AHRQ's Safety Program for Nursing Homes: On-Time Preventable Hospital and Emergency Department Visits

Functional Specifications

Current as of August 2017

Contents

On-Time Quality Improvement for Long-Term Care

Functional Specifications for On-Time Preventable Hospital and ED Visits

1. General Information

1.1. Background

The Agency for Health Care Research and Quality (AHRQ) developed evidence-based tools for nursing home clinical staff in facilities that have an electronic medical record (EMR). These tools are used as part of the On-Time Quality Improvement Program for Long Term Care (On-Time), a facilitator-directed quality improvement program. On-Time provides EMR reports for improving clinical decisionmaking for pressure ulcer prevention, pressure ulcer healing, prevention of inappropriate hospitalizations, and falls prevention. Each of these efforts was developed independently as separate modules for long-term care EMRs.

On-Time reports are designed to be added to the existing reporting feature of EMR products and to use existing EMR data elements as data sources for reports. This eliminates the need for EMR vendors to develop new software features, modify existing software, or make any changes to system design in order to add the On-Time modules to their system. An On-Time module, once added to the EMR product, does not interfere with routine use of the product by end users.

Data elements and data sources are described for each report, and the vendor or facility representative determines the availability of data elements required for each report by conducting a brief gap analysis. The vendor will add data elements as needed or make recommendations to the nursing home clinical representative for EMR development if substitute data elements are available and appropriate to accomplish the same report results and maintain the integrity of report design and meaning.

1.2. Electronic Medical Record Vendor Prerequisites

The following EMR capabilities are necessary to provide the required data elements for On-Time reports:

- Emergency department (ED) visit note capture,
- Ability of registration system to store hospital admission dates,
- Hospital discharge diagnosis,
- Nurse documentation of clinical assessments,
- Physician orders,
- Wound assessment documentation,
- Minimum Data Set (MDS) assessments, and
- Medication profiles by resident, medication administration records (MARs), or physician orders for resident medications.

1.3. Report Users

Administrators, directors of nursing, nurse managers, and any clinician or quality improvement staff involved in the management of resident transfers from the nursing home to the hospital.

2. AHRQ On-Time Preventable Hospital and ED Visits Reports

The AHRQ On-Time Preventable Hospital and ED Visits Reports are listed in the table below.

Table 1. On-Time Reports

	Reports Included in the Module
1	Transfer Risk Reports: High Risk and Medium Risk
2	ED Treat and Release Report
3	Monthly Summary of Transfers by Facility or Nursing Unit
4	Monthly Summary of Transfers by Provider
5	Key Metrics Trend Report

2.1. Report Titles

The functional specifications for all On-Time reports are available to any long-term care EMR vendors wanting to incorporate On-Time reports into their product; however, all reports must be labeled "On-Time" and developed as specified, to maintain the integrity of the reports for facilities participating in On-Time Preventable Hospital and ED Visits.

To integrate the reports into day-to-day workflow, nursing home staff work with an On-Time facilitator who adheres to a structured implementation plan using detailed implementation and guidance materials for each report.

2.2. Report Headers and Footers

The table below provides general report header and footer information. If this information differs by report, instructions will appear in the section of this document where the report is described.

Table 2. Standard Headers and Footers

Header	Date Source	Valid Input and Display
Report Title	Reports	Display report title top center. Display facility name and/or logo per EMR vendor format.
Facility Name	System	IF the report is generated for a facility versus a single nursing unit, display the facility name in the top left margin or display using vendor-specific format.
Nursing Unit	System	IF the report is generated for a single nursing unit, display the nursing unit name that is selected by the user during report parameter setup. Display in the top left margin.
Report Ending Date	System	Display the report ending date that is specified by the user during report parameter setup. Display in the top left margin.
Footer	**Date Source**	**Valid Input and Display**
Print Date	System	Display month/date/year the report was generated. Use EMR vendor format for month, date, year displays.
Text		Display: "Source: Agency for Healthcare Research and Quality; 2017 [or current year]" in the bottom left margin. IF the vendor has standard information that displays, then display in the bottom right margin.

2.2.1. Unit- or Facility-Level Reports

Unit- or facility-level reports will display the facility name or nursing unit name in the header. Use the EMR vendor format for display information on the facility-level or unit-level reports.

2.2.2. Resident-Level Reports

Resident-level reports will display the resident name in the header: Last name, first name, and room number. Use the EMR vendor format for displaying resident name for resident-level reports or display in the top left margin.

2.3. General Report Rules

The following rules apply to all reports.

2.3.1. Exclusions

- **Residents no longer being treated at the facility**, which includes residents with discharge dates within 7 days prior to the report date.
- **Resident diagnosis codes** inactive or discontinued within 7 days prior to the report date and during calculation periods.
- **Physician orders** with discontinuation dates or expiration dates within 7 days prior to the report date and during calculation periods, including resident medication profiles.

2.3.2. Report Parameters

End users must be able to:

- Filter reports by nursing unit or by facility,
- Specify a report end date to generate reports for specific periods, and
- Specify a date range or calendar month, depending on available report parameters.

3. Specifications for Each Preventable Hospital and ED Visits Report

3.1. Transfer Risk Report

3.1.1. Report Description

The Transfer Risk Report provides a weekly snapshot of residents in a nursing home at high risk for transfer to a hospital or ED that may be avoidable. The report is designed to help nursing staff see changes in resident clinical status earlier and identify residents at high risk for transfer. The report summarizes risk elements recorded on Minimum Data Set (MDS) assessments, medication profiles, and daily or weekly nurse documentation and applies risk rules to provide a list of residents meeting criteria for high risk of transfer to the hospital or ED.

3.1.2. Dependencies and Clinical Assumptions

- Only residents meeting criteria for risk display on the reports; residents display either on high or medium risk, never both.
- A resident may have multiple transfers to the ED on the same date, so the system must assign a date and time to each unique transfer.
- A transfer note is completed for each transfer to the ED or hospital and an intake note is completed for each return from the ED and each hospital admission/readmission to the facility. The two notes are linked to a unique transfer or admission/readmission.
- For reports that display resident medications, the vendor determines the data source for resident medications: MDS data element for medications, medication administration record (MAR), or other vendor source.

3.1.3. Report Example: High Transfer Risk Report

Facility Name:
Unit:
Report Date:

Resident Name and Advance Directive Status			# ED Visits Within:			ED Discharge Diagnosis	# Hospital Admits Within:			Hospital Discharge Diagnosis		High-Risk Diagnoses Associated With Transfer Risk												Current Clinical Conditions Contributing to Transfer Risk								Polypharmacy	High-Risk Change in Condition (Based on Assessment Data Within 7 Days of Report Date)					
	Age	DNR,DNH, MOLST, or POLST Order in Place	0-7 Days	8-30 Days	31-90 Days	For Most Recent ED Visit	0-7 Days	8-30 Days	31-90 Days	For Most Recent Hospital Stay	LOS for Most Recent Hospitalization	Congestive Heart Failure	Myocardial Infarction	Angina	Pneumonia or Bronchitis	Asthma or COPD	Urinary Tract Infection	Sepsis or Fever or Infection	Dehydration	Circulatory Problems*	Renal Failure	Diabetes or Hypoglycemia	Anemia	Gastroenteritis	Oxygen Therapy	Catheter or Ostomy Present	Stage II or > Pressure Ulcer	Fall Risk	Late-Loss ADL Score ≥12	Cognitive Impairment	Medical Conditions**	High-Risk Medications***	Medication Total ≥15	CHF or Chest Pain or MI	Pneumonia or Bronchitis	Mental Status Change or Neurological Symptoms	Urinary Tract Infection	Sepsis or Fever or Infection	Dehydration
Resident A	79				2	Fever - unknown origin			1	Myocardial infarction	5		X								X	X								1	X		1	1				1
Resident B	81	1			1	Urinary tract infection		1		Cellulitis	10	X		X			X		X	X							X			X	X		2	X	X	1			1	1	
Resident C	82			1		Anemia		1	1	COPD	4				X	X			X				X		X						X	1	X	X		2	2		1	
Resident D	80			1		Gastroenteritis			1	GI bleed	3							X	X				X	X					X	X		2	X					1	1
Resident E	76						1		1	Altered mental status	2											X							X		1		X			2				
Resident F	84	1																	X		X					X	X	X				X						1
Total Residents		2	0	2	2		1	2	4			1	1	1	1	1	1	1	4	1	2	2	2	1	1	2	1	4	3	1	5	4	4	2	2	2	1	3	3

Key: ED=emergency department; DNR=Do Not Resuscitate; DNH=Do Not Hospitalize; MOLST=Medical Order for Life-Sustaining Treatment; POLST=Physician Order for Life-Sustaining Treatment; LOS=length of stay; COPD=chronic obstructive pulmonary disease; GI=gastrointestinal; ADL=activities of daily living.
* Circulatory problems include vascular disease, and venous and arterial ulcer.
** Medical conditions include cellulitis, hypertension, deep vein thrombosis, moderate dementia, peripheral neuropathies, quadriplegia, paraplegia, and hemiparesis.
*** High-risk medication include insulin, anticoagulants, antibiotics, alpha blockers, antipsychotics, antianxiety, sedative hypnotics, anticonvulsants, antihypertensives, opioids, and diuretics.

3.1.4 Valid Input and Displays for High Transfer Risk Report

	Column Header	Data Source	Valid Input	Rule/Display
	# ED Visits Within:	.	ED visit date	
1	0-7 days (# of visits)	ADT or registration system or Transfer Note	Compute using ED Visit Date(s).	Count the number of ED visits within 0-7 days of report date and display sum total.
2	8-30 days (# of visits)	ADT or registration system or Transfer Note	Compute using ED Visit Date(s).	Count the number of ED visits within 8-30 days of report date and display sum total.
3	31-90 days (# of visits)	ADT or registration system or Transfer Note	Compute using ED Visit Date(s).	Count the number of ED visits within 31-90 days of report date and display sum total.
4	ED Discharge Diagnosis	Vendor determined or Intake Note	TBD by vendor as text entry or diagnosis code.	IF “ED Visit History <30 days” OR ”ED Visit History 31-90 days” contains a count, then display discharge diagnosis as text (use vendor format); else leave blank. IF multiple ED visit dates: • IF multiple ED visits identified within the report period, then display the ED discharge diagnosis associated with the ED visit nearest and prior to or on report date. IF multiple discharge diagnoses selected for ED visit nearest and prior to or on report date: • Display diagnosis indicated as ”primary”; IF more than one indicated as “primary,” then display first diagnosis selected; display as text. IF no discharge diagnosis selected or entered, then leave blank.
5	# Hospital Admits Within:			
6	0-7 days (# of visits)	ADT or registration system or Transfer Note	Compute using Hospital Admission Date(s).	Count the number of admissions within 0-7 days of report date and display sum total.
7	8-30 days (# of visits)	ADT or registration system or Transfer Note	Compute using Hospital Admission Date(s).	Count the number of admissions within 8-30 days of report date and display sum total.
8	31-90 days (# of visits)	ADT or registration system or Transfer Note	Compute using Hospital Admission Date(s).	Count the number of admissions within 31-90 days of report date and display sum total.

	Column Header	Data Source	Valid Input	Rule/Display
9	Hospital Discharge Diagnosis for Most Recent Hospital Stay	ADT or registration system or Intake Note	TBD by vendor as text entry or diagnosis code. IF Intake Note, use example options that display on the Intake Note. Facilities may modify the list to include preferred elements and format.	IF "Hospital Admission History <30 Days" OR "Hospital Admission History 31-90 Days" contains a count, then display discharge diagnosis as text (use vendor format); else leave blank. IF multiple Hospital Admission dates: • IF multiple Hospital Admissions identified within the report period, then display the Hospital Discharge Diagnosis associated with the Hospital Admission nearest and prior to report date. IF multiple discharge diagnoses selected: • IF one discharge diagnosis selected, then display selection as text. • IF more than one discharge diagnosis selected, then display diagnosis indicated as "primary"; IF more than one indicated as "primary," then display first diagnosis on list as text. • IF more than one discharge diagnosis selected and none marked as "primary," then display first diagnosis on list as text. IF no discharge diagnosis selected, then leave blank.
10	LOS for Most Recent Hospital Stay, ≤90 Days	ADT or registration system	Compute.	IF hospital admission date AND hospital discharge dates are known, then compute length of stay as "hospital discharge date − hospital admission date" or use vendor rule to determine LOS. IF Intake Form/LOS field contains value, then display value entered, else leave blank, valid number input xxx.
11	High-Risk Diagnoses Associated With Transfer Risk			Diagnosis codes are suggestions. The vendor and facility will confirm diagnosis codes available in the EMR.
12	CHF	Vendor determined or Transfer Note	402.01-428.1; 428.20-428.9	IF ICD-9-CM diagnosis codes present then true and display X.
13	MI	Vendor determined or Transfer Note	410.0-410.92	IF ICD-9-CM diagnosis codes present then true and display X.
14	Angina	Vendor determined or Transfer Note	413.9	IF ICD-9-CM diagnosis codes present then true and display X.
15	Pneumonia or Bronchitis	Vendor determined or Transfer Note	466; 481-482.9; 483.0-486; 490;491	IF ICD-9-CM diagnosis codes present, then true and display X.
16	Asthma or COPD	Vendor determined or Transfer Note	491.0-491.9; 492.0-492.8; 493.00-493.92; 496; 518.81-518.84	IF ICD-9-CM diagnosis codes present, then true and display X.

	Column Header	Data Source	Valid Input	Rule/Display
17	UTI	Vendor determined or Transfer Note	599.0	IF ICD-9-CM diagnosis codes present, then true and display X.
18	Sepsis or Fever or Infection	Vendor determined or Transfer Note	002.1-002.9; 003.1-003.9; 004.0-004.0; 006.1-006.9; 007.1; 008.00-008.8; 009.0-009.3; 020.0-020.9; 021.1-021.9; 022.0-022.9; 023.0-023.9; 024; 025; 026.0-026.9; 027.0-0.27.9; 038.0-038.9	IF ICD-9-CM diagnosis codes present, then true and display X.
19	Dehydration	Vendor determined or Transfer Note	E904.2, 276.51, 643.1, 775.5, 778.4, 783.9	IF any ICD-9-CM diagnosis codes present, then true and display X.
20	Circulatory Problems	Vendor determined or Transfer Note	451-459	IF any ICD-9-CM diagnosis codes present, then true and display X.
21	Renal Failure	Vendor determined or Transfer Note	581.0-581.9; 585.6	IF ICD-9-CM diagnosis codes present, then true and display X.
22	Diabetes	Vendor determined or Transfer Note	250.00-250.93; 357.2; 362.0; 366.41; 648.00-648.04	IF ICD-9-CM diagnosis codes present, then true and display X.
23	Anemia	Vendor determined or Transfer Note	280.0-280.9; 281.1-281.9; 283.9; 284.9; 285.0-285.1; , , 285.21-285.29; 648.20-648.24; 776.5	IF ICD-9-CM diagnosis codes present, then true and display X.
24	Gastroenteritis	Vendor determined or Transfer Note	003.0, 005.9, 008.66, 008.69, 008.8, 009.0, 009.3, 487.8, 488.09, 488.19, 556.9, 558.1-9, 988, 995.7	IF ICD-9-CM diagnosis codes present, then true and display X.
25	Current Clinical Conditions Contributing to Transfer Risk			
26	Oxygen Therapy	Vendor determined or physician order	Use vendor inputs.	IF physician order for oxygen therapy during report week is true within 7 days, then Oxygen Therapy is true and display X; this includes PRN order.
27	Presence of Catheter or Ostomy	Vendor determined or physician order	Use vendor inputs.	IF physician order for Foley catheter OR suprapubic catheter OR ostomy is true within 7 days, then Catheter or Ostomy Present is true and display X.
28	Stage II or > Pressure Ulcer	Vendor determined or Wound Assessment	Pressure ulcer Stage II, III, IV, or unstageable.	IF wound assessment date ≤7 days of report date AND at least one pressure ulcer with ulcer stage = II, III, OR IV OR unstageable, then Stage II or > Pressure Ulcer is true and display X.
29	Fall Risk	On-Time Fall Risk indicator or facility-defined source	Use vendor inputs.	IF fall date within 7 days of report date, then Fall Risk is true and display X.

	Column Header	Data Source	Valid Input	Rule/Display
30	ADL Late Loss	MDS	G0110 1A (Bed Mobility/Self-Performance) G0110 1B (Transfer/Self-Performance) G0110 1H (Eating/Self-Performance) G0110 1I (Toilet Use/Self-Performance)	Use the same computation used for MDS score. Compute Late-Loss ADL Score IF all four components contain values. Late Loss Score = G0110 1A + G0110 1B + G0110 1H + G0110 1I IF Late-Loss ADL Score ≥12 is true within 7 days of report date, then Late-Loss ADL is true and display X.
31	Cognitive Impairment	MDS	MDS C0500 = 0, 1, 2, 3, 4, 5, 6, or 7	IF C0500 has a value 0–7, then display X. IF C0500 does not have a value, then use the following rule in row 32:
32		MDS	OR B0700 = 1, 2, or 3 C0700 = 1 C1000 = 1, 2, or 3	B0700 = 1, 2, or 3 OR C0700 = 1 OR C1000 = 1, 2, or 3, then display X.

33	Medical Conditions	ADT or Registration System	Cellulitis
			681 or 682
				• Count the number of medical conditions present and display sum.
				• Valid diagnosis codes are provided for each of the conditions included:
				  • Cellulitis
				  • Hypertension
				  • Deep vein thrombosis
				  • Moderate dementia
				  • Peripheral neuropathies
				  • Quadriplegia
				  • Paraplegia
				  • Hemiparesis
				• IF any valid diagnosis code for the medical conditions (1-8) is present OR considered active within 7 days and prior to report date, that medical condition is true and count +1.
				IF codes 681 and 682 are present, then Cellulitis is true and count +1;

34		ADT or Registration System	Hypertension 401.0, 401.1, or 401.9	IF codes 401.0, 401.1, OR 401.9 are present, then Hypertension is true and count +1.
35		ADT or Registration System	Deep Vein Thrombosis (DVT) 453.40	IF 453.40 is present, then DVT is true and count +1.
36		ADT or Registration System	Moderate Dementia 290.0	IF code 290.0 is present, then Moderate Dementia is true and count +1.
37		ADT or Registration System	Peripheral Neuropathies 356.0 or 356.9	IF code 356.0 OR 356.9 is present, then Peripheral Neuropathies is true and count +1.
38		ADT or Registration System	Quadriplegia 344.0	IF code 344.0 is present, then Quadraplegia is true and count +1.
39		ADT or Registration System	Paraplegia 334.1	IF code 334.1 is present, then Paraplegia is true and count +1.

	Column Header	Data Source	Valid Input	Rule/Display
40		ADT or Registration System	Hemiparesis 342.9 or 438.2	IF code 342.9 OR 438.2 is present, then Hemiparesis is true and count +1.
41	High-Risk Medications	MAR	• Insulin • Anticoagulants • Antibiotics (used as a marker for infection and risk for *C. difficile*) • Alpha blockers • Antipsychotics • Antianxiety drugs • Sedative-hypnotics • Anticonvulsants • Antihypertensives • Opioids • Diuretics	Work with facility vendor to learn how the software classifies medications and flags medications as active. IF any high-risk medications are active within ≤7 days of report date, then High-Risk Medications is true and display X.
42	Polypharmacy			
43	Medication Total ≥15	MAR	Active medications	Count active medications. IF medication count ≥15, then Medication Total ≥15 is true and display X. Include over-the-counter medications; exclude PRN medications.
44	High-Risk Change in Condition (based on nurse assessment data within 7 days of report date)	Vendor determined (e.g.. nurse documentation, physician orders, or vital signs)	See separate table below.	See Table 3 below, High-Risk Change in Condition Elements. The sum of risk elements related to condition occurring in last 7 days is shown.

3.1.5 Valid Input and Displays for High-Risk Change in Condition Elements

High-risk change in condition (HRCC) elements are captured from multiple data sources within the facility's electronic medical record and represent changes in a resident's clinical condition within 7 days of the report date.

The six HRCC categories are:

- CHF or chest pain or MI.
- Pneumonia or Bronchitis.
- Mental Status Change or Neurological Symptoms.
- Urinary Tract Infection.
- Sepsis, Fever, or Infection.
- Dehydration.

Rules for HRCC elements are:

- Elements are symptoms and treatments that suggest recent changes (last week) in HRCCs.
- Each HRCC row element may be linked to one or more HRCCs (see table below.).

- Each HRCC element = 1 point for each HRCC to which it is linked. For example, nausea (Row 16) would contribute 1 point to CHF or Chest Pain or MI AND 1 point to Dehydration.
- For each high or moderate risk resident, HRCC elements are counted for each HRCC and the sum total displays under each HRCC in Transfer Risk Reports.

Table 3. High-Risk Change in Condition Elements

	Documentation Element	CHF or Chest Pain or MI	Pneumonia or Bronchitis	Mental Status Change or Neurological Symptoms	Urinary Tract Infection	Sepsis or Fever or Infection	Dehydration
1	Cardiopulmonary						
2	Shortness of breath (SOB): Unrelieved or new SOB at rest; unable to lie flat	1					
3	SOB: Labored breathing		1				
4	Wheezing and chest tightness at rest	1					
5	Inability to sleep without sitting up	1					
6	Chest pain: new or unrelieved	1					
7	Chest pain: with inspiration or coughing		1				
8	Cough: new or worsening cough	1	1				
9	Sputum production: new or increased		1				
10	Dizzy/lightheaded upon standing	1					
11	Edema: worsening edema lower extremities or worsening edema generalized	1					
12	Fatigue: easily fatigued/weakness	1					
13	Difficulty swallowing						1
14	Gastrointestinal						
15	Diarrhea (recurrent for last 24 hours)						1
16	Nausea or vomiting (recurrent for last 24 hours)	1					1
17	Genitourinary						
18	Abdominal pain: lower				1		
19	Hematuria				1		
20	Incontinence: new or worsened				1		
21	Urination: painful or burning or increased urgency/ frequency				1		
22	Infection						
23	IV fluids given					1	1
24	Blood cultures obtained					1	
25	Mental or Behavior						
26	Agitation: new or worsened			1			
27	Anxiety: new or worsened	1		1			

	Documentation Element	CHF or Chest Pain or MI	Pneumonia or Bronchitis	Mental Status Change or Neurological Symptoms	Urinary Tract Infection	Sepsis or Fever or Infection	Dehydration
28	Confusion or disorientation: new or worsened			1			
29	Depressive symptoms: new or worsened	1		1			
30	Inattention or lack of focus or withdrawn or distracted or not attending activities			1			
31	Nutrition						
32	Appetite: poor or loss of appetite	1	1	1	1		1
33	Decreased oral intake over the last 24 hours		1	1	1		1
34	Diuretic use						1
35	Vital Signs						
36	Orthostatic hypotension						1
37	Weight loss 5% ≤30 days; 10% ≤180 days						1
38	Weight gain of >5 lb in 3 days	1					
39	Fever: temp >102° F	1	1	1		1	1
40	Fever: temp >100° F		1		1	1	
41	Fever: two or more temps >99° F					1	
42	Fever: increase in temp >2° above baseline				1	1	

3.1.6. Determining Transfer Risk

3.1.6.1. Components of Transfer Risk Rules

Table 4. Criteria Used To Determine Transfer Risk

1	ED Visit History	The resident has ED visit within 90 days of report date.
2	Hospital Admission History	The resident has hospitalization within 90 days of report date.
3	Active High-Risk Diagnoses	Certain medical diagnoses are associated with avoidable transfers and contribute to transfer risk, such as congestive heart failure (CHF).
4	Current Clinical Conditions Contributing to Risk	Certain medical conditions and treatments are associated with avoidable transfers and contribute to transfer risk, such as fall risk and pressure ulcer.
5	Polypharmacy	Residents receiving 15 or more medications are associated with higher risk for transfer to the hospital.
6	High-Risk Change in Condition Within 7 Days	Certain clinical conditions or symptoms present within 7 days of report date that are associated with any HRCC condition.

3.1.6.2. High Transfer Risk Rules

The resident is at high risk for transfer to the hospital or ED if *any of three conditions is true*:

- Prior ED visit or hospitalization within 90 days of report date AND at least one additional high-risk factor from one of the following (Table 5, Rows 1-4):
    - Active High-Risk Diagnoses
    - Current Clinical Conditions Contributing to Risk
    - Polypharmacy: ≥15 Medications
    - High-Risk Change in Condition Within 7 Days
- A minimum of 4 diagnoses or conditions from Active High-Risk Diagnoses OR Current Clinical Conditions Contributing to Risk combined AND Polypharmacy (Table 5, Row 5). For example:
    - CHF+UTI+Dehydration+Anemia+Polypharmacy (4 Active High-Risk Diagnoses+Polypharmacy)
    - CHF+UTI+Renal Failure+StageII or > Pressure Ulcer+Polypharmacy (3 active High-Risk Diagnoses+1 Clinical Condition+Polypharmacy)
    - UTI+Oxygen Therapy+Catheter+Medical Conditions+Polypharmacy (1 active High-Risk Diagnosis+ 3 Clinical Conditions+Polypharmacy)
- At least one Active High-Risk Diagnosis AND at least one High-Risk Change in Condition Within 7 Days of report date (Table 5, Row 6).

Table 5. Rules for High and Medium Transfer Risk

	Risk Factors					Risk Level		
	1. ED Visit History or 2. Hospital Admission History Within 90 Days	**3. Active High-Risk Diagnoses**	**4. Current Clinical Conditions Contributing to Risk**	**5. Polypharmacy: ≥15 Medications**	**6. High-Risk Change in Condition Within 7 Days**	**High Risk**	**Medium Risk**	**No Risk**
1	X	X				X		
2	X		X			X		
3	X			X		X		
4	X				X	X		
5		(At least 4 elements in these 2 categories)		X		X		
6		X			X	X		
7	X						X	
8			X				X	
9				X			X	
10					X		X	
11		X						X

3.1.7. Report Sort

3.1.7.1. High Transfer Risk (put the HRCCs first)

1. ED Visit or Hospital Admission History + High-Risk Change in Condition Within 7 Days (Table 5, Row 4) THEN
2. Active High-Risk Diagnosis + High-Risk Change in Condition Within 7 Days (Table 5, Row 6) THEN
3. Resident age oldest to youngest in descending age order

3.1.7.2. Medium Transfer Risk

1. High-Risk Change in Condition Within 7 Days (Table 5, Row 10) THEN
2. Resident age oldest to youngest in descending age order

3.2. ED Treat and Release Report by Unit

3.2.1. Report Description

The ED Treat and Release Report is a monthly report that displays a list of residents who were transferred to the ED for treatment and returned to the nursing homewithout a hospitalization. Any resident with an ED visit date within 30 days of the report date displays on this report.

3.2.2. Dependencies and Clinical Assumptions

- The EMR captures and stores ED visit dates for each resident transfer.
- The resident must have an ED visit date within ≤30 days of report date to display on this report.
- Each row on the report represents a unique transfer for a single resident.
- A single resident may have multiple transfers in one month; multiple transfers for the same resident are grouped together on the report.
- A Transfer Note is completed for each transfer from the facility to the ED or hospital.
    - Although a Transfer Note is not required, the elements need to be available in the EMR. The Transfer Note can be added to the system as designed or elements may be added to an existing Transfer Note or other documentation; the vendor determines where report elements may be incorporated into the software.
- The user selects the report month to view or print.
- ED discharge diagnoses are stored in the registration system and captured upon resident return to the nursing home. The vendor displays diagnosis text, if possible, versus a diagnosis code.

3.2.3. Report Example: ED Treat and Release Report by Unit

Facility Name:
Month:

	Average Daily Census	30	**Total Transfers (Obs, ED)**	11
	Resident Days (including bed holds)	300	**Total Residents (Obs, ED)**	10

	ED Visit		Reason for Transfer													Reason for Transfer: Treatment Unavailable at Facility				Authorized by:					Nursing Home Treatments 24 Hours Prior to Transfer									Seen by (Within 24 Hours Prior to Transfer):						Prior ED Visit		Prior Hospital Discharge	
Resident	ED Visit Date	ED Discharge Diagnosis	Cardiac/Circulatory Symptoms	Respiratory Symptoms	Mental/Psychiatric/Neurological Symptoms	Gastrointestinal/Genitourinary Symptoms	Endocrine/Metabolic/Nutrition Issues	Wound or Skin Issues	Injury: Fall Related	Injury: Not Fall Related	Musculoskeletal Symptoms	Abnormal Labs or Anemia	Fever/Possible Infection	Malaise/Fatigue	Possible Surgical Complication	Diagnostics: Radiology, Imaging	IV Access: PICC, Central, Periph; Meds or Fluids	Transfusion	Catheter Insertion/ Reinsertion	Primary Care Physician	Covering Provider	Medical Director	Medicare Managed Care Organization	Outside Clinic or Service	Labwork Obtained	X Rays Obtained	IV Fluids/Subcutaneous Fluids	Oxygen	Respiratory Treatment	Respiratory Suctioning	Medications: IV, Intramuscular, or SQ	Medications: Oral	Primary Care Physician	Covering Provider	Consulting Physician	Nurse Practitioner or Physician's Assistant	Respiratory Therapist	Other	0-3 Days	4-30 Days	0-7 Days	8-30 Days
Resident A	11/11/2013	Angina	X																	X								X				X	X									
Resident B	11/20/2013	UTI			X															X											X				X					1		
Resident C	11/15/2013	Anemia										X		X				X			X				X										X							1
Resident D	11/13/2013	COPD		X									X									X						X	X										1		
Resident G	11/2/2013	Gastro-enteritis				X	X					X									X				X			X					X									
Resident G	11/11/2013	Fracture							X												X																		1			
Resident J	11/20/2013	G tube replacement				X													X		X																		1			
Resident P	11/10/2013	Dehydration				X	X					X		X						X					X	X													3		1
Resident R	11/1/2013	Pneumonia		X								X	X				X			X					X	X		X	X			X				X					
Resident T	11/30/2013	Asthma		X									X										X					X	X				X						1		1
Resident Y	11/30/2013	Laceration								X										X																					
Total reasons		21	1	3	1	3	2	0	1	1	0	4	3	2	0																										
% Total reasons			5	14	5	14	10	0	5	5	0	19	14	10	0																										

3.2.4. Valid Input and Displays for ED Treat and Release Report

If elements are available electronically in the EMR system, use EMR as data source, else use the suggested data sources listed in the table below.

	Column Header	Source	Valid Input	Rule/Display
	ED Visit			
1	ED Visit Date	ADT or registration system	Admit date	

2	ED Discharge Diagnosis	ADT or registration System	Valid diagnosis code or text	Display text, IF possible, else display diagnosis code.
				• IF multiple discharge diagnoses are provided:
				  • IF more than one discharge diagnosis is available, display diagnosis indicated as "primary"; IF more than one indicated as "primary," then display first diagnosis on list as text.
				  • IF more than one discharge diagnosis selected AND none marked as "primary," then display first diagnosis on list as text.
				• IF no discharge diagnosis is available, then leave blank.

3	Reason for Transfer Out of the Facility			
4	Cardiac/ Circulatory	Transfer Note	• Anemia • Cardiac arrest • Chest pain/angina • Coagulation defects • Dizzy/lightheaded • Hypertension/uncontrolled hypertension • Hypotension • Rule out congestive heart failure • Rule out DVT • Cardiac arrest	IF any selected, then display X in Cardiac/Circulatory column.
5	Respiratory	Transfer Note	• Abnormalities of breathing • COPD • Cough or wheezing • Hypoxia • SOB • Rule out pneumonia	IF any selected, then display X in Respiratory column.
6	Mental/Psych/ Neurological	Transfer Note	• Change in mental status (agitation, anxiety, confusion) • Delirium • Dementia • Rule out cerebrovascular accident • Seizure/epilepsy/convulsion • Symptoms of decline in cognitive function and awareness • Psychiatric (psychosis, suicidal)	IF any selected, then display X in Mental/Psych/Neurological column.

	Column Header	Source	Valid Input	Rule/Display
7	Gastro-intestinal/ Genitourinary	Transfer Note	• Abdominal/pelvic pain • Diarrhea/gastroenteritis • Dysphagia • GI bleed • Hematuria • Nausea or vomiting • Renal failure • Rule out kidney or urinary tract infection	IF any selected, then display X in Gastrointestinal/Genitourinary column.
8	Endocrine/ Metabolic/ Nutrition	Transfer Note	• Dehydration • Malnutrition • Uncontrolled diabetes	IF any selected, then display X in Endocrine/Metabolic/Nutrition column.
9	Wound or Skin	Transfer Note	• Cellulitis • Edema • Infected wound or decubitus ulcer • Jaundice • Rash	IF any selected, then display X in Wound or Skin Column.
10	Injury: Fall Related	Transfer Note	• Major injury • Minor injury	IF either selected, then display X in Injury: Fall Related column.
11	Injury: Non-Fall Related	Transfer Note	• Major injury • Minor injury	IF either selected, then display X in Injury: Non-Fall Related column.
12	Musculo-skeletal	Transfer Note	• Joint pain/joint disorder • Weakness	IF any selected, then display X in Musculoskeletal column.
13	Abnormal Labs or Anemia	Transfer Note	• Abnormal lab results • Anemia	IF Other Changes in Condition = abnormal lab results or anemia, then display X in Abnormal Labs or Anemia column.
14	Fever/ Possible Infection	Transfer Note	Fever/possible infection	IF Other Changes in Condition = fever/possible infection, then display X in Fever/Possible Infection column.
15	Malaise/ Fatigue	Transfer Note	Malaise/fatigue	IF Other Changes in Condition = malaise/fatigue infection, then display X in Malaise/Fatigue column.
16	Possible Surgical Complication	Transfer Note	Potential surgical complication	IF Other Changes in Condition = possible surgical complication, then display X in Possible Surgical Complication column.
17	Treatment Unavailable at Transferring Facility	Transfer Note	• Diagnostics • IV access • Transfusion • Catheter insertion/reinsertion	IF any selected, then display X in appropriate column.
18	Authorized by	Transfer Note	• Resident's primary physician • Covering provider • Medical Director • Medicare managed care organization • Outside clinic or service	IF any selected, then display X in appropriate column.

	Column Header	Source	Valid Input	Rule/Display
19	Nursing Home Treatments 24 Hours Prior to Transfer	Transfer Note or Physician Orders	• Labwork obtained • X rays obtained • IV fluids • Subcutaneous fluids • Oxygen • Respiratory treatment • Respiratory suctioning • Medications: IV • Medications: IM or SQ • Medications: PO	IF any selected, then display X in appropriate column. IF using Physician Orders as input: • IF physician order date is within 24 hours and prior to the transfer date, then display X in the appropriate column. Valid orders types are linked to each column. The facility will identify specific orders or order types to use for each valid input item listed (e.g., lab orders). Use medication routes for medications: IV, IM or SQ, or PO.
20	Seen by (Within 24 Hours Prior to Transfer)	Transfer Note or system	• Primary physician • Covering provider • Consulting physician • Nurse practitioner or physician's assistant • Respiratory therapist • Other	IF any selected, then display X in appropriate column. IF using system as input: • IF "seen by date" for any valid input is within 24 hours and prior to transfer date, then display X in the appropriate column. Use input options that are available in the EMR system.
21	Prior ED Visits			
22	Within 3 Days	System computes	ED visit date	IF ED visit within 0-3 days and prior to transfer date, then display X.
23	Within 4-30 Days	System computes	ED visit date	IF ED visit date within 4-30 days and prior to transfer date, then display X.
24	Prior Hospital Discharge			
25	Within 7 Days	System computes	• Admit date to nursing home • Admit from = hospital	IF "admit from" = hospital AND nursing home admit date within 0-7 days and prior to report date, then display X.
26	Within 8-30 Days	System computes	• Admit date to nursing home • Admit from = hospital	IF "admit from" = hospital AND nursing home admit date within 8-30 days and prior to report date, then display X.

3.2.5. Transfer Note

The Transfer Note is one of several documents a nurse completes when a resident is transferred out of the facility. Elements of the Transfer Note populate the ED Treat and Release Report.

The vendor may incorporate the Transfer Note as designed or incorporate the required note elements into existing functionality or notes. For example, elements on the Transfer Note that are not already available in the EMR may be added to an existing Transfer Note in the EMR.

3.2.6. Transfer Note Example

An example of a Transfer Note follows. Elements that display on the note are described in Section 3.2.4 above.

Resident Name:	Transfer Date: Transfer Time:	Transfer to: ☐ Emergency Department ☐ Hospital

Reason for Transfer Out of Facility

Cardiac/Circulatory
- ☐ Anemia
- ☐ Cardiac arrest
- ☐ Coagulation defect
- ☐ Chest pain/angina
- ☐ Dizzy/lightheaded
- ☐ Hypertension/uncontrolled HTN
- ☐ Hypotension
- ☐ Rule out congestive heart failure
- ☐ Rule out DVT

Respiratory
- ☐ Abnormalities of breathing
- ☐ COPD
- ☐ Cough or wheezing
- ☐ Hypoxia
- ☐ Shortness of breath
- ☐ Rule out pneumonia

Mental Disorders/Neurological/Psych
- ☐ Change in mental status (e.g. agitation, anxiety, confusion)
- ☐ Delirium
- ☐ Depression
- ☐ Dementia
- ☐ Rule out CVA
- ☐ Seizure/epilepsy/convulsion
- ☐ Decline in cognitive function and awareness
- ☐ Psychiatric (psychosis, suicidal)

Gastrointestinal/Genitourinary
- ☐ Abdominal/pelvic pain
- ☐ Diarrhea/gastroenteritis
- ☐ Dysphagia
- ☐ GI bleed
- ☐ G tube
- ☐ Hematuria
- ☐ Nausea or vomiting
- ☐ Renal failure
- ☐ Rule out kidney or urinary tract infection

Endocrine/Nutritional/Metabolic
- ☐ Dehydration
- ☐ Malnutrition
- ☐ Uncontrolled diabetes

Wound or Skin
- ☐ Cellulitis
- ☐ Edema
- ☐ Infected wound or decubitus ulcer
- ☐ Jaundice
- ☐ Rash

Fall-Related Injury
- ☐ Major injury
- ☐ Minor injury

Non-Fall-Related Injury
- ☐ Major injury
- ☐ Minor injury

Musculoskeletal
- ☐ Joint pain/joint disorder
- ☐ Weakness

Other Changes in Condition, Not Specified Elsewhere:
- ☐ Abnormal lab results
- ☐ Failure to thrive
- ☐ Fever/possible infection
- ☐ Functional decline
- ☐ Malaise/fatigue
- ☐ Potential surgical complication
- ☐ Poor intake or nutritional decline
- ☐ Weight loss

Treatment Unavailable at Transferring Facility
- ☐ Diagnostics: radiology, imaging
- ☐ IV access/fluids
- ☐ Transfusion
- ☐ Catheter insertion/reinsertion

Treatments Prior to Transfer
- ☐ Labs
- ☐ X ray
- ☐ IV fluids
- ☐ Subcutaneous fluids
- ☐ NG tube
- ☐ Oxygen
- ☐ Respiratory treatment
- ☐ Respiratory suctioning
- ☐ Medication: IV
- ☐ Medications: IM or SQ
- ☐ Medications: PO

Seen by (Within 24 Hours of Transfer)
- ☐ Primary Physician
- ☐ Covering Provider
- ☐ Consulting Physician
- ☐ Nurse Practitioner or PA
- ☐ Respiratory Therapist
- ☐ Other
- ☐ Transfer requested by resident/family

Authorized by:
- ☐ Resident's Primary Physician/Name_____
- ☐ Other Provider/Name_____
- ☐ Medical Director/Name_____
- ☐ Medicare Managed Care Organization
- ☐ Outside Clinic or Service

3.3. Monthly Transfers by Nursing Unit Report

3.3.1 Report Description

The monthly report summarizes ED visits and hospitalizations and displays transfer reasons and hospital discharge diagnoses associated with each transfer.

3.3.2. Dependencies and Clinical Assumptions

- An Intake Note is completed for each return to the facility from the ED or the hospital.
- Transfer Note elements are completed for each transfer from the facility to the ED or hospital.
- If transfer and intake note elements are not being captured, the notes can be added to the system as designed or the vendor can determine where report elements may be incorporated into the software.

3.3.2.1. Transfer Note and Intake Note Linked

- The system must assign a unique transfer ID for each resident transfer. The purpose of the linkage is to display intake information only for residents previously transferred from the facility.
- If a unique transfer ID is not assigned, the system must provide an alternative mechanism to link facility transfers to subsequent returns (admissions or readmissions) to the facility.
- For each admission to the facility, the system checks for a transfer ID within 90 days of admission date. If found, the admission is treated as an admission associated with a prior transfer.
- Parameters must be set on transfer ID date and hospital admit date intervals (e.g., no greater than 90 days).

3.3.3. Report Example: Monthly Transfers by Nursing Unit

Average Daily Census		30														TOTAL Transfers (in/out, no returns)														16	
Resident Days (including bed holds)		900														Total Residents														15	
		Reason for Transfer														**Discharge Diagnosis: Potentially Avoidable**															
Transfers That Result in Observation Stays or ED Visits or Hospitalizations	Total Counts	Mental/Psychiatric/Neurological Symptoms	Cardiac/Circulatory Symptoms	Pneumonia/Respiratory Symptoms	Gastrointestinal/Genitourinary Symptoms	Endocrine/Nutritional/Metabolic Issues	Musculoskeletal/Joint Symptoms	Wound or Skin Issues	Fall-Related Injury	Non-Fall-Related Injury	Abnormal Labs	Fever/Possible Infection	Malaise/Fatigue	Potential Surgical Complications	Treatment Unavailable at Facility	Congestive Heart Failure	Pneumonia	Urinary Tract Infection	Sepsis or Fever or Infection	Skin Ulcers or Cellulitis	Dehydration or Metabolic Issues	Chronic Obstructive Pulmonary Disease	Asthma	Circulatory Problems	Hypertension	Gastroenteritis	Angina	Falls/Trauma	Anemia	Diabetes
Observation Stays	10%																													
# Observations	2				2													1								1				
# Residents	2				2													1								1				
ED Visits	43%																													
# ED Visits	9			2	1					1	3	1			1				1		3		2						1	1
% Total Transfers				22	11					11	33	11			11				11		33		22						11	11
# Residents	8			2	1					1	2	1			1				1		2		2						1	1
Top 5 (Rank Order)				2	3					3	1	3			3				3		1		2						3	3
Hospitalizations	14%																													
# Hospitalizations	3		2	1												2	1													
% Total Hospitalizations			67	33												67	33													
# Residents	3		2	1												2	1													
Top 5 (Rank Order)			1	2												1	2													
Transfers Out, No Return	10%																													
# Transfers	2		1								1																			
% Total Transfers			50								50																			
# Residents	2		1								1																			
Top 5 (Rank Order)			1								1																			
Transfers In/Out Prior Month	24%																													
# Transfers	5		2					3																						
% Total Transfers			40					60																						
# Residents	3		1					2																						
Top 5 (Rank Order)			2					1																						
Unit Totals																														
TOTAL Transfers (in/out, no returns)	21	0	5	3	3	0	0	3	0	1	4	1	0	0	1	2	1	1	1	0	3	0	2	0	0	1	0	0	1	1
Total Residents	18	0	4	3	3	0	0	2	0	1	3	1	0	0	1	2	1	1	1	0	2	0	2	0	0	1	0	0	1	1

3.3.4. Valid Input and Displays for Monthly Transfers

The table below describes the valid input and displays for information that displays in the Monthly Transfer Report in addition to standard header information, such as report title, report date, and nursing unit. The system is the data source for all elements and computes all information that displays. If visit type is not captured in the EMR registration system, the Intake Note elements can be used as the data source.

	Column Header	Rule/Display for Total Counts
1	Average Daily Census (ADC)	• Display average daily census. • IF a facility-level report is generated, compute ADC for entire facility; IF unit-level report is generated, use ADC for specified nursing unit.
2	Resident Days (including bed holds)	• Calculation: Average daily census x number of days in month. • IF a facility-level report is generated, compute ADC for entire facility; IF unit-level report is generated, use ADC for specified nursing unit. • Count resident flagged as bed hold as active resident.
3	TOTAL Transfers (in/out, no returns)	Count the number of Observation Stays and ED Visits and Hospital Admits within the report month and display count.
4	Total Residents	Count the number of unique residents with an Observation Stay or ED Visit or Hospital Admission during the report month and display count.
5	**Observation Stays**	• Transfer date must be within the report month AND intake type must be Observation Stay. • Count transfer reasons and discharge diagnoses associated with each Intake Type = Observation Stay.
6	# Observations	Count total Observation Stays and display count.
7	# Residents	Count the number of unique residents with observation visits and display count.
8	**ED Visits**	• Transfer date must be within the report month AND intake type must be ED Visit. • Count transfer reasons and discharge diagnoses associated with each Intake Type = ED Visit.
9	# ED Visits	Count total number Intake Type = ED Visit and display count.
10	# Residents	Count total number of unique residents with Intake Type = ED Visit and display count.
11	**Hospitalizations**	• Admit to Nursing Home admit date must be within report month AND Intake Type must be Hospital Admit. • Use Hospital Admit details only for residents linked to a facility transfer. Do not use data for all admissions. • Count transfer reasons and discharge diagnoses associated with each Intake Type = Hospital Admit.
12	# Hospital Visits	Count total number for Intake Type = Hospital Admit and when there is an associated Transfer ID, and display count.
13	# Residents	Count the total number of unique residents with Intake Type = Hospital Admit and when there is an associated Transfer ID, and display count.

3.3.5. Valid Input and Displays for Monthly Transfers: Reason for Transfer and Discharge Diagnosis

The table below describes valid input and displays for the Reason for Transfer and Discharge Diagnosis section of the report. The EMR registration system, Transfer Note, and Intake Note are the data sources for these sections of the report. Transfer categories and transfer reasons are described in Section 3.2.4 above.

	Rows	Rule/Display for Reason for Transfer and Discharge Diagnosis
1	Observation Stays	• Transfer date must be within the report month AND intake type must be Observation Stay. • Count transfer reasons and discharge diagnoses associated with each Intake Type = Observation Stay.
2	Observation Reasons and Discharge Diagnosis	For each Observation Stay: • Count the number of transfer reasons and display sum in appropriate transfer reason column. • Count the number of discharge diagnosis types and display sum in appropriate discharge column.
3	# Residents	• Count the number of unique residents associated with each transfer reason and display sum in the appropriate column. • Count the number of unique residents associated with each discharge diagnosis and display sum in the appropriate column.
5	Emergency Department Visits	• Transfer date must be within the report month AND intake type must be ED Visit. • Count transfer reasons and discharge diagnoses associated with each Intake Type = ED Visit.
6	ED Visits	For each ED Visit: • Count the number of transfer reasons and display sum in appropriate transfer reason column. • Count the number of discharge diagnosis types and display sum in appropriate discharge column.
7	# Residents	• Count the number of unique residents associated with each transfer reason and display sum in the appropriate column. • Count the number of unique residents associated with each discharge diagnosis and display sum in the appropriate column.
8	% Total Transfers	For each transfer reason and discharge diagnosis: • Numerator: transfer reason count or discharge diagnosis count • Denominator: total ED visits Display as x% or xx%, no leading zeros.
9	Top 5 (Rank Order)	• Display top 5 reason for transfer by percentage with 1 = highest percentage. • Display value 1, 2, 3, 4, and 5 for transfer reason and 1, 2, 3, 4, and 5 for discharge diagnosis.
10	Hospitalizations	• Nursing home admit date must be within the report month AND Intake Type must be Hospital Admit AND have an associated transfer ID. • Use Hospital Admit details only for residents linked to a facility transfer. Do not use data for all admissions. • Count transfer reasons and discharge diagnoses associated with each Intake Type = Hospital Admit.
11	Hospitalizations	For each Intake Type = Hospital Admit that is linked to a prior transfer from the facility: • Count the number of transfer reasons and display sum in appropriate transfer reason column. • Count the number of discharge diagnosis types and display sum in appropriate discharge column.
12	# Residents	• Count the number of unique residents associated with each transfer reason and display sum in the appropriate column. • Count the number of unique residents associated with each discharge diagnosis and display sum in the appropriate column.
13	% Total Hospitalizations	For each transfer reason and discharge diagnosis: • Numerator: transfer reason count or discharge diagnosis count • Denominator: total hospital admits Display as x% or xx%, no leading zeros.
14	Top 5 (Rank Order)	• Display top 5 reason for transfer by percentage with 1 = highest percentage. • Display value 1, 2, 3, 4, and 5 for transfer reason and 1, 2, 3, 4, and 5 for discharge diagnosis.
15	Unit Totals	• For each transfer reason display total sum. • For each discharge diagnosis display total sum.

3.3.6. Intake Note

An Intake Note is completed for each return to the nursing home from an observation stay in the ED, ED visit, and hospital stay. If the EMR system has another assessment or note that captures the same data elements, the Intake Note is not required. A sample Intake Note is provided below.

Intake Note Example

Resident Name:	Admit Date: Admit Time:	Admit to: ☐ Long-Term Care ☐ Subacute or Rehab
Intake Type: ☐ ED Visit ☐ Observation Stay ☐ Hospital Admit (Enter one of the following) ☐ Hospital Admission Date OR ☐ Hospital LOS	*If admitted from one of the following, do not complete this form:* ☐ Long-Term Care Facility ☐ Assisted Living ☐ Home	

Treatments Received in the ED/HOSP	**ED Discharge/Hospital Discharge Diagnoses: Primary & Secondary (***Indicate principal or secondary if more than one hospital discharge diagnosis.*)		
Catheter Insertion/Reinsertion ☐ Foley ☐ Ostomy ☐ PEG ☐ Suprapubic **Diagnostics** ☐ EKG ☐ CT scan ☐ Doppler studies ☐ MRI ☐ Ultrasound ☐ X rays ☐ Other **IV Access/Insertion and Fluids** ☐ PICC ☐ Central ☐ Peripheral ☐ IV fluids **Labs Obtained** ☐ Electrolytes ☐ Cardiac workup ☐ CBC ☐ Blood cultures ☐ Other **Medications** ☐ Oral ☐ IM or IV ☐ Subcutaneous ☐ Observation only **Respiratory** ☐ Oxygen therapy ☐ Respiratory treatment ☐ Suctioning ☐ Transfusion ☐ Other _____ **Surgical Procedure During Hospital Stay?** ☐ Abdominal ☐ Cardiac ☐ Hip fracture ☐ Other fracture ☐ Joint replacement ☐ Other major surgery, not listed above		**Principal**	**Secondary**
	Anemia	☐	☐
	Angina	☐	☐
	Asthma	☐	☐
	Atrial fibrillation	☐	☐
	Acute MI	☐	☐
	Cellulitis	☐	☐
	CHF	☐	☐
	Circulatory problems	☐	☐
	COPD	☐	☐
	CVA	☐	☐
	Dehydration	☐	☐
	Dementia	☐	☐
	Depression	☐	☐
	Diabetes	☐	☐
	Dysrhythmias	☐	☐
	Electrolyte imbalance	☐	☐
	Fever	☐	☐
	Fall - injury	☐	☐
	Gastroenteritis	☐	☐
	Genitourinary problems	☐	☐
	GI bleed	☐	☐
	Hypotension	☐	☐
	Hypertension	☐	☐
	Hypoglycemia	☐	☐
	Hyperglycemia	☐	☐
	Kidney infection	☐	☐
	Medication reaction	☐	☐
	Mental status change	☐	☐
	Mental disorder/psychosis	☐	☐
	Neoplasm	☐	☐
	Pneumonia	☐	☐
	Pressure ulcer	☐	☐
	Peripheral vascular disease	☐	☐
	Respiratory, other nonpneumonia	☐	☐
	Renal disease	☐	☐
	Seizure	☐	☐
	Sepsis/urosepsis	☐	☐
	Surgical complications or infection	☐	☐
	Syncope	☐	☐
	Urinary tract infection	☐	☐
	Other _____	☐	☐

3.4 Monthly Transfers by Provider

3.4.1. Report Description

The report displays the number of observation stays, ED treat and release visits, hospitalizations, and total transfers for each of the facility's providers. Each transfer is counted once.

3.4.2. Dependencies and Clinical Assumptions

- The name or role of the "authorizing provider" is recorded when the resident is transferred.
- The EMR system stores transfer details: Hospital and ED Visit dates and authorizing provider.
- The system tracks resident transfers that result in hospitalizations.

3.4.3. Report Example: Monthly Transfers by Provider

Primary Care Provider	Authorizing Provider	ED Visits	Observation Stays	Hospitalizations	Total Transfers
Brown, B.	Primary care physician	2	0	1	3
Brown, B.	Covering provider	4	1	0	5
Total					8
White, W.	Primary care physician	2	1	1	4
Total					5
Franklin, B	Primary care physician	2	1	1	4
Franklin, B	Medical director	1	0	0	1
Franklin, B	Managed care case manager	1	0	0	1
Total					6

3.4.4. Valid Input and Displays for Monthly Transfers by Provider

Only providers having at least one observation stay, ED visit, or hospital admit (associated with a prior transfer) display on this report.

	Column Header	Source	Rule/Display for Reason for Transfer
1	Primary Care Provider	Valid Primary Care Provider	• Display Last Name, First name or first initial. • Note: PCP display is defined by the vendor or facility.
2	Authorizing Provider	Transfer Note:	Display selection on Transfer Note for type of authorizing provider, for example, or provide name: • Resident's Primary Physician • Nurse practitioner • Covering Provider • Medical Director • Medicare Managed Care Organization • Outside Clinic or Service
3	Observation Stays	System or Intake Note	For each provider having transfers within the report month: • Count the number of Observation Stays and display count.
4	ED Visits	System or Intake Note	For each provider having transfers within the report month: • Count the number of ED Visits and display count.
5	Hospitalizations	System or Intake Note	For each provider having transfers within the report month: • Count the number of Hospital Admits associated with a prior transfer and display count.
6	Total Transfers	Compute	For each provider: • Total Observation Stay count + ED Visit count + Hospital Admit count and display sum.

3.5 Key Metrics Trended Report

3.5.1. Report Description

This report summarizes and shows the monthly trends for key metrics related to rates of transfer to the ED and hospital. Key rates are calculated each month and trended over time.

3.5.2. Dependencies and Clinical Assumptions

- Monthly census and resident days are computed by the EMR for a single nursing unit or for a facility, depending on the type of report generated (unit level or facility level).
- All report data are generated from transfer and intake notes.

3.5.3. Report Example: Key Metrics Trended Report by Unit or Facility

Unit Name: A100	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Monthly Census (ADC)	30	28	35	35	31	30	30	23	24	27	32	30
Resident Days (Including Bed Hold)	900	840	1,050	1,050	930	900	900	690	720	810	960	900
Total Transfers From Nursing Home to ED or Hospital	24	14	14	14	16	25	11	11	12	11	3	15
Total Residents Transferred From Nursing Home to ED or Hospital	19	10	14	9	20	14	14	10	10	10	3	17
Observation Stays												
# Observation Stays	2	3	1	0	3	5	5	2	1	0	0	3
Observation Stay Rate: # Observation Stays/1,000 Resident Days	2.2	3.6	1.0	0.0	3.2	5.6	5.6	2.9	1.4	0.0	0.0	3.3
# Residents in Observation Stays	2	3	1	0	1	3	4	2	1	0	0	2
Residents in Observation Stays/Monthly Census (ADC) (%)	7%	11%	3%	0%	3%	10%	13%	9%	4%	0%	0%	7%
ED Visits (Treat and Return to Nursing Home)												
# ED Visits	10	8	3	10	11	5	3	4	3	5	0	10
ED Visit Rate: # ED Visits/1,000 Resident Days	11.1	9.5	2.9	9.5	11.8	5.6	3.3	5.8	4.2	6.2	0.0	11.1
# Residents to ED	9	4	3	8	10	3	2	3	2	3	0	10
Residents to ED/Monthly Census (ADC) (%)	30%	14%	9%	23%	32%	10%	7%	13%	8%	11%	0%	33%
# Residents With >1 ED Visit in Last 30 Days	1	1	1	1	1	1	1	1	1	1	1	1
Hospital Visits												
# Hospital Visits of Nursing Home Residents	12	3	10	4	2	15	3	5	8	6	3	2
# Hospital Visits With Preventable Discharge Diagnosis	4	0	8	4	2	1	1	1	3	4	2	1
Hospital Visits With Preventable Discharge Diagnosis/Total Hospital Visits (%)	33%	0%	80%	100%	100%	7%	33%	20%	38%	67%	67%	50%
Hospitalization Rate: # Hospitalizations/1,000 Resident Days	13.3	3.6	9.5	3.8	2.2	16.7	3.3	7.2	11.1	7.4	3.1	2.2
# Residents Readmitted to Nursing Home From Hospital	8	3	10	1	9	8	8	5	7	7	3	5
Residents Hospitalized/Monthly Census (ADC) (%)	27%	11%	29%	3%	29%	27%	27%	22%	29%	26%	9%	17%

Unit Name: A100	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Hospital Readmissions (All Cause)												
# Residents Hospitalized With Previous Hospitalization in Last 3 Days	1	1	3	0	3	0	0	0	0	1	0	0
# Residents Hospitalized With Previous Hospitalization in Last 7 Days	1	1	3	0	4	0	0	0	3	1	0	0
# Residents Hospitalized With Previous Hospitalization in Last 30 Days	3	1	5	0	4	0	2	1	4	1	0	0
# Residents Hospitalized With Previous Hospitalization in Last 90 Days	4	1	5	0	4	0	2	1	7	3	0	0
# Residents Hospitalized With Previous Hospitalization in Last 180 Days	5	1	6	1	5	0	5	1	7	5	0	0

Note: An example unit-level report is shown; the report can display facility- or unit-level data.