstracts data
2. Use EHR to directly transmit information to receiving facility – create an electronic transfer summary
3. The only time there might be any missing documentation is if the patient is a John Doe and the demographic information might be incomplete

Facility 2:

1. The information could be located in many locations in the record, but the abstractor knows where to look and is confident the information will be in the documents sent with the patient.
2. This abstractor is clinical and very familiar with the ER practices

Facility 3:

1. Use their EHR's CCD Summary and have created an e-transfer form
2. Need to standardize where documentation is found: set up auto stops

Survey Findings: Practices used to consistently document communications

Facility 4:

1. Good communication with ED providers and staff on what is required. Routine reporting of reports/scores to the Medical Staff for accountability
2. Use EHR to directly transmit information to receiving facility
3. Use a paper checklist/Transfer Summary

Facility 5:

1. The documentation is part of the ED Transfer Summary report and mapped to the fields. Printed at time of transfer.
2. Ideally we would use an electronic process whereby data would come from direct source documentation or queries to be answered as a checklist. The query process, aka checklists, would be initiated by the ward clerks and nurses would answer the queries which would provide the data for the report.. Responses are query based for our ED Transfer communication. The Ward Clerk must initiate the interventions to provide the queries within the record and if this is not done, then the QIC must do 100% chart review to pull the data from the referenced locations. Staff are so use to the old paper forms that transitioning to electronic is very, very challenging. They don't feel as if they have completed the required documentation without the paper process.
3. Still Working On: Consistent documentation within the queries initiated by the ward clerks and/or mapping of the fields from direct documentation to avoid double documentation. This is the PDSA we are working on at this time.

Facility 6:

1. CNO abstracts data
2. Use a standard form to document all elements

Survey Findings: Issues faced, what is needed?

- Use of Travel Staff and they may miss part of documentation
- An EMTALA form with all the information that needs to be provided on it
- Education for staff and providers: to get buy-in, and standardized charting, complete documentation
- Stressing the importance of communication between facilities for the best outcomes for our patients
- Facility-wide support of standardized documentation

- The importance of the documentation has been internalized by all of our ER nurses. We have the majority who do a great job, and then some that do not meet even 50%
- Modify Transfer Summary reports in Cerner to pull in as much information as it can. (i.e. Nursing notes do not get pulled in, they need to be printed separately)
- Checklists not always used by nurse
- Providers not always putting time on communication with receiving facility
- The providers don't always document that they provided the H & P. Some of them dictate.
- Home medication and insurance card documentation. Many patients in ER say it is in file or do not have a copy or list with them. Nurse may forget to make a note that this information is not available
- I question whether I complete the NPO questions correctly. Very few have this order. I don't feel it's clarified very well. When should the pt be NPO? All surgeries? Please help clarify this answer.

WHY??

EMTALA Refresher

- Prohibits delaying care, refusing treatment, or transferring a patient to another facility if the patient cannot pay for the services
- We may only transfer unstable patients with an emergency medical condition to another facility if:
  - The patient requests the transfer and has been informed of the hospital's obligation and the risks and benefits of transfer; or
  - A physician certifies that the medical benefits provided at another facility are reasonably expected to outweigh the increased risks involved with the transfer.

EMTALA Refresher

- CMS Interpretive Guidelines: A medical screening examination is not an isolated event. It is an ongoing process. The record must reflect continued monitoring according to the patient's needs and must continue until he/she is stabilized or appropriately transferred. There should be evidence of this evaluation prior to discharge or transfer.

EMTALA Refresher

- A transfer to another medical facility will be appropriate only in those cases in which
  - The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child
  - The receiving facility
    - Has available space and qualified personnel for the treatment of the individual; and
    - Has agreed to accept transfer of the individual and to provide appropriate medical treatment

Failure to document EMTALA compliance rather than failure to comply is the #1 cause of EMTALA deficiencies!!!!!!!

EMTALA Documentation Requirements

- ED Log
- Transfer Form
- all medical records (or copies thereof) related to the emergency condition …including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) and the name and address of any on-call physician (described in paragraph (f) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer.

EMTALA Documentation Requirements

- Express Written Physician Certification
- Reason for transfer
- Method of transfer
- Refusal of consent to treatment
- Refusal of consent to transfer
- The Interpretive Guidelines indicate that the record must reflect continued monitoring according to the patient's needs and must continue until he/she is stabilized or appropriately transferred. There should be evidence of this evaluation prior to discharge or transfer.

TOOLS & RECOMMENDATIONS

PAPER TRANSFER SUMMARY, EMTALA TRANSFER FORM/POLICY & CHECKLISTS

Sample forms in Shared Documents

CCD Summary??

Can anyone tell me more about the CCD/ Summary of Care Record?

- Can additional templates be added to the summary that are not part of the standard list?
- How long is the reporting period for MU in order to meet the minimum reporting requirement (100 transfers to another setting)?

Stage 2
Eligible Professional
Meaningful Use Core Measures
Measure 15 of 17
Last Updated: August, 2015

Summary of Care	
Objective	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.
Measures	EPs must satisfy both of the following measures in order to meet the objective: Measure 1: • The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. Measure 2: • The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN. Measure 3: An EP must satisfy one of the following criteria: • Exchange a summary of care with a provider or third party who has different CEHRT (and different vendor) as the sending provider as part of the 10% threshold for measure #2, allowing the provider to meet the criteria for measure #3 without the CMS Designated Test EHR (for EPs the measure at §495.6(j)(14)(ii)(C)(1) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2). OR • If unable to exchange summary of care documents with recipients using a different CEHRT in common practice, retain documentation on circumstances and attest "Yes" to meeting measure 3 if using a certified EHR which meets the standards required to send a CCDA (§ 170.202).
Exclusion	Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.

CCD Templates:

- **CCD Templates* include:**
- Header
- Allergies
- Problems
- Procedures
- Family history
- Social history
- Payers
- Advance directives
- Medications
- Immunizations
- Medical equipment
- Vital signs
- Functional stats
- Results
- Encounters
- Plan of care

SUGGESTIONS??
QUESTIONS???

THANKS FOR YOUR TIME!!