

Safe Transitions Best Practice Measures for Hospitals

Setting-specific process measures focused on cross-setting communication and patient activation, supporting safe patient care across the continuum

MEASURE SET:**Safe transitions best practice measures for hospitals****MEASURES:**

The best practice measures for hospitals are nine (9) process measures:

1. Notification of hospitalization sent to primary care providers at beginning of hospital visit
2. Hospital clinicians' contact information provided to receiving clinicians upon discharge
3. Effective education provided to patients prior to discharge
4. Written discharge instructions provided to patients prior to discharge
5. Follow-up phone number provided to patients prior to discharge
6. Medication reconciliation completed prior to discharge
7. Follow-up appointment scheduled prior to discharge
8. Hospital summary clinical information sent to primary care providers at discharge
9. Primary care providers invited to participate in hospital end-of-life discussions

PURPOSE:

The best practice measures are intended to improve provider-to-provider communication and patient activation during patient transitions between any two settings. Hospitals can use these measures to evaluate performance and implement targeted improvement to: 1) improve partnerships with community providers, 2) improve patient experience and/or 3) reduce unplanned utilization.

Some of these processes are adapted from interventions proven to improve care transitions outcomes, such as hospital readmission, in the medical literature. Others are based on national campaigns and standards.

POPULATION:

All patients in the hospital for outpatient observation or an inpatient admission

CARE SETTING:

Hospital or acute-care facility

RECIPROCAL MEASURES:

In addition to the best practices for hospitals, Healthcentric Advisors developed five (5) additional sets of setting-specific measures, for:

1. Community physician offices
2. Emergency departments
3. Home health agencies
4. Nursing homes
5. Urgent care centers

NOTES:

Because these measures are intended to set minimum standards for all patients, no sampling guidelines are provided. Providers who cannot calculate the measures electronically may wish to implement a representative sampling frame to calculate performance on an ongoing basis.

Providers may also wish to implement small-scale pilots to measure baseline performance and implement targeted improvement strategies before expanding efforts facility wide.

For those seeking assistance, Healthcentric Advisors provides consultative services related to quality improvement, measurement and care transitions.

MEASURE SET HISTORY:

These measures were developed by Healthcentric Advisors, the Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) for New England, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (hospitals) and their community partners (e.g., primary care providers) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health’s Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

The Rhode Island Office of the Health Insurance Commissioner currently requires that commercial health plans include the hospital measures in contracting with all acute-care hospitals in the state.¹

MEASURE INFORMATION:

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LAST UPDATED: May 2018

MEASURE:**Notification of hospitalization sent to primary care providers at beginning of hospital visit****MEASURE SET:**

Safe transitions best practice measures for hospitals (Best Practice #1)

MEASURE DESCRIPTION:

This measure estimates the frequency with which hospitals notify primary care providers when their patients are admitted to the hospital.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes,² but a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between hospital physicians and primary care physicians occurs infrequently, in only 3%-20% of cases studied.³ Community-based primary care providers indicate that they are often unaware of their patients' hospital utilization and want to be notified at patient intake.

NUMERATOR:

Documentation of notification of the primary care provider's office within 24 hours of the initial order for outpatient observation or inpatient admission, regardless of whether the patient has since been discharged

DENOMINATOR:

All patients in the hospital for outpatient observation or an inpatient admission

EXCLUSIONS:

Patients:

- Without a known primary care provider
- Admitted for labor and delivery
- At non-acute hospitals (e.g., rehabilitation hospitals) and day hospitals
- Who request that their information not be shared with their primary care provider

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

Hospital visit: Outpatient observation or an inpatient admission

Notification: Fax, phone call, email, or other electronic means that indicates the patient is in the hospital and that provides a phone number the office can use to contact a clinician caring for the patient (or with access to the patient's medical record)

Primary care provider: The clinician identified by the patient as their usual source of care or regular physician or the primary care provider designated in the medical record. Contact information may be sent to a primary care physician, specialist, advanced practitioner, office location, facility or clinic.

For long-stay nursing home residents, notification should be sent to the long-term care physician

For short-stay skilled nursing patients, who will resume care with their primary care provider upon skilled nursing facility discharge, notification should be sent to the community-based primary care provider; the skilled nursing facility is already aware of the hospital visit

NOTES:

If the patient does not have a primary care provider, this best practice should prompt the patient and hospital physician to identify a primary care provider for the patient and to schedule a new patient appointment.

CLASSIFICATION:

National Quality Strategy Priorities:	Promoting effective communication and coordination of care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Hospital or acute-care facility
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) for New England, using a multi-stage stakeholder consensus process. It has since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (hospitals) and their community partners (e.g., primary care providers) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health’s Institutional Review Board. As a quality improvement project that incorporated local preference, this measure (and the other Safe Transitions Best Practice Measures) may not be generalizable to other states and regions, but can inform the development of local standards.

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MEASURE LAST UPDATED: May 2018

MEASURE:**Hospital clinicians' contact information provided to receiving clinicians upon discharge****MEASURE SET:**

Safe transitions best practice measures for hospitals (Best Practice #2)

MEASURE DESCRIPTION:

This measure estimates the frequency with which receiving clinicians are provided with the hospital clinician's contact information at the time of patient discharge from the hospital.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes,⁴ but a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between hospital physicians and primary care physicians occurs infrequently, in only 3%-20% of cases studied.⁵ Downstream providers often indicate that they do not know how to reach their patients' hospital clinicians to learn more about care provided during the acute-care episode, if they need additional information or have questions.

NUMERATOR:

Documentation of the provision of the hospital clinician's contact information within 24 hours of discharge to:

- The primary care provider's office, *and*
- The clinician at a downstream acute care, long-term care or skilled nursing facility, if applicable.

DENOMINATOR:

All patients in the hospital for outpatient observation or an inpatient admission

EXCLUSIONS:

Patients:

- Without a known primary care provider
- Who request that their information not be shared with their primary care provider

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

Contact information: Beeper number, cell phone number, landline or email address

Discharge: Patient discharge from outpatient observation or inpatient admission

Hospital clinician: Physician, nurse practitioner or physician assistant who cared for the patient or has access to the patient's medical record

Hospital visit: Outpatient observation or inpatient admission

Primary care provider: The clinician identified by the patient as their usual source of care or regular physician or the primary care provider designated in the medical record. This may be a primary care physician, specialist, advanced practitioner, office location, facility or clinic to meet the measure.

For long-stay nursing home residents, the primary care provider is the long-term care physician.

For short-stay skilled nursing patients, who will resume care with their primary care provider upon skilled nursing facility discharge, information should be sent both to the skilled nursing facility and the patient's community-based primary care provider.

Provision: By fax, phone call, email or other electronic means

Receiving clinician: Primary care provider or the physician, nurse practitioner, physician assistant, or nurse at the next inpatient care setting (e.g., acute care, long-term care or skilled nursing facility), if applicable

NOTES:**CLASSIFICATION:**

National Quality Strategy Priorities: Promoting effective communication and coordination of care

Actual or Planned Use: Quality improvement with benchmarking; contracting; pay for performance

Care Setting: Hospital or acute-care facility

Patient Condition: Not applicable – all patients

Data Source: Medical record or electronic audit trail

Level of Analysis: Practitioner, unit, facility or community (e.g., health system or state)

Measure Type: Process measure

Target Population: All patients in the hospital for outpatient observation or an inpatient admission

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) for New England, using a multi-stage stakeholder consensus process. It has since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (hospitals) and their community partners (e.g., primary care providers) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, this measure (and the other Safe Transitions Best Practice Measures) may not be generalizable to other states and regions, but can inform the development of local standards.

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MEASURE LAST UPDATED: May 2018

MEASURE:**Effective education provided to patients prior to discharge****MEASURE SET:**

Safe transitions best practice measures for hospitals (Best Practice #3)

MEASURE DESCRIPTION:

This measure estimates the frequency with which patients in the hospital are provided with discharge education and evaluated to ensure their comprehension of that information.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes,⁶ but current practice often limits discharge education to the provision of written or verbal instructions, absent assessment of patient comprehension or the opportunity for patients to ask questions. There is a robust literature, particularly in the emergency department, which indicates patient comprehension of such information is low and may impact post-discharge follow-up care and medication adherence.⁷

NUMERATOR:

Documentation of all of the following prior to discharge:

- Provision of patient education to the patient or informal caregiver (such as family),
- Evidence that understanding of the education provided was assessed, *and*
- An opportunity for the patient to ask questions.

DENOMINATOR:

All patients in the hospital for outpatient observation or an inpatient admission

EXCLUSIONS:

Patients:

- Discharged to a long-term care or skilled nursing facility or transferred to another acute-care hospital
- Born during the hospital stay (i.e., neonates) and whose mothers have a separate hospital record
- Who leave against medical advice
- Who expire in the hospital

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS:

Discharge:	Patient discharge from outpatient observation or inpatient admission
Effective education:	Education that incorporates testing of the patient’s understanding (e.g., use of a teach-back method)
Hospital visit:	Outpatient observation or inpatient admission
Informal caregiver:	A family member or other person who provides care and support to the patient
Patient education:	Includes, at minimum, the reason for hospitalization, any changes to medications and the reason for the change, condition-specific “red flags” that should prompt the patient to seek

medical attention and whom the patient should call, activity and other limitations, and necessary post-hospital follow-up appointments and tests

NOTES:

Communication with patients should incorporate concepts of health literacy and cultural competence, and should adhere to interpreter requirements, per state and Federal law

Although patients who leave against medical advice are excluded from this measure, it is often still possible to provide discharge education to patients before they leave the hospital. When it is not possible to do so, discharge education may instead be provided by telephone or by mail after they leave the hospital.

CLASSIFICATION:

National Quality Strategy Priorities:	Ensuring that each person and family are engaged as partners in their care Promoting effective communication and coordination of care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Hospital or acute-care facility
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) for New England, using a multi-stage stakeholder consensus process. It has since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (hospitals) and their community partners (e.g., primary care providers) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health’s Institutional Review Board. As a quality improvement project that incorporated local preference, this measure (and the other Safe Transitions Best Practice Measures) may not be generalizable to other states and regions, but can inform the development of local standards.

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MEASURE LAST UPDATED: May 2018

MEASURE:**Written discharge instructions provided to patients prior to discharge****MEASURE SET:**

Safe transitions best practice measures for hospitals (Best Practice #4)

MEASURE DESCRIPTION:

This measure estimates the frequency with which patients in the hospital are provided with written discharge instructions.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes.⁸ It is important to share this information with patients to provide patient-directed care and empower patients to self-manage their follow-up. Provision of written discharge instructions ensures that patients have information to refer to and may be helpful to downstream providers, if patients are coached to bring this information to follow-up appointments.

The multi-disciplinary Transitions of Care Consensus Policy Statement also recommends that patients and informal caregivers (such as family members) “must receive, understand and be encouraged to participate in the development of a transition record [that takes] into consideration the patient’s health literacy and insurance status.”¹

NUMERATOR:

Documentation that written discharge instructions were provided to the patient, family or other informal caregiver prior to discharge

DENOMINATOR:

All patients in the hospital for outpatient observation or an inpatient admission

EXCLUSIONS:

Patients:

- Discharged to a long-term care or skilled nursing facility or transferred to another acute-care hospital
- Born during the hospital stay (i.e., neonates) and whose mothers have a separate hospital record
- Who leave against medical advice
- Who expire in the hospital

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS:

Discharge: Patient discharge from outpatient observation or inpatient admission

Discharge Instructions: Should include, at a minimum:

- The information provided verbally as part of effective education including:
 - hospital diagnosis,
 - Any changes to medications and the reason for the change,
 - Condition-specific “red flags” that should prompt the patient to seek medical attention and whom the patient should call, and
 - Recommended follow-up appointments and tests.
- Name of the hospital clinician and hospital contact information.

Hospital clinician: Physician, nurse practitioner, or physician assistant who cared for the patient
Hospital visit: Outpatient observation or inpatient admission
Informal caregiver: A family member or other person who provides care and support to the patient

NOTES:

Communication with patients should incorporate concepts of health literacy and cultural competence and should adhere to interpreter requirements, per state and Federal law.

Engagement of the broader community should be included in the written discharge information including information on available resources (to include social, community, and any other available resources that may support a transition of care)⁹. These resources may include meals-on-wheels, heating assistance, and transportation.

Although patients who leave against medical advice are excluded from this measure, it is often still possible to provide written discharge instructions before they leave the hospital. When it is not possible to do so, written discharge instructions may instead be provided by mail after they leave the hospital.

CLASSIFICATION:

National Quality Strategy Priorities: Ensuring that each person and family are engaged as partners in their care
Promoting effective communication and coordination of care
Actual or Planned Use: Quality improvement with benchmarking; contracting; pay for performance
Care Setting: Hospital or acute-care facility
Patient Condition: Not applicable – all patients
Data Source: Medical record or electronic audit trail
Level of Analysis: Practitioner, unit, facility or community (e.g., health system or state)
Measure Type: Process measure
Target Population: All patients in the hospital for outpatient observation or an inpatient admission

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) for New England, using a multi-stage stakeholder consensus process. It has since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (hospitals) and their community partners (e.g., primary care providers) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health’s Institutional Review Board. As a quality improvement project that incorporated local preference, this measure (and the other Safe Transitions Best Practice Measures) may not be generalizable to other states and regions, but can inform the development of local standards.

The Rhode Island Office of the Health Insurance Commissioner currently requires that commercial health plans include this measure in hospital contracting with all acute-care hospitals in the state.¹⁰

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MEASURE DEVELOPED: 2009**MEASURE LAST UPDATED:** May 2018

MEASURE:**Follow-up phone number provided to patients prior to discharge****MEASURE SET:**

Safe transitions best practice measures for hospitals (Best Practice #5)

MEASURE DESCRIPTION:

This measure estimates the frequency with which patients in the hospital are provided with a phone number that they can call with questions after they leave the hospital.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes.¹¹ The multi-disciplinary Transitions of Care Consensus Policy Statement also recommends that communication be two-way, saying that “each sending provider needs to provide a contact name and number of an individual who can respond to questions or concerns.”¹¹

NUMERATOR:

Documentation that a follow-up phone number was provided to the patient, family or other informal caregiver prior to discharge

DENOMINATOR:

All patients in the hospital for outpatient observation or an inpatient admission

EXCLUSIONS:

Patients:

- Discharged to a long-term care or skilled nursing facility or transferred to another acute-care hospital
- Born during the hospital stay (i.e., neonates) and whose mothers have a separate hospital record
- Who leave against medical advice
- Who expire in the hospital

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

Discharge:	Patient discharge from outpatient observation or inpatient admission
Follow-up phone number:	A phone number that connects patients to a clinician who can answer questions about their hospital stay or follow-up care
Hospital clinician:	Physician, nurse practitioner or physician assistant who cared for the patient
Informal caregiver:	A family member or other person who provides care and support to the patient
Hospital visit:	Outpatient observation or inpatient admission

NOTES:

Although patients who leave against medical advice are excluded from this measure, it is often still possible to provide this information before they leave the hospital. When it is not possible to do so, the follow-up phone number may instead be provided by telephone or by mail after they leave the hospital.

CLASSIFICATION:

National Quality Strategy Priorities:	Ensuring that each person and family are engaged as partners in their care Promoting effective communication and coordination of care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Hospital or acute-care facility
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) for New England, using a multi-stage stakeholder consensus process. It has since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (hospitals) and their community partners (e.g., primary care providers) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health’s Institutional Review Board. As a quality improvement project that incorporated local preference, this measure (and the other Safe Transitions Best Practice Measures) may not be generalizable to other states and regions, but can inform the development of local standards.

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MEASURE LAST UPDATED: May 2018

MEASURE:**Medication reconciliation completed prior to discharge****MEASURE SET:**

Safe transitions best practice measures for hospitals (Best Practice #6)

MEASURE DESCRIPTION:

This measure estimates the frequency with which patients in the hospital receive medication reconciliation before they leave the hospital.

Studies estimate that one in five patients discharged from the hospital to home experience an adverse event within just three weeks, and that two-thirds of these adverse events are drug-related events that could have been avoided or mitigated.¹² Yet a 2012 systematic review showed that hospital medication reconciliation was associated with decreased risk for adverse drug events.¹³ Additional research shows that discharge summaries often lack important information, such as discharge medications.¹⁴ Medication reconciliation is a Joint Commission patient safety goal and can help to ensure that: 1) providers identify potential medication errors and 2) patients understand which medications to stop, start or adjust after hospital discharge.

NUMERATOR:

Documentation of medication reconciliation prior to discharge

DENOMINATOR:

All patients in the hospital for outpatient observation or an inpatient admission

EXCLUSIONS:

Patients:

- Born during the hospital stay (i.e., neonates) and whose mothers have a separate record
- Who leave against medical advice
- Who expire in the hospital

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

Discharge: Patient discharge from outpatient observation or inpatient admission

Hospital visit: Outpatient observation or inpatient admission

Medication reconciliation: The process of: 1) comparing the patient's pre-hospital medication regimen (including non-prescription medications), the in-hospital regimen, and the proposed discharge regimen to identify and resolve any discrepancies, and 2) providing the patient and informal caregiver (such as family) and/or downstream provider with an updated list, with information about which medications the patient should start, stop, continue or adjust the dose of after hospital discharge and the reasons for any change

NOTES:

In addition to performing medication reconciliation, the multi-disciplinary Transitions of Care Consensus Policy Statement also recommends that patients be provided with a medication list that is accessible (paper or electronic), clear and dated.¹⁵

The Joint Commission recommends that the medication reconciliation process also include an explanation of *why* it is important to manage medication information¹⁶.

Although patients who leave against medical advice are excluded from this measure, it is still often possible to perform medication reconciliation before they leave the hospital. When it is not possible to do so, medication reconciliation may be performed by telephone or by mail after they leave the hospital.

CLASSIFICATION:

National Quality Strategy Priorities:	Making care safer by reducing harm caused in the delivery of care Promoting effective communication and coordination of care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Hospital or acute-care facility
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

MEASURE HISTORY:

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MEASURE DEVELOPED: 2009

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MEASURE LAST UPDATED: May 2018

MEASURE:**Follow-up appointment scheduled prior to discharge****MEASURE SET:**

Safe transitions best practice measures for hospitals (Best Practice #7)

MEASURE DESCRIPTION:

This measure estimates the frequency with which patients in the hospital have a scheduled follow-up appointment with their primary care provider or specialist before they leave the hospital.

Although improved communication between the hospital and community-based primary care provider can help to close knowledge gaps at admission and during the hospital stay, many primary care providers (or specialists, as appropriate) do not fully assume responsibility for patients discharged from the hospital until the patient's follow-up appointment. The follow-up appointment is important for the provider to: 1) assume professional responsibility for patient care, 2) assess and facilitate adherence to discharge instructions and medications, and 3) provide an opportunity for patients to ask questions. Scheduling during the hospitalization ensures that patients leave the hospital with the date and time of their follow-up appointments included with their discharge instructions.

NUMERATOR:

Documentation that both of the following occur within one business day of discharge:

- An outpatient primary care provider or specialist visit, as appropriate, is scheduled to occur within 14 days (unless timeframe otherwise specified and documented in the medical record), *and*
- Information about the follow-up appointment is provided to the patient or informal caregiver.

DENOMINATOR:

All patients in the hospital for outpatient observation or an inpatient admission

EXCLUSIONS:

Patients:

- Discharged to a long-term care or skilled nursing facility or transferred to another acute-care hospital
- Who decline to have an outpatient visit scheduled for any reason
- Whose outpatient provider prefers to schedule the appointment
- Who leave against medical advice
- Who expire in the hospital

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

Discharge:	Patient discharge from outpatient observation or inpatient admission
Informal caregiver:	A family member or other person who provides care and support to the patient
Information about the follow-up appointment:	Date, time, location and contact information for questions or to reschedule

Primary care provider: The clinician identified by the patient as their usual source of care or regular physician or the primary care provider designated in the medical record. This may be a primary care physician, specialist, advanced practitioner, office location, facility or clinic.

NOTES:

If the patient does not have a primary care provider, this process should involve identifying a primary care provider for the patient and scheduling a new patient appointment. Scheduling appointments should involve the patient and/or informal caregiver (such as family), in order to identify a date and time when the patient is available and can get to the primary care provider's office (e.g., has transportation), minimizing the risk of cancellations or "no-shows."

Although patients who leave against medical advice are excluded from this measure, it is often possible to schedule an appointment before they leave the hospital. When it is not possible to do so, an appointment may still be scheduled by the hospital physician or the primary care provider's office and the patient notified by telephone or mail after they leave the hospital.

CLASSIFICATION:

National Quality Strategy Priorities:	Promoting effective communication and coordination of care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Hospital or acute-care facility
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

MEASURE HISTORY:

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MEASURE INFORMATION:

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MEASURE DEVELOPED: 2009

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MEASURE LAST UPDATED: May 2018

MEASURE:**Hospital summary clinical information sent to primary care providers at discharge****MEASURE SET:**

Safe transitions best practice measures for hospitals (Best Practice #8)

MEASURE DESCRIPTION:

This measure estimates the frequency with which hospitals send summary clinical information about the patient's hospitalization to primary care providers when their patients are discharged from the hospital.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes,¹⁸ but a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between hospital physicians and primary care physicians occurs infrequently, in only 3%-20% of cases studied.¹⁹ Although the hospital discharge summary is likely the most common tool for information transfer, another study found that the discharge summary reaches the primary care provider by the time of the first follow-up visit only 12-34% of the time, and often lacks key information.²⁰

Medicare billing codes for Transitional Care Management Services require primary care providers' offices to outreach to patients within two business days of discharge²¹ this measure will facilitate this outreach.

NUMERATOR:

Documentation that summary clinical information is sent to the primary care provider's office within 24 hours of patient discharge

DENOMINATOR:

All patients in the hospital for outpatient observation or an inpatient admission

EXCLUSIONS:

Patients:

- Discharged to long-term care or transferred to another acute-care hospital
- Who are cared for by their own primary care provider while in the hospital
- Who request that their information not be shared with their primary care provider
- Who decline to have a Primary Care Provider assigned to them
- Who expire in the hospital

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

Discharge: Patient discharge from outpatient observation or inpatient admission

Hand-off: Transfer of clinical information and care responsibilities from one clinician to another.

Primary care provider: The clinician identified by the patient as their usual source of care or regular doctor or the primary care provider designated in the medical record. Summary clinical information may be sent to a primary care physician, specialist, advanced practitioner, office location, facility, or

clinic. If the patient does not have a primary care provider and will be seen in a transition clinic after discharge, information may be sent there instead.

For long-stay nursing home residents, information should be sent to the long-term care doctor.

For short-stay skilled nursing patients, who will resume care with their primary care provider upon skilled nursing facility discharge, information should be sent to the community-based primary care provider; the skilled nursing facility is already aware of the hospital visit.

**Summary
clinical information:**

Should include, at a minimum: the presenting complaint and reason for hospitalization, major diagnoses, significant tests and procedure results, presence of pending tests, name of hospital physician, updated medication list with reason for any changes, discharge condition, discharge instructions and recommended follow-up. This may be accomplished via written information, such as a discharge summary or standardized form, that includes: 1) a brief narrative of the hospital visit, or 2) a verbal hand-off between the hospital clinician and primary care provider.

NOTES:

If the patient does not have a primary care provider, this best practice should prompt the patient and hospital physician to identify a primary care provider for the patient and to schedule a new patient appointment.

CLASSIFICATION:

National Quality Strategy Priorities:	Promoting effective communication and coordination of care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Hospital or acute-care facility
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) for New England, using a multi-stage stakeholder consensus process. It has since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (hospitals) and their community partners (e.g., primary care providers) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health’s Institutional Review Board. As a quality improvement project that incorporated local preference, this measure (and the other Safe Transitions Best Practice Measures) may not be generalizable to other states and regions, but can inform the development of local standards.

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MEASURE DEVELOPED: 2009

MEASURE LAST UPDATED: May 2018

MEASURE SET:**Safe transitions best practice measures for hospitals (Best Practice #9)****MEASURE DESCRIPTION:**

This measure estimates the frequency with which primary care providers are invited to participate in end-of-life discussions, when a patient's care requires such discussions. Although end-of-life discussions ideally occur in advance of acute-care episodes in the outpatient setting, they may be triggered by a hospital stay or revisited during the hospital care episode.

Primary care emphasizes the longitudinal relationship between the primary care provider, the patient and, if applicable, informal caregivers (such as family members). Inviting primary care providers to participate in end-of-life discussions in the hospital recognizes both the patient-provider relationship and the value that primary care providers can bring to the conversation, given their longitudinal perspective about patients' medical histories and preferences. Many primary care providers indicate that they want to have the opportunity to participate in such discussions.

NUMERATOR:

Documentation of invitation to primary care provider to participate in hospital end-of-life discussions

DENOMINATOR:

All patients in the hospital for outpatient observation or an inpatient admission whose care requires end-of-life discussions

EXCLUSIONS:

Patients:

- Without a known primary care provider
- Who request that their primary care provider not be invited

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

End-of-life discussions: Conversations and decision-making regarding end-of-life topics such as comfort care only, change of code status from full code, hospice and other related goals of care

Invitation: Fax, phone call, email or other electronic means of communication

Primary care provider: The clinician identified by the patient as their usual source of care or regular physician or the primary care provider designated in the medical record. This may be a primary care physician, specialist, advanced practitioner, office location, facility or clinic.

For long-stay nursing home residents, this is the long-term care physician.

For short-stay skilled nursing patients, who will resume care with their primary care provider upon skilled nursing facility discharge, this is the community-based primary care provider discharge, and the invitation does not need to extend to the skilled nursing facility doctor.

NOTES:

This is not intended to reflect routine discussions during admission, such as asking the patient about their code status, nor is there an expectation that the primary care provider participates (in person or via phone) every meeting. This measure focuses on patients whose “care requires an end-of-life discussion”; that clinical determination is left to the discretion of hospital clinicians. It also focuses on the *invitation* (not *participation*), which ensures that the primary care provider is: 1) aware of the discussion and 2) has an opportunity to participate. The primary care provider may also be able to use their knowledge about ongoing end-of-life discussions to outreach to the patient or informal caregivers (such as family members).

CLASSIFICATION:

National Quality Strategy Priorities:	Ensuring that each person and family are engaged as partners in their care Promoting effective communication and coordination of care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Hospital or acute-care facility
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

MEASURE HISTORY:

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This process involved: (1) reviewing the medical literature (where it exists) and national campaigns and standards; (2) collecting input about community preferences; (3) drafting measures; and (4) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (hospitals) and their community partners (e.g., primary care providers) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health’s Institutional Review Board. As a quality improvement project that incorporated local preference, this measure (and the other Safe Transitions Best Practice Measures) may not be generalizable to other states and regions, but can inform the development of local standards.

The Rhode Island Office of the Health Insurance Commissioner currently requires that commercial health plans include this measure in hospital contracting with all acute-care hospitals in the state.²²

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