Quality Improvement Toolkit for Emergency Department Transfer Communication Measures

Stratis Health, based in Bloomington, Minnesota, is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

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The electronic version of this document contains clickable links to online tools and resources, and is available for download on the Stratis Health website at:

http://www.stratishealth.org/documents/ED_Transfer_QI_Toolkit_Communication_Measures.pdf

Section 1: Recommendations and Principles of Care Transitions from the Emergency Department

The importance of communication has been recognized as a key factor in safe and efficient patient transfers and several leading organizations have highlighted recommendations and principles specific to emergency department situations.

1.1 Care Transitions and the Emergency Department: Overview

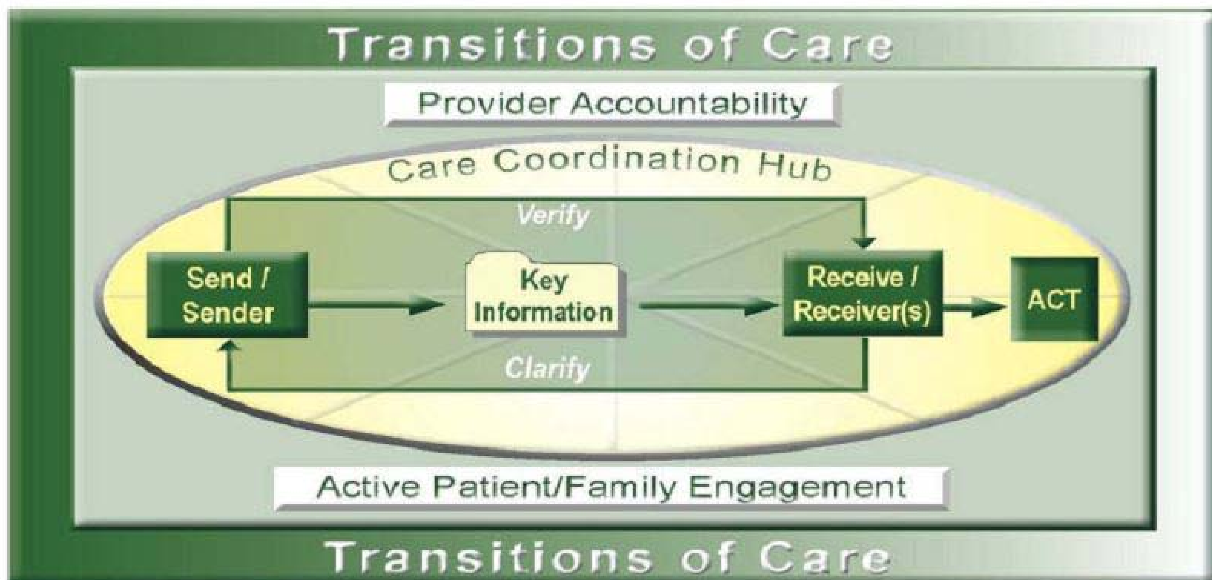
"The single biggest problem with communications is the illusion that it has taken place."
- George Bernard Shaw

As health care has become more specialized, with greater numbers of clinicians in different care settings involved in patient care, patients are likely to encounter more handoffs than in years past. Clinical environments are dynamic and complex, presenting many challenges for effective communication among health care providers, patients, and families.

Transfers from the emergency department often result in a series of handoffs between emergency medical services (ground and/or air transport) other hospital emergency departments and a receiving facility. Many of the health care providers and staff engaged in these transfers are unfamiliar with the settings and the care delivery details where they are sending patients and may not provide adequate communication to support effective care. Ineffective and inefficient transitions can lead to poor outcomes such as: delays in diagnosis, medication errors, adverse events, inappropriate or unnecessary treatments, patient complaints, increased lengths of stay, and/or increased costs.

The conceptual model for Transitions of Care (Figure 1 below) was developed by the National Transitions of Care Coalition to help provide context for the importance of accurate and timely transfer of information from emergency room providers and the next setting of care.

Figure 1 - Conceptual Model for Transitions of Care



Source: Improving Transitions of Care: Hospital to Home, National Transitions of Care Coalition, October 2009, page 25.

1.2 American College of Emergency Physicians Care Transition Task Force Recomendations:

To better support effective transfers from the emergency department the American College of Emergency Physicians outlined several recommendations in a 2012 report on improving care coordination. The following recommendations are relevant to the Emergency Department Transfer Communication Measure Set:

- Enhance and promote training and education for all emergency department personnel regarding the importance of transitions of care and how to implement effective policies and procedures.
- Assess provider performance, with appropriate feedback, and provide training in communication skills as necessary.
- Work with emergency department information system vendors to produce transition support tools and identify the components of a minimum data set for all transitions.

Full Report: ACEP Transitions of Care Task Force Report, 2012

1.3 Safe Transfers and Hand-offs: Emergency Department Principles

The American College of Emergency Physicians (ACEP), Emergency Nurses Association (ENA), National Association of EMS Physicians (NAEMSP), National Association of Emergency Medical Technicians (NAEMT), and National Association of State EMS Officials (NASEMSO) have developed a series of principles to ensure safe transfers and hand-offs from hospital to hospital and from EMS to the hospital. When thinking about making improvement to your emergency department transfer processes, consider these principles:

Principles for Interhospital Transfers[1]

- The optimal health and well-being of the patient should be the principal goal of patient transfer.
- Emergency physicians and hospital personnel should abide by applicable laws regarding patient transfer. All patients should be provided a medical screening examination (MSE) and stabilizing treatment within the capacity of the facility before transfer. If a competent patient requests transfer before the completion of the MSE and stabilizing treatment, these should be offered to the patient and documented. Hospital policies and procedures should articulate these obligations and ensure safe and efficient transfer.
- The transferring physician should inform the patient or responsible party of the risks and the benefits of transfer and document these. Before transfer, patient consent should be obtained and documented whenever possible.
- The hospital policies and procedures and/or medical staff bylaws should identify the individuals responsible for and qualified to perform MSEs. The policies and procedures or bylaws must define who is responsible for accepting and transferring patients on

[1] Appropriate Interhospital Patient Transfer, ACEP, retrieved January 11, 2014, http://www.acep.org/content.aspx?id=29114.

behalf of the hospital. The examining physician at the transferring hospital will use his or her best judgment regarding the condition of the patient when determining the timing of transfer, mode of transportation, level of care provided during transfer, and the destination of the patient.

- Transfers are effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.
- Agreement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of transfer. When a patient requires a higher level of care other than that provided or available at the transferring facility, a hospital with the capability and capacity to provide a higher level of care may not refuse any request for transfer.
- An appropriate medical summary and other pertinent records should accompany the patient to the receiving facility or be electronically transferred as soon as is practical.
- When transfer of patients is part of a regional plan to provide optimal care at a specialized medical facility, written transfer protocols and interfacility agreements should be in place.

Notes: To ensure optimal patient care, nonhospital satellite medical facilities should abide by transfer standards much the same as those outlined above. Laws and regulations relevant to the Emergency Medical Treatment and Labor Act[1] (EMTALA) exist in many states. Physicians who participate in patient transfer decisions should be aware of applicable state-specific transfer laws and regulations.

[1]The Emergency Medical Treatment and Active Labor Act, as established under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 USC 1395 dd) and 42 CFR 489.24; 42 CFR 489.20 (EMTALA regulations).

Principles for Hand-offs Between EMS and Receiving Facilities[2]

- In addition to a verbal report from EMS providers, minimum key information required for patient care must be provided in written or electronic form at the time of transfer of patient care. This ensures that physicians and other health care providers who deliver subsequent care for the patient receive more accurate information and avoid potential errors inherent with second-hand information. The minimum key information reported at the time of hand-off must include information that is required for optimal care of the patient – examples include vital signs, treatment interventions, and the time of symptom onset for time-sensitive illnesses.
- All members of the health care team, including EMS providers, nurses, and physicians, must communicate with mutual respect for each other and respect the verbal and written communication from EMS as an important part of the patient's history. During the transfer of patient care, the receiving health care providers should have an opportunity to ask questions to clarify information that is exchanged.

[2] Transfer of Patient Care Between EMS Providers and Receiving Facilities, ACEP, retrieved January 11, 2014, http://www.acep.org/Clinical---Practice-Management/Transfer-of-Patient-Care-Between-EMS-Providers-and-Receiving-Facilities/.

- Health care facilities should attempt to receive patient care transfer reports in a timely manner, facilitating the return of EMS units to service.
- EMS transfer of care documentation should be treated as part of the health care record and must be professional, accurate, and consistent with information included in the final complete electronic or written EMS patient care report. Hospital systems should preserve written transfer of care documentation in the patient's permanent medical record.
- Copies of all results of medical tests performed by EMS providers (eg 12-lead ECGs, results of blood chemistry testing, any medical imaging, etc) must be available to the receiving facility with the EMS transfer-of-care documentation.
- Developers of electronic EMS patient care reports and health information exchanges should develop products that efficiently provide real-time digital transfer and preservation of the transfer-of-care documentation into the patient medical record.
- In addition to the information exchanged contemporaneously at the time of transfer of patient care, the complete EMS patient care report must be available to the receiving facility within a clinically relevant period of time.

Section 2: Developing and Implementing an Action Plan

2.1 Quality Improvement Basics

"Quality improvement (QI) consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups. The Institute of Medicine (IOM) which is a recognized leader and advisor on improving the Nation's health care, defines quality in health care as a direct correlation between the level of improved health services and the desired health outcomes of individuals and populations."[3]

> **"A goal without a plan is just a wish."**
> - ***Antoine de Saint-Exupery***

The IOM outlines six Aims for Improvement for health care:

- Safe - avoiding injuries to patients
- Timely - reducing waits for both recipients and providers of care
- Effective - providing care based on scientific knowledge
- Efficient - avoiding waste
- Equitable - ensuring that the quality of care does not vary because of characteristics such as gender, ethnicity, socio-economic status, or geographic location
- Patient-centered - is providing respectful and responsive care that ensures the patient values guide clinical decisions.[4]

[3] Health Resources and Services Administration, http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/index.html.
[4] Crossing the Quality Chasm, Institute of Medicine.

The foundations of QI are customer focused, process oriented and data driven. There are many models used to identify and address quality improvement needs. One common example is the Plan-Do-Study-Act (PDSA) model for improvement.[5] In essence, it asks, what are we trying to accomplish? How will we know that a change is an improvement? What change can we make that will result in an improvement? Each of these is outlined in the table below. The model uses the following approach: 1) encourages learning by testing change on a small scale, 2) eliminates studying the problem endlessly, 3) minimizes data collection/overload, 4) works well with small numbers, and 5) uses three questions as its framework. PDSA is a perpetual cycle for continuous improvement.

PDSA Cycle

Plan	Do	Study	Act
What are we trying to accomplish? • Aim: How will we know that a change is an improvement? • Measures: What changes can we make to achieve our goal? • Strategies	Implement Solutions • Rapid cycle PDSA	Study the results • Display data (graphical or tables) • Trend data over time • Describe what the data mean	Standardize the solution • Make system/process changes Plan for the future • Next steps?

[5] William Nolan, Institute for Healthcare Improvement.

A wide variety of QI education and resources are available online. A sampling is listed below:

Health Resources and Services Administration QI Guide: Includes six modules outlining steps of a quality improvement initiative.

New Performance Improvement Coordinator Education, Montana Rural Healthcare Performance Improvement Network. Specific for CAHs, designed to provide new quality professionals with basic education about quality management and the tools used in implementing an effective, organization-wide quality program

Stratis Health Quality Improvement Basics Webinar Series. Stratis Health produced a series of recorded Webinars on the basics of quality improvement. These sessions allow provider organizations to hone a specific quality improvement skill set, orient new staff, or offer in-service workshops for teams.

2.2 Establishing an ED Transfer Improvement Team

Quality improvement requires the involvement of multiple stakeholders. This is no different when working to improve emergency department transfer communications.

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

Tips for gaining leadership commitment:

- Show them the data! The purpose of data collection on the Emergency Department Transfer Communication measures is to identify opportunities for improvement.
- Identify a realistic timeframe. Leaders and team members are more likely to offer support and input if they have an expectation of how long a particular improvement effort will take.
- Share how improvments in ED Transfer Communication align with other priority health care efforts. For example:
    - *Effective transfer of patient information from the Emergency Department to the next site of care can foster continuity of patient care and help to reduce errors, improve outcomes, and increase patient and family satisfaction.*
    - *Stabilization and transfer of patients in emergency situations is a fundamental role of Critical Access Hospitals in the health care safety net for rural communities. This effort allows our CAH to evaluate and demonstrate the effectiveness of that important role.*

> ***"Talent wins games, but teamwork and intelligence wins championships."***
>
> ***- Michael Jordan***

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

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

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

The emergency department transfer improvement team should meet regularly to review performance data, identify and discuss areas needing improvement, and make and monitor improvement plans. It is always important to have a clearly identified champion who is both invested in the process but also interested in building capacity that results in outcomes.

According to the Agency for Healthcare Research and Quality, every quality improvement team should include: clinical leadership, technical expertise, day-to-day leadership, and project sponsorship. [6] The team should consist of 5-8 individuals; however, size is less important than the team including, "a diverse group of individuals who have different roles and perspectives on the patient care or other processes under consideration."[7]

Resources:

Sample ED Transfer Communications Improvement Team form. Adapted from the Minnesota Hospital Association's Safe Transitions toolkit, this form can be used or adapted further to identify and establish your ED Transfer Communications Improvement Team.

Sample agenda to use as guide for team meetings.

[6] http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod14.html, retrieved, January 27, 2014.
[7] Ibid.

Additional information and resources on QI Teams:

Health Resources and Services Administration Quality Improvement Methodology - Improvement Teams. Provides an overview of the characteristics and benefits of an improvement team for quality improvement (QI) work, the functioning roles and responsibilities of the various team members, the stages of growth as a team evolves into a cohesive entity with a single focus as well as tools, tips, and resources.

Institute of Healthcare Improvement website. Includes sections on the *Science of Improvement* including suggestions on forming a team, setting aims, and testing changes.

2.3 Developing an Action Plan

Once the improvement team is established, the action plan can be developed. Action plans are developed and used to move from a vision, to strategies, to meeting objectives. Action plans will be unique to each hospital and the processes in place.

Each action step or change should include: what actions or changes will occur, who will carry out the changes, start and end dates for making the changes, resources needed to carry out the changes, and communication plans for the changes (who will know, receive, and participate in what). Action plans should be complete, clear, and current. This includes anticipating any new barriers or opportunities.

Below is a list of items to consider when developing your action plan:

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

In some instances, additional steps are needed before or during the action plan development process. This may be due to a lack of clarity with the processes currently in place and/or the roles of individuals, departments or organizations.

Process mapping is one common method used to clarify roles, create a view of the process, and identify opportunities for improvement. This visual can be particularly helpful for multiple care providers who are less familiar with one another's processes.

When process mapping and developing plans to address emergency department transfer communication, consider some of the common barriers that can impact care transitions[8]:

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

When evaluating the outcomes of your action plan and the information communicated between providers, consider the timeliness, completeness, and accuracy of information transferred; the protocol of shared accountability in effective information transfer; and whether insurance requirements were met.[9]

For more information on Process Mapping:

HRSA Redesigning a System of Care to Promote QI

Action Plans can be developed in a variety for formats but will be most useful if they include the critical information of Who, What, When, Where, Why, and How.

Sample Action Plan formats:

Sample Action Plan 1

Sample Action Plan 2

Sample Action Plan 3

[8] Massachusetts Strategic Plan for Care Transitions, Massachusetts State Quality Improvement Institute, Page 9, February 2010, http://www.patientcarelink.org/uploadDocs/1/Strategic-Plan-for-Care-Transitions_2-11-2010-(2).pdf.

2.4 Implementing your Action Plan: Education and Training

An often forgotten component to quality improvement is educating and training staff on process improvements/changes. This includes training staff at both ends of the care transfer/transition process and others inbetween (e.g., local EMS). Within the context of care transitions, there are different approaches that can be taken such as[10]:

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

It is important to determine the education needs of all staff, assign responsibility, and be explicit in what each person needs to know. In some instances, an education/training team will need to be assembled to identify and define the training requirements keeping in mind that the transfer of learning is not the same for all people so different training techniques may be needed for different people who serve in the same or similar roles.

[10] Adapted from National Transitions of Care Coalition's *Improving Transitions of Care: Hospital to Home*,

Section 3: Sample Checklists, Logs, and Transfer Forms

One component to emergency department transfer communications is documenting the flow of information between the emergency department and the entities receiving the patient. Tools such as checklists and and transfer forms can be used both internally and externally to support the flow of patient information and to better understand where information sharing gaps are occuring. They can guide process improvement but also serve as a visual reminder of the documentation required to support communications and the quality of patient care.

3.1 Sample Checklist

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

Safer Handoff: Patient Handoff Checklist. *Emergency Nurses Association (ENA).* Developed to highlight information that should be transferred to and from emergency departments and Long Term Care facilities/agencies.

Transfer Checklist and Feedback Form. *Northeast Health Care Quality Foundation.* Checklist and feedback form for interfacility transfers. Allows receiving facility to provide feedback and suggestions if information was not received or is incomplete.

Acute Care Transfer Document Checklist. *Interact. Florida Atlantic University.* Designed for long term care facilities to ensure appropriate documentation is sent with a resident to the Emergency Department. Could be adapted to address communication from the emergency department to other settings of care.

3.2 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

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
- 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. *American Medical Directors Association (AMDA*).

Safer Handoff: Patient Handoff/Transfer Form. *Emerency Nurses Association (ENA).*

Universal Transfer Form. *New Jersey Department of Health*.

Interact Hospital to Post Acute Care Transfer Form. *Florida Atlantic University*. Designed for acute care discharges to post-acute facilities. Could be adapted for emergency department use.

Model Transfer Form: Nursing Facility to Emergency Department/Hospital. *Virginia Department of Health.* Designed for nursing facility use, could be adapted or used as a tool with local nursing home partners.

Additional Resources

Appropriate Interhospital Patient Transfer. *American College of Emergency Physicians*. This website includes policy statements and principles regarding patient transfers.

Care Transitions Program. *Dr. Eric Coleman*. This website includes tools and resources to support care transitions, including those with Spanish and Russian translations.

Care Transitions: Strengthening Communication, Improving Outcomes. *Oregon Patient Safety Commission*. Retrieved January 1, 2014. This website discusses care transitions between various health care settings and presents tools and resources to support improvements.

Got Transition. *Center for Health Care Transition Improvement*. This toolkit focuses specifically on transitions related to young adults and children with special needs. It includes policies and procedures, action plans, and checklists.

Critical Care in the Emergency Department: Patient Transfer. *Emergency Medical Journal*, January 2007, "This article reviews current recommendations for the transfer of critically ill patients, with a particular focus on pre-transfer stabilization, hazards during transport and the personnel, equipment and communications necessary throughout the transfer process."

Care Transitions Reference Literature Repository. *Colorado Foundation for Medical Care*, August 14, 2013. This document includes a listing of care transition research articles, toolkits, articles, white papers, and websites that can be accessed without a subscription.

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.

Emergency Transfers of the Elderly from Nursing Facilities to Critical Access Hospitals: Opportunities for Improving Patient Safety and Quality. *Flex Monitoring Team*, January 2013. "This Policy Brief reviews the literature on transfer of nursing facility residents to the hospital emergency department, with a focus on the transfer protocols as an indicator of patient safety."

Enabling Effective Nurse Communications. *Avaya*, retrieved January 5, 2014. "This paper demonstrates one of the avenues hospitals may take to solve some of these challenges through improving nurse communications."

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.

Massachusetts Strategic Plan for Care Transitions. *Massachusetts State Quality Improvement Institute*, February 2010. This document is a tool designed to, "support integrated, high quality, coordinated and efficient health care delivery." It includes a care transitions overview and discussion, recommendations, goals, action plans, performance measures and targets for achievement.

National Transitions of Care Coalition Toolbox. This website includes a series of tools, resources, and links to websites to support care transitions.

New Performance Improvement Coordinator Education. *Montana Rural Healthcare Performance Improvement Network*. "This resource is specifically designed to provide new quality professionals with basic education about quality management and the tools used in implementing an effective, organization-wide quality program. The resources are designed for individual educational purposes as well as for the education and training of facility staff in the basic principles of quality management."

Patient Safety and Quality: An Evidenced-Based Handbook for Nurses. *Agency for Healthcare Research and Policy*, April 2008. This handbook describes the handoff process in various care settings and presents strategies to improve handoff communications.

Project BOOST: Better Outcomes for Older Adults Through Safe Transitions. *Society of Hospital Medicine*, retrieved January 19, 2014. This website includes the tools and resources developed to support and implement Project BOOST.

Quality Improvement. *Health Resources and Services Administration*, retrieved January 16, 2014. This website includes basic information and tools regarding quality improvement and establishing a quality improvement program.

Quality Improvement Basics. *Stratis Health*, retrieved December 29, 2013. This website includes handouts and a series of webinars that provide an overview of quality improvement, as well as specific information related to data and measurement, reporting, change management, facilitation, and other topics.

Readmissions and Safe Transitions of Care. *Minnesota Hospital Association*. Retrieved December 17, 2013. This website includes information on a safe transitions pilot project conducted in Minnesota along with a toolkit of resources to support safe transitions.

Secondary Transport of the Critically Ill and Injured Adult. *Emergency Medicine Journal*, September 29, 2003. "This review describes the core issues relevant to emergency medicine relating to the transportation of the critically ill and injured."

STAAR Issue Brief: Reducing Barriers to Care Across the Continuum – Working Together in a Cross Continuum Team. Amy Boutwell and Marian Bihrle Johnson, *Institute for Healthcare Improvement, STAAR Issue Brief Series 2010, Number 3*. This issue brief discusses care transitions from the hospital to other care settings and strategies to improve them.

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.