ED Transfer Communication

USING DATA TO DRIVE IMPROVEMENT!

EDTC-4: Medication information

June 16th 2016
Presented By: Shanelle Van Dyke
Agenda

- EDTC-4 Measure Overview
- Review of Data Results - Discussion amongst CAHs
- Review of EDTC-4 Abstraction Guidelines *(If Necessary)*
  - *Roles and Responsibilities*
- Interpretation of EDTC-4 Reports (Q1 2016)
- Sharing of Best Practices
- Plan, Do, Study/Check, Act (PDSA/PDCA)
- Sample forms, checklists, fact sheets, etc.
- Additional resources
### Measure Overview

#### ED Transfer Communication Measures

<table>
<thead>
<tr>
<th>Category</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Transfer Communication Information</strong></td>
<td></td>
</tr>
<tr>
<td>Nurse communication with receiving hospital</td>
<td></td>
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<tr>
<td>Physician communication with receiving physician</td>
<td></td>
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<tr>
<td><strong>Patient Identification</strong></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
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<tr>
<td>Gender</td>
<td></td>
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<tr>
<td>Significant others contact information</td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
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<tr>
<td><strong>Vital Signs</strong></td>
<td></td>
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<tr>
<td>Pulse</td>
<td></td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
</tr>
<tr>
<td>Oxygen Saturation</td>
<td></td>
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<tr>
<td>Temperature</td>
<td></td>
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<tr>
<td>Glasgow score (trauma or neuro patients)</td>
<td></td>
</tr>
<tr>
<td><strong>Medication-related Information</strong></td>
<td></td>
</tr>
<tr>
<td>Medications Given</td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
</tr>
<tr>
<td>Medications from home</td>
<td></td>
</tr>
<tr>
<td><strong>Practitioner generated information (History and Physical)</strong></td>
<td></td>
</tr>
<tr>
<td>Physical exam, history of current event, chronic conditions</td>
<td></td>
</tr>
<tr>
<td>Physician orders and plan</td>
<td></td>
</tr>
<tr>
<td><strong>Nurse generated information</strong></td>
<td></td>
</tr>
<tr>
<td>Nurse documentation includes:</td>
<td></td>
</tr>
<tr>
<td>Assessment/interventions/response</td>
<td></td>
</tr>
<tr>
<td>Impairments</td>
<td></td>
</tr>
<tr>
<td>Catheters</td>
<td></td>
</tr>
<tr>
<td>Immobilizations</td>
<td></td>
</tr>
<tr>
<td>Respiratory support</td>
<td></td>
</tr>
<tr>
<td>Oral limitations</td>
<td></td>
</tr>
<tr>
<td><strong>Procedures and tests</strong></td>
<td></td>
</tr>
<tr>
<td>Tests and procedures done</td>
<td></td>
</tr>
<tr>
<td>Tests and procedure results sent</td>
<td></td>
</tr>
</tbody>
</table>
WY CAH EDTC Results Q1 2015 - Q1 2016

Performance %

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 Aggregate EDTC Measure Results_Q3 2015-Q1 2016 Comparison

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

Performance %

3Q2015 4Q2015 1Q2016
Review of Data Results: Discussion amongst CAHs

- Insert notes form discussion here...
Measure EDTC-SUB 4

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 4
Performance Measure Name: Medication 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 medication information.
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 from an ED to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of departure.
- Medications administered in ED
- Allergies
- Home medications

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 4

<table>
<thead>
<tr>
<th>Numerator</th>
<th># of patients who have a yes or NA for all measures: Medications administered in ED, allergies and home medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>All transfers from ED to another health care facility</td>
</tr>
</tbody>
</table>
**Medications Administered in ED**

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 list of medication(s) administered or that no medications were administered in the ED was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the list of medications administered were sent to the receiving facility.
N (No) Select this option if there is no documentation that the list of medications administered were sent to the receiving facility.

Notes for Abstraction:
- If no medications were given during the ED visit, documentation must state that there were no medications given to select yes.
- Medication information documented anywhere in the ED record is acceptable.

Suggested Data Sources:
- Emergency Department record
- Medication Administration Record (MAR) if part of the ED documentation for the current encounter
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
**Allergies/Reactions**

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’s allergy history was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation the patient’s allergy information was sent to the receiving facility.
N (No) Select this option if there is no documentation the patient’s allergy information was sent to the receiving facility.

Notes for Abstraction:
- See inclusion guidelines for what should be contained in the allergy information.
- If documentation is sent that allergies are unknown, select yes.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:
- Food allergies/reactions
- Medication allergies/reactions
- Other allergies/reactions

Exclusion Guidelines for Abstraction: None
Home Medications

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’s medication history was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation medication history was sent to the receiving facility.
N (No) Select this option if there is no documentation medication history was sent to the receiving facility.

Notes for Abstraction:
- If documentation indicates patient is not on any home medications, select yes.
- If documentation is sent that home medications are unknown, select yes

Suggested Data Sources:
- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:
- Complimentary medications
- Over the counter (OTC) medications

Exclusion Guidelines for Abstraction:
None
Communication & Documentation

- Encourage healthcare professionals to take personal responsibility for the transfer of information about medicines.
- Provide a common data set for the improvement and development of organizational systems and processes to support the safe transfer of information about patients’ medicines.
- Engage with patients to encourage them to take an active role in understanding their medicines to improve their safe management when they move between care providers and healthcare settings.
“the single biggest problem in communication is the illusion that it has taken place”

-George Bernard Shaw
Communication & Documentation

Four core principles for health care professionals:

1. Health care professionals transferring a patient should ensure that all necessary information about the patient’s medicines is accurately recorded and transferred with the patient, and that responsibility for ongoing prescribing is clear.

2. When taking over the care of a patient, the healthcare professional responsible should check that information about the patient’s medicines has been accurately received, recorded and acted upon.

3. Patients (or their parents, or advocates, or caregivers, etc.) should be encouraged to be active partners in managing their medicines when they move, and know in plain terms why, when and what medicines they are taking.

4. Information about patients’ medicines should be communicated in a way which is timely, clear, unambiguous and legible; ideally generated and/or transferred electronically
Three key responsibilities for organizations providing care:

1. Provider organizations must ensure that they have safe systems that define roles and responsibilities within the organization, and ensure that healthcare professionals are supported to transfer information about medicines accurately.

2. Systems should focus on improving patient safety and patient outcomes. Organizations should consistently monitor and audit how effectively they transfer information about medicines.

3. Good and poor practice in the transfer of medicines should be shared to improve systems and encourage a safety culture.
Everyone Plays a Role

**Physician Responsibilities:**
- Write complete transition orders, including medications according to the facility’s Medication Reconciliation process.

**Nurse Responsibilities:**
- Discuss new medications ordered with the patient/family. Arrange to have medication prescriptions filled.
- Complete any required teaching for continued treatments and medication at home and document on a Discharge Instructions form.
- Assure medication reconciliation is complete

**Patient Responsibilities:**
- Play an active role in understanding their medicines to improve their safe management
Tips for Taking Medication History

Use a systematic approach
- For example, begin by asking about prescription medications, then over-the-counter products, and last vitamins/herbals/nutritional supplements—or develop and implement a standardized process workflow.

Engage patients
- Explain the importance of carrying an updated medication list to share with all healthcare providers.
- Explain the importance of obtaining a complete and accurate medication history.

Avoid yes/no questions
- Ask open-ended questions to solicit additional information.
- Review medical history - inquire about commonly prescribed medications for health conditions listed.
Tips for Taking Medication History

Consider all sources to obtain medication history and/or to clarify conflicting information, such as:

- Patient
- Patient’s medication list - ask when the list was last updated
- Caregiver/family member
- Prior care provider
- Community pharmacy
- Physician(s)
- Past medical records

For each medication, record: name, strength, dose, route, frequency, and last dose taken.

*Note any discrepancies in prescribed medications vs. what the patient reports he/she is actually taking.
ALLERGIES
- What medication allergies do you have?
- What type of bad reactions did you have?
- What other allergies do you have (such as food, latex, or environmental allergies)?

REVIEW OF COMMON HEALTH CONDITIONS/AILMENTS
- What medications do you take for:
  - Headaches? Seizures?
  - Sadness? Anxiety? Sleep?
  - Memory? Confusion?
  - Allergies? Your eyes?
  - Breathing? Inhalers?
  - Your heart? Blood pressure?
  - Blood thinners?
  - Diabetes? Thyroid?
  - Your stomach? Bowels?
  - Your bladder?
  - Your bones? Joints?
  - Pain? Fever?
  - Anything you put on your skin?

FOR MEDICATIONS/CONDITIONS WITH INCOMPLETE INFORMATION, CONSIDER:
- Who ordered the medication?
- What is the dose?
- When did you last take it?
- Where do you get your medications?
- Why do you take it?

OVER-THE-COUNTER MEDICATIONS
- What medicines do you take that you do not need a doctor’s prescription to purchase?
- What do you take when you get constipation or diarrhea, heartburn, cough/cold, or headache? How often do you take it? How much?
- What do you take when you get sick? How often? How much?

SAMPLE Questions
SAMPLE Questions

PRESCRIPTIONS
- What pharmacy/pharmacies do you use?
- Are you taking any other medications prescribed by other healthcare professionals like your dentist, ophthalmologist, or chiropractor?
- What medications do you take every day? When do you take them?
- Are there any medications that you take only sometimes or when you need it? What are they? When do you take them?
- Have you used any patches?
- Have you had any injections given at a doctor’s office or anywhere else?
- Has your doctor given you any sample drugs to take?

HERBAL/NATURAL SUPPLEMENTS
- What vitamins do you take?
- What herbal medications do you take?
- What natural supplements do you take?
- What supplements do you take to improve your diet?

MEDICATION CONCERNS
- Can you tell me about any missed doses in the past week?
- What problems or concerns do you have with your medications?
- What concerns do you have about side effects?
- Are there medications that you don’t think are helping you?
- Are you having difficulty paying for your medications?
ED Transfer Comm. Data Collection Tool

EDTC Report Interpretation
## Emergency Department Transfer Communication
### Hospital Report

**CMS Certified Number (CCN): 123456**

### Measures

<table>
<thead>
<tr>
<th>Data Elements</th>
<th>Q1 2016</th>
<th>Q2 2016</th>
<th>Q3 2016</th>
<th>Q4 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Healthcare Facility to Healthcare Facility Communication</td>
<td>100.00% (n=5)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Physician to Physician Communication</td>
<td>100.00% (n=5)</td>
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<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>All EDTC-1 Data Elements</td>
<td>100.00% (n=5)</td>
<td>N/A</td>
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</tbody>
</table>

#### 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
2. Physician to Physician Communication

### 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
2. Patient Address
3. Patient Age
4. Patient Gender
5. Patient Contact Information
6. Patient Insurance Information

### 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
2. Respiratory Rate
3. Blood Pressure
4. Oxygen Saturation
5. Temperature
6. Neurological Assessment
### EDTC - 4 Medication Information

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Percentage</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medication Given in ED</td>
<td>100.00% (n=5)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Allergies/Reactions</td>
<td>20.00% (n=1)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>3. Medication History</td>
<td>40.00% (n=2)</td>
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<td>N/A</td>
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<td><strong>All EDTC-4 Data Elements</strong></td>
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</table>

### EDTC - 5 Physician or Practitioner Generated Information

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<tr>
<th>Data Element</th>
<th>Percentage</th>
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<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History and Physical</td>
<td>100.00% (n=5)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Reason for Transfer/Plan of Care</td>
<td>100.00% (n=5)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>All EDTC-5 Data Elements</strong></td>
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### EDTC - 6 Nurse Generated Information

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<th>Percentage</th>
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<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nursing Notes</td>
<td>100.00% (n=5)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>2. Sensory Status (formerly Impairments)</td>
<td>100.00% (n=5)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Catheters/IV</td>
<td>100.00% (n=5)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Immobilizations</td>
<td>100.00% (n=5)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>5. Respiratory Support</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>6. Oral Restrictions</td>
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<tr>
<td><strong>All EDTC-6 Data Elements</strong></td>
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### EDTC - 7 Procedures and Tests

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<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tests/Procedures Performed</td>
<td>100.00% (n=5)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Tests/Procedures Results</td>
<td>100.00% (n=5)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td><strong>All EDTC-7 Data Elements</strong></td>
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<td>N/A</td>
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### All EDTC Measures

<table>
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<th>N/A</th>
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</thead>
<tbody>
<tr>
<td><strong>All EDTC Measures</strong></td>
<td>20.00% (n=1)</td>
<td>N/A</td>
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<td>N/A</td>
<td>N/A</td>
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</tbody>
</table>
High Performer
Sharing of Best Practices
Sharing of Best Practices

- RECOMMENDED TRANSITIONS OF CARE PRINCIPLES AND STANDARDS
- IMPROVE ACCOUNTABILITY
- IDENTIFY RESPONSIBILITY
- COORDINATE CARE
- INVOLVE FAMILY
- CLEARLY COMMUNICATE
- ASSURE TIMELINESS
- UTILIZE NATIONAL STANDARDS AND METRICS
15. **SKIN CONDITION:**
- [ ] No Wounds
- [ ] YES, Pressure, Surgical, Vascular, Diabetic, Other
- [ ] See Attached TAR

<table>
<thead>
<tr>
<th>Type</th>
<th>P</th>
<th>S</th>
<th>V</th>
<th>D</th>
<th>O</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Site</th>
<th>Size</th>
<th>Stage (Pressure)</th>
<th>Comment</th>
</tr>
</thead>
</table>

16. **DIET:**
- [ ] Regular
- [ ] Special (describe): 

- [ ] Tube feed
- [ ] Mechanically altered diet
- [ ] Thicken liquids

17. **IV ACCESS:**
- [ ] None
- [ ] PICC
- [ ] Saline lock
- [ ] IVAD
- [ ] AV Shunt
- [ ] Other: 

18. **PERSONAL ITEMS SENT WITH PATIENT:**
- [ ] None
- [ ] Glasses
- [ ] Walker
- [ ] Cane
- [ ] Hearing Aid: [ ] Left [ ] Right
- [ ] Dentures: [ ] Upper/Partial [ ] Lower/Partial [ ] Other:

19. **ATTACHED DOCUMENTS:**
- [ ] MUST ATTACH CURRENT MEDICATION INFORMATION
- [ ] Face Sheet
- [ ] MAR
- [ ] Medication Reconciliation
- [ ] TAR
- [ ] POS
- [ ] Diagnostic Studies
- [ ] Labs
- [ ] Operative Report
- [ ] Respiratory Care
- [ ] Advance Directive
- [ ] Code Status
- [ ] Discharge Summary
- [ ] PT Note
- [ ] OT Note
- [ ] ST Note
- [ ] HX/PE
- [ ] Other:

20. **SENDING FACILITY CONTACT:**

<table>
<thead>
<tr>
<th>Title</th>
<th>Unit</th>
<th>Phone</th>
</tr>
</thead>
</table>

21. **RECG FACILITY CONTACT (if known):**

<table>
<thead>
<tr>
<th>Title</th>
<th>Unit</th>
<th>Phone</th>
</tr>
</thead>
</table>

22. **FORM PREFILLED BY (if applicable):**

<table>
<thead>
<tr>
<th>Title</th>
<th>Unit</th>
<th>Phone</th>
</tr>
</thead>
</table>

23. **FUNCTION:**
- [ ] Self
- [ ] With Help
- [ ] Not Able

<table>
<thead>
<tr>
<th>Walk</th>
<th>Transfer</th>
<th>Toilet</th>
<th>Feed</th>
</tr>
</thead>
</table>

24. **IMMUNIZATIONS/SCREENING:**
- [ ] Flu Date: 
- [ ] Tetanus Date: 
- [ ] Pneumo Date: 
- [ ] PPD +/- Date: 
- [ ] Other: 

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

25. **BOWEL:**
- [ ] Continent
- [ ] Incontinent
- [ ] Date last BM: 

<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
</table>

26. **BLADDER:**
- [ ] Continent
- [ ] Incontinent
- [ ] Foley Catheter

<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
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27. **FORM COMPLETED BY:**

<table>
<thead>
<tr>
<th>Title</th>
<th>Unit</th>
<th>Phone</th>
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</table>
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
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

Act

Do

Study
**PLAN-DO-STUDY-ACT**

**Act**
- What changes are to be made?
- Next cycle?

**Plan**
- Objective
- Questions and predictions
- Plan to carry out the cycle (who, what, where, when)

**Study**
- Complete the analysis of the data
- Compare to predictions
- Summarize what was learned

**Do**
- Carry out plan
- Document problems and unexpected observations
Show Sample Medication Transfer Sheet(s)
Bring this form with you and show it to your prescriber or MTM provider any time you have a doctor’s appointment you have to go to the hospital, and whenever you have a new prescription filled at your pharmacy.

**Patient Name:**

**Date of Birth:** __/__/_____  **Date Form Updated:** __/__/_____

:mm/dd/yyyy  

:mm/dd/yyyy

**Allergies / Reaction:**


**Medications:**

<table>
<thead>
<tr>
<th></th>
<th>Start Date / Stop Date</th>
<th>Name of Medicine</th>
<th>Tablet Strength</th>
<th>How to Use / When to Use</th>
<th>What is this Medicine for?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>15</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Please bring this updated form with you to all of your medical office visits. If your medicines change, please tell your medical provider.
Check the detailed drug sheets provided by the pharmacy with each medication, or talk to your doctor about possible side effects, danger signs and interactions.

**Allergies to:**

**Other Medical Providers that you are seeing (please include dentist and eye doctor):**

<table>
<thead>
<tr>
<th>Last Seen</th>
<th>Provider Name</th>
<th>Specialty</th>
<th>Problem they are treating</th>
<th>Comments</th>
</tr>
</thead>
</table>
Sample Checklist

While some aspects of emergency department transfer communication may be unique, many of the communication 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 | ☐ Treatment orders (wound care, nursing care, OT/PT/Speech therapy, lab orders) |
| ☐ Medication list incomplete, missing: | ☐ H & P or Medical History |
| ☐ Reason for transfer | ☐ Verbal Report or Nurse to Nurse Report |
| ☐ Face to Face | ☐ Inadequate supplies for care |
| ☐ Advance Directives and/or Code Status | ☐ Other: |
| ☐ Safety Concerns/Special Treatments: | |

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*
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:

- 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.
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: June version to go out the 17th
- MBQIP Deadline Reminders:
  - Q1 2016 Outpatient Core Measures (AMI, CP, PM) due August 1st 2016
  - Q1 2016 Inpatient Core Measures (IMM-2) due August 15th 2016
  - Q1 2016 Inpatient & Outpatient Population & Sampling due August 1st 2016
THANK YOU!

Questions ???

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Rspinarski@rhsnow.com
Review EHR Medication Profile Sample
# Medication Profile

**Individual's Name:** Andrew Jackson  
**Time Zone:** US/Eastern

## Active Medication List

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Form</th>
<th>Route</th>
<th>Frequency</th>
<th>Begin Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>L I Q U I D C A L C U M 6 0 0 - V I T D CAP</td>
<td>400.0</td>
<td>Capsules</td>
<td>Oral (mouth)</td>
<td>11/01/2012</td>
<td>11/22/2012</td>
<td></td>
</tr>
<tr>
<td>PARA-TIME 150 MG CAPSULE SA</td>
<td></td>
<td></td>
<td></td>
<td>11/01/2012</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All active medications and medications with current date as an end date are listed under this section.

## Home Medication

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Form</th>
<th>Route</th>
<th>Frequency</th>
<th>Begin Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>L I Q U I D C A L C U M 6 0 0 - V I T D CAP</td>
<td>400.0</td>
<td>Capsules</td>
<td>Oral (mouth)</td>
<td>11/01/2012</td>
<td>11/22/2012</td>
<td></td>
</tr>
</tbody>
</table>

## Historical Medication List

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Home Medication</th>
<th>Dose</th>
<th>Form</th>
<th>Frequency</th>
<th>Begin Date</th>
<th>End Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYLENOL COLD M-S NIGHTTIME LIQUID</td>
<td>No</td>
<td>4.0</td>
<td>Liquid</td>
<td>11/01/2012</td>
<td>11/17/2012</td>
<td>Approved</td>
<td></td>
</tr>
<tr>
<td>ACETAMINOPHENV PM TABLET</td>
<td>No</td>
<td>250.0</td>
<td>Tablet</td>
<td>2 X DAILY</td>
<td>11/01/2012</td>
<td>Discontinued</td>
<td></td>
</tr>
</tbody>
</table>

All discontinued and inactive medications appear under this section.

Jump to: Historical Medication | Medication Review | Medication Reconciliation
### Allergy Profile of Mary Active, 000001

*Created By:* Ray Helper, Direct Support Professional on 06/16/2011 03:10 AM  
*Last Updated By:* Ray Helper, Direct Support Professional on 06/20/2011 07:36 AM  
*Time Zone:* US/Eastern  
*Update History* (4)

**NOTE:** Highlighted allergies represent manual entries, these will not be considered for Drug-Allergy interaction.

#### Active Allergies

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Type</th>
<th>Severity</th>
<th>Reaction</th>
<th>Identification Date</th>
<th>Added By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid Green 50</td>
<td>Food Allergy</td>
<td>Severe</td>
<td>Rashes are found all over the body.</td>
<td>06/01/2011</td>
<td>Ray Helper</td>
</tr>
<tr>
<td>Acid Mantine</td>
<td>Drug Allergy</td>
<td>Moderate</td>
<td>Rashes are found over the body.</td>
<td>06/01/2011</td>
<td>Ray Helper</td>
</tr>
<tr>
<td>Nut Allergy</td>
<td>Food Allergy</td>
<td>Mild</td>
<td>Irritation occurs.</td>
<td>06/01/2011</td>
<td>Ray Helper</td>
</tr>
</tbody>
</table>

#### Inactive Allergies

#### Deleted Allergies

**Comment**

Items that cause allergy to Mary should not be provided to her.
Review recommended core content of “records for medicines” when Patients transfer care Providers
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.


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.”