

Safe Transitions Best Practice Measures for Emergency Departments

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 emergency departments (EDs)****MEASURES:**

The best practice measures for EDs are eight (8) process measures:

1. Documentation of patients' primary care provider
2. Documentation of patients' home care provider
3. Summary clinical information provided to primary care provider upon ED discharge
4. Summary clinical information provided to home care provider upon ED discharge
5. Summary clinical information provided to receiving provider upon ED discharge or transfer to another facility
6. Medication reconciliation completed prior to discharge
7. Effective education provided to patients prior to discharge
8. Written discharge instructions provided to patients prior to discharge

PURPOSE:

The best practice measures are intended to improve provider-to-provider communication and patient activation during patient transitions between any two settings. EDs can use these measures to evaluate performance and implement targeted improvement to: 1) improve partnerships with inpatient and outpatient 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:

Varies by measure, but generally includes patients currently being seen or recently discharged from the ED

CARE SETTING:

Emergency department

RECIPROCAL MEASURES:

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

1. Community physician offices
2. Home health agencies
3. Hospitals
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 (EDs) and their partners (e.g., primary care providers and urgent care centers) 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.

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LAST UPDATED: May 2018

MEASURE:**Documentation of patients' primary care provider****MEASURE SET:**

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

MEASURE DESCRIPTION:

This measure estimates the frequency with which emergency departments (EDs) ask patients for the name of their primary care provider. Asking for the name of the patient's primary care provider is the first step towards bi-directional communication of questions and clinical 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.¹ Community-based primary care providers indicate that they are often unaware of their patients' ED utilization and want to be notified at patient intake. If aware of patients' arrival in the ED, primary care providers could help to prevent unnecessary healthcare utilization (e.g., duplicate testing or hospital admission).

NUMERATOR:

Documentation of one of the following:

- The name of the patient's primary care provider,
- The fact that the patient does not have a primary care provider, or
- The fact that the patient is unsure of their primary care provider's name or otherwise unable to answer.

DENOMINATOR:

All patients seen in the emergency department

EXCLUSIONS:

None

RISK ADJUSTMENT:

None

DEFINITIONS

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.

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.

NOTES:

If patients do not have a primary care provider, are unsure of their primary care provider's name or are otherwise unable to answer, this should be noted in the medical record instead (i.e., do not leave the field blank). The best practice is for the emergency department to ask this question with every patient, at every visit, since this information is subject to change over time.

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:	Emergency department
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, department or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the emergency department

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. The measure 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 (EDs) and their community partners (e.g., primary care providers and urgent care centers) 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 (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

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MEASURE LAST UPDATED: May 2018

MEASURE:**Documentation of patients' home care provider****MEASURE SET:**

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

MEASURE DESCRIPTION:

This measure estimates the frequency with which emergency departments (EDs) ask patients for the name of their home care provider. Asking for the name of the patient's home care provider is the first step towards bi-directional communication of questions and clinical 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.² Community-based home care providers may not be aware of their patients' ED utilization and, if aware, could help to prevent unnecessary healthcare utilization, such as duplicate testing or an inpatient admission.

Notification may be particularly important for hospice patients, many of whom have Medicare and therefore no insurance coverage outside the hospice plan of care for their terminal diagnosis. If the hospice agency is aware of the ED visit while the patient is in the ED, they can send a nurse. This can prevent unwanted admissions or diagnostic studies and other interventions, for which patients could be financially responsible.

NUMERATOR:

Documentation of one of the following:

- The name of the patient's home care provider, if the patient is currently receiving services (i.e., not if they have ever received services in the past),
- The fact that the patient does not currently have home care, or
- The fact that the patient has home care, but is unsure of their provider's name or otherwise unable to answer.

DENOMINATOR:

All patients seen in the emergency department

EXCLUSIONS:

Patients who come from a skilled nursing or long-term care facility

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

Home care provider: Any organization that provides home-based or community-based medical, nursing, social or therapeutic treatment to the patient, including home health agencies, hospice, PACE, etc.

NOTES:

If patients do not currently have home care, are unsure of their provider's name or are otherwise unable to answer, this should be noted in the medical record instead (i.e., do not leave the field blank). The best practice to ask this question with every patient, at every visit, since this information is subject to change over time.

The name of the home care provider should be documented only if the patient is *currently* receiving services, not if they have ever received services in the past.

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:	Emergency department
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, department or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the emergency department

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. The measure 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 (EDs) and their partners (e.g., primary care providers and urgent care centers) 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 (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:**Summary clinical information provided to primary care provider upon emergency department discharge****MEASURE SET:**

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

MEASURE DESCRIPTION:

This measure estimates the frequency with which emergency departments (EDs) provide primary care providers with summary clinical information about their patients' ED visits.

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.³ Effective transfer of information allows outpatient physicians to immediately assume care of discharged patients without spending time on record requests or repeat testing and without defaulting (in the absence of information) to referring patients back to the ED.

Community-based primary care providers indicate that they are often unaware of their patients' ED utilization and want to be notified of the visit, even if urgent clinical follow-up is not warranted for the patient's complaint. (For example, an ED visit for a sore throat may not require follow-up, but could provide an opportunity for patient education about where to access appropriate care.)

NUMERATOR:

Documentation of the following sent to primary care provider within one (1) hour of patient discharge:

- Medical diagnosis,
- Updated medication list with reason for any changes,
- Results of relevant diagnostic tests and presence of pending tests,
- Name of ED clinician and ED contact information,
- Discharge instructions,
- Recommended follow-up, and
- Name of informal caregiver and contact information.

DENOMINATOR:

All patients discharged home from the ED

EXCLUSIONS:

Patients without a known primary care provider

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

Discharge Instructions: Should include, at a minimum:

- The information provided verbally as part of effective education including:
 - ED 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 ED clinician and ED contact information.

ED contact information:	Phone number the primary care provider can call for more information about the ED stay and recommended follow-up, if needed.
Informal caregiver:	A family member or other person who provides care and support to the patient.
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.
Relevant diagnostic tests:	Imaging or other tests performed as part of the ED evaluation that, in the ED physician's judgment, would be useful for the patient's follow-up care. EDs can opt to send more information if they feel referring primary care providers want this.
Sent:	Transmitted from the ED to the primary care provider's office via fax, email or other electronic means.

NOTES:

The information may come from the patient's discharge paperwork and therefore may be patient-oriented. The summary clinical information here is the same as the information sent to home care providers as part of Best Practice #4.

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:	Emergency department
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, department or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients discharged home from the ED

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. The measure 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 (EDs) and their partners (e.g., primary care providers and urgent care centers) 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 (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:**Summary clinical information provided to home care provider upon emergency department discharge****MEASURE SET:**

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

MEASURE DESCRIPTION:

This measure estimates the frequency with which emergency departments (EDs) provide home care providers with summary clinical information about their patients' ED visits.

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 Home care providers indicate that they are often unaware of their patients' ED utilization and want to be notified of the visit, even if clinical follow-up is not warranted for the patient's complaint. (For example, an ED visit for a sore throat may not require follow-up, but could provide an opportunity for patient education about where to access appropriate care.)

Notification may be particularly important for hospice patients, many of whom have Medicare and therefore no insurance coverage outside the hospice plan of care for their terminal diagnosis. If the hospice is aware of the ED visit while the patient is in the emergency department, they can send a nurse. This can prevent unwanted admissions or diagnostic studies and other interventions, for which patients could be financially responsible.

NUMERATOR:

Documentation of the following sent to home care provider, if applicable, within 1 hour of patient discharge:

- Medical diagnosis,
- Updated medication list with reason for any changes,
- Results of relevant diagnostic tests and presence of pending tests,
- Name of ED clinician and ED contact information,
- Discharge instructions,
- Recommended follow-up, and
- Name of informal caregiver and contact information.

DENOMINATOR:

All patients discharged home from the ED who are *currently* receiving home care services

EXCLUSIONS:

Patients without a known home care provider

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS

Discharge Instructions: Should include, at a minimum:

- The information provided verbally as part of effective education including:
 - ED 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 ED clinician and ED contact information.

ED contact information:	Phone number the primary care provider can call for more information about the ED stay and recommended follow-up, if needed.
Home care provider:	Any organization that provides home- or community-based medical, nursing, social or therapeutic treatment to the patient, including home health agencies, hospice, PACE, etc.
Informal caregiver:	A family member or other person who provides care and support to the patient.
Relevant diagnostic tests:	Imaging or other tests performed as part of the ED evaluation that, in the ED physician's judgment, would be useful for the patient's follow-up care. EDs can opt to send more information if they feel referring home care providers want this.
Sent:	Transmitted from the ED to the home care provider office via fax, email, or other electronic means.

NOTES:

Summary clinical information should be sent to the home care provider only if the patient is *currently* receiving services, not if they have ever received services in the past.

The information may come from the patient's discharge paperwork and therefore may be patient-oriented.

The summary clinical information here is the same as the information sent to primary care physicians as part of Best Practice #3.

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:	Emergency department
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, department or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients discharged home from the ED who are receiving home care services

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. The measure 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) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (EDs) and their partners (e.g., primary care providers and urgent care centers) 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 (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:**Summary clinical information provided to receiving provider upon emergency department discharge or transfer to another facility****MEASURE SET:**

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

MEASURE DESCRIPTION:

This measure estimates the frequency with which emergency departments (EDs) provide receiving providers with summary clinical information about patients' ED visits, when the patient is discharged from the ED to another facility (skilled nursing, long-term care or acute care).

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.⁵ Information transfer to the next facility helps receiving or downstream providers prepare for patient intake (if transmitted prior to patient discharge from the ED) and ensure continuity of care.

NUMERATOR:

Documentation of the following sent to the receiving provider with the patient or within 1 hour of patient discharge:

- Medical diagnosis,
- Clinical services provided,
- Results of relevant diagnostic tests and presence of pending tests,
- Name of ED clinician and ED contact information, and
- Name of informal caregiver and contact information.
- For skilled nursing facility and long-term care discharges, updated medication list with reason for any changes, recommended follow-up, expected plan of care and anticipated contingencies.

DENOMINATOR:

Patients:

- Discharged to a skilled nursing or long-term care facility, or
- Transferred from the ED to another acute-care hospital.

EXCLUSIONS: None

RISK ADJUSTMENT: None

DEFINITIONS

Clinical services provided: This may include medications dispensed, procedures performed, relevant vitals and physical exam findings, nursing notes, and other events in the ED course that, in the ED physician's judgment, would be useful for the patient's care in the receiving facility.

ED contact information: Phone number the receiving provider can call for more information about the ED stay and recommended follow-up, if needed.

Informal caregiver: A family member or other person who provides care and support to the patient.

Receiving provider: The physician, advanced practitioner or nurse at the next facility (skilled nursing, long-term care or acute care) who will immediately be assuming care of the patient after ED discharge or transfer.

Relevant diagnostic Imaging or other tests performed as part of the ED evaluation that, in the ED physician's

tests: judgment, would be useful for the patient’s care in the receiving facility. EDs can opt to send more information if they feel their receiving facilities want this.

Sent: Transmitted from the ED to the facility via the patient’s transport, fax, email or other electronic means.

NOTES:

This Best Practice refers to communication with physicians who will be assuming care of a patient in another facility—not communication with hospital physicians in the same hospital.

If patients are coming from a skilled nursing facility, they will resume care with their primary care provider (PCP) upon skilled nursing facility discharge; therefore, it is recommended to send the summary clinical information, not only to the skilled nursing facility, but also to the PCP listed in the medical record.

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:	Emergency department
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, department or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the emergency department who are discharged home or to a skilled nursing or long-term care facility

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. The measure 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) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (EDs) and their partners (e.g., primary care providers and urgent care centers) 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 (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:**Modified medication reconciliation completed prior to discharge****MEASURE SET:**

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

MEASURE DESCRIPTION:

This measure estimates the frequency with which patients in the emergency department (ED) receive modified medication reconciliation before they leave the ED.

A 2012 systematic review showed that hospital medication reconciliation was associated with decreased risk for adverse drug events.⁶⁷ 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 ED discharge. Recognizing the unique clinical environment in the ED, the Joint Commission has modified the medication reconciliation requirements delineated in their patient safety goals for hospitals.⁸

NUMERATOR:

Documentation of medication reconciliation prior to discharge

DENOMINATOR:

All patients discharged home or to a skilled nursing or long-term care facility

EXCLUSIONS:

Patients transferred from the ED to another acute-care hospital

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS

Modified medication reconciliation: The process of: 1) identifying which medications the patient should stop, start, or adjust the dose of after the ED visit; and 2) providing both the patient and their providers (e.g., primary care provider and skilled nursing or long-term care facility) with a written list of medications, along with the reason for any changes.

NOTES:

A more robust definition of medication reconciliation, used in most other healthcare settings, includes identifying the name, dosage, route and frequency for every medication a patient is currently taking or should be taking. Although this approach is not currently required in the ED by the Joint Commission, some EDs may wish to perform medication reconciliation using this more comprehensive definition.

The National Quality Forum recommends performing medication reconciliation for high-risk medications collaboratively with the patient's prescribing physician in the community.⁹ High-risk medications might include opioids, diabetic agents, anticoagulants, and antipsychotic medications.

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:	Emergency department
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, department or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the emergency department who are discharged home or to a skilled nursing or long-term care facility

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. The measure 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 (EDs) and their partners (e.g., primary care providers and urgent care centers) 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 (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 emergency departments (Best Practice #7)

MEASURE DESCRIPTION:

This measure estimates the frequency with patients in the emergency department (ED) 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,¹⁰ 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 ED, which indicates patient comprehension of such information is low and may impact post-discharge follow-up care and medication adherence.¹¹

NUMERATOR:

Documentation that all of the following occurred prior to discharge:

- Provision of patient education to the patient and informal caregiver,
- Evidence that understanding of the education provided was assessed, and
- An opportunity for the patient to ask questions.

DENOMINATOR:

All patients discharged home from the ED

EXCLUSIONS:

Patients discharged to a skilled nursing or facility or transferred from the ED to another acute-care hospital

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS

Effective education: Education that incorporates testing of the patient's understanding (e.g., use of a teach-back method).

Informal caregiver: A family member or other person who provides care and support to the patient.

Patient education: Includes, at minimum: the ED 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; activity and other limitations; and recommended 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.

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:	Emergency department
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, department or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients discharged home from the ED

MEASURE HISTORY:

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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 emergency departments (Best Practice #8)

MEASURE DESCRIPTION:

This measure estimates the frequency with which patients in the emergency department (ED) 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.¹² Patients discharged home from the ED are expected to self-manage their follow-up, and provision of written discharge instructions ensures that patients have information to refer to. It may also 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 and informal caregiver prior to discharge

DENOMINATOR:

All patients discharged home from the ED

EXCLUSIONS:

Patients discharged to a skilled nursing or facility or transferred from the ED to another acute-care hospital

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS

Discharge Instructions: Should include, at a minimum:

- The information provided verbally as part of effective education including:
 - ED 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 ED clinician and ED contact information.

Informal caregiver: A family member or other person who provides care and support to the patient.

ED contact information: Phone number the patient can call for more information about the ED stay or discharge instructions, if needed.

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)¹³. These resources may include meals-on-wheels, heating assistance, and/or transportation.

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:	Emergency department
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, department or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients discharged home from the ED

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. The measure 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 (EDs) and their partners (e.g., primary care providers and urgent care centers) 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.

MEASURE INFORMATION:

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

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⁶ Mueller SK, Sponsler KC, Kripalani S, Schnipper JL. Hospital-based medication reconciliation practices: a systematic review. *Arch Intern Med.* 2012;172(14):1057.
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⁹ National Quality Forum. Emergency Department Transitions of Care: A Quality Measurement Framework. 2017; pg 38.
¹⁰ Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. *J Gen Intern Med.* 2009; 24(8):971-6.
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¹³ National Quality Forum. Emergency Department Transitions of Care: A Quality Measurement Framework. 2017, pg 41.