Healthcentric Advisors

Safe Transitions Best Practice Measures for Urgent Care Centers

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

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Providence, RI • Woburn, MA • Brunswick, ME

MEASURE SET:

Safe transitions best practice measures for community physician offices

MEASURES:

The best practice measures for community physician offices are six (6) process measures:

1. Clinical information sent with emergency department (ED) referrals
2. Real-time verbal information provided to ED or hospital clinicians, if needed
3. Clinical information provided to ED or hospital clinicians, if needed
4. High-risk patients contacted via phone after ED or hospital discharge
5. Follow-up visits conducted after patient discharge from the hospital
6. Medication reconciliation completed after ED or hospital discharge

PURPOSE:

The best practice measures are intended to improve provider-to-provider communication and patient activation during patient transitions between any two settings. Community physician offices 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 in or recently discharged from the ED or the hospital

CARE SETTING:

Community physician offices

RECIPROCAL MEASURES:

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

1. Emergency departments
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) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) 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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LAST UPDATED: May 2018

MEASURE:

Clinical information sent with emergency department referrals

MEASURE SET:

Safe transitions best practice measures for community physician offices (Best Practice #1)

MEASURE DESCRIPTION:

This measure estimates the frequency with which community physician offices send clinical information to the emergency department (ED), when referring a patient for evaluation.

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] The Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care.[1]

Although information is sparse regarding communication from primary care providers to the ED, a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between primary care providers (PCPs) and hospital physicians occurs infrequently, in only 3%-20% of cases.[2] ED clinicians express a desire to have pertinent, up-to-date clinical information accompany arriving patients. This information transfer allows ED clinicians to more effectively focus their work-up and management strategies, without repeat testing or duplication of other services, and ensures that a PCP's specific concerns are adequately addressed.

NUMERATOR:

Documentation of provision of clinical information and contact information by the referring physician's office either:

- At the time of patient referral for ED evaluation, or
- Within one hour of patient referral for ED evaluation, if the patient is referred following an after-hours or weekend phone call with the community physician.

DENOMINATOR:

All patients referred for ED evaluation by their community physician

EXCLUSIONS:

Patients whose care is supervised/directed by their community physician while in the ED

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS

Clinical information:	Verbal or written information that includes the main reason for referral to the ED, expectation, problem list, medication list and applicable labs or studies.
Community physician:	The PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a physician or advance practice provider, or be an office location, facility or clinic.
Contact information:	Phone number that connects the ED to office staff who can address the ED clinician's clinical question.
Patients referred for ED evaluation:	Patients sent to the ED by their community physician or another clinician in their physician's office for further evaluation of a clinical problem that may or may not lead to inpatient

admission. This can occur either from the office or following a phone call during which the physician office directs the patient to the ED.

NOTES: None

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:	Community physician office
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:

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) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) 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:

Real-time verbal information provided to emergency department or hospital clinicians, if needed

MEASURE SET:

Safe transitions best practice measures for community physician offices (Best Practice #2)

MEASURE DESCRIPTION:

This measure estimates the frequency with which community physician offices respond to emergency department (ED) and hospital clinicians' verbal requests for time-sensitive clinical information at the time of the initial call or within one hour.

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, and the Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care.[3] Although information is sparse regarding primary care providers' response to requests from the ED for information, a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between primary care providers (PCPs) and hospital physicians occurs infrequently, in only 3%-20% of cases.[4]

ED and hospital clinicians indicate that they may have difficulty reaching patients' PCPs, when they have a time-sensitive need for clinical information to inform patient care. Reasons may include lack of information about the patient's PCP and the inability to speak directly with a clinician in a timely manner.

NUMERATOR:

Documentation that if an ED or hospital clinician called the community physician office, one of the following occurred:

- A conversation between the ED or hospital clinician and the community physician or an outpatient staff member who can address the question at the time of the initial call, or
- A return phone call from the community physician or an office staff member who can address the question within 1 hour of the ED or hospital clinician's phone call to the office

DENOMINATOR:

All patients whose care requires a phone call from the ED or hospital to the community physician's office for time-sensitive clinical conversations

EXCLUSIONS: None

RISK ADJUSTMENT: None

DEFINITIONS

Community physician:	The PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a physician or advance practice provider, or be an office location, facility or clinic.
ED or hospital clinician:	Physician, nurse practitioner, physician's assistant or nurse who is taking care of the patient.
Office staff member:	Clinical or clerical staff who can address the ED or hospital clinician's specific question.
Time-sensitive clinical question:	Whether or not a patient's care "required" a conversation and in what timeframe is a subjective determination left to the ED or hospital clinician's discretion, with the understanding that outreach is intended to be limited to situations where information is needed to inform the patient's care.

NOTES:

The verbal information provided by the community physician to the ED or hospital clinician in this Best Practice differs from the information described in BP #3. This verbal communication is intended to capture time-sensitive information that will immediately inform clinical decision-making; BP #3, in contrast, addresses clinical information that is still important to patient care but may be less time-sensitive (in certain scenarios), such as an updated medication list or recent office visit notes.

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:	Community physician office
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:

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) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) 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:

Clinical information provided to emergency department or hospital clinicians, if needed

MEASURE SET:

Safe transitions best practice measures for community physician offices (Best Practice #3)

MEASURE DESCRIPTION:

This measure estimates the frequency with which community physician offices respond to emergency department (ED) and hospital clinicians' requests for outpatient clinical information within 2 hours of the request.

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] The Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care.[1]

Although information is sparse regarding primary care providers' (PCPs') response to requests from the ED for information, a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between PCPs and hospital physicians occurs infrequently, in only 3%-20% of cases.[6] ED clinicians report occasional difficulty obtaining outpatient clinical information to inform patient care, particularly after regular business hours.

NUMERATOR:

Documentation of the community physician office's provision of clinical information within 2 hours of ED or hospital request

DENOMINATOR:

All ED or hospital patients whose care requires ED or hospital clinician outreach to obtain outpatient clinical information

EXCLUSIONS: None

RISK ADJUSTMENT: None

DEFINITIONS

Clinical information:	Verbal or written information that includes the information requested by the ED/hospital and may include clinical complaint/problem, main reason for referral to the ED/hospital, expectation, problem list, medication list and applicable labs or studies.
Community physician:	The PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a physician or advance practice provider or be an office location, facility or clinic.
ED or hospital clinician:	Physician, nurse practitioner, physician's assistant or nurse who is taking care of the patient.
Provision:	Via email, phone, fax, remote access to office medical record or other electronic means.

NOTES:

The clinical information provided by the community physician's office to the ED or hospital clinician in this Best Practice differs from the verbal information described in BP #2. This communication is intended to capture clinical information that is still important to patient care but may be less time-sensitive (in certain scenarios), such as an updated medication list or recent office visit notes; BP #2, in contrast, addresses time-sensitive information that will immediately inform clinical decision-making.

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:	Community physician office
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:

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) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) 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:

High-risk patients contacted via phone after emergency department or hospital discharge

MEASURE SET:

Safe transitions best practice measures for community physician offices (Best Practice #4)

MEASURE DESCRIPTION:

This measure estimates the frequency with which community physician offices call high-risk patients within 72 hours of patients' discharge from the emergency department (ED) or hospital.

Patients are at risk for poor outcomes and increased healthcare utilization if they: are over the age of 80 years; have cancer, chronic obstructive pulmonary disease or congestive heart failure; have polypharmacy (8+ medications); or have experienced a hospitalization in the previous 6 months.[7] This risk could be exacerbated by poor health literacy, stress and other factors, making it important for the patient's outpatient clinician to ascertain the patient's condition and their adherence to recommended care and follow-up quickly after a healthcare episode.

The follow-up phone call may be particularly important if the patient's scheduled follow-up visit does not immediately follow ED or hospital discharge, to preemptively catch any potential problems and to ensure that the patient knows that their primary care provider is now responsible for their care, and how they can outreach with questions.

NUMERATOR:

Documentation of a follow-up phone call within 72 hours of patient discharge from the ED or hospital

DENOMINATOR:

All patients discharged from the ED or hospital who are characterized as high-risk

EXCLUSIONS:

Patients who:

- Are followed by their community physician's office while in the ED or hospital,
- Are discharged to acute care, long-term care or skilled nursing facilities,
- Decline a follow-up phone call, or
- Have an outpatient follow-up appointment within 72 hours of ED or hospital discharge

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS

Follow-up phone call:	An outpatient clinician phone call with the patient, family or informal caregiver to assess the patient's condition and adherence to recommended care and to reinforce follow-up.
High-risk patients:	Patients with one or more of the following: • Age 80 years or older, • A diagnosis of cancer, chronic obstructive pulmonary disease or congestive heart failure, • Polypharmacy (8+ medications), • A hospitalization in the previous 6 months, or • Any other risk factors identified by the community physician office
Informal caregiver:	A family member or other person who provides care and support to the patient
Outpatient clinician:	Physician, nurse practitioner, physician assistant or nurse at the community physician's office, which can be an office location, facility or clinic.

NOTES:

This measure includes hospital discharges for both inpatient admissions and observation stays.

CLASSIFICATION:

National Quality Strategy Priorities:	Promoting effective communication and coordination of care Ensuring that each person and family are engaged as partners in their care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Community physician office
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 or who visit the ED and are discharged home

MEASURE 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) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) 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:

Follow-up visits conducted after patient discharge from the hospital

MEASURE SET:

Safe transitions best practice measures for community physician offices (Best Practice #5)

MEASURE DESCRIPTION:

This measure estimates the frequency with which community physician offices conduct office visits with patients discharged from hospital.

The post-hospital follow-up visit provides an opportunity for the community physician office to fully assume responsibility for patient care—which is transferred from the hospital to the office at the time of hospital discharge—and to ascertain the patient's condition and their adherence to recommended care and follow-up. The visit is also an opportunity to activate and engage patients and their informal caregivers (such as family) in their care and to prevent any worsening signs or symptoms from resulting in an avoidable emergency department (ED) visit or hospital admission.[8]

NUMERATOR:

Documentation of one of the following:

- A follow-up phone call within 72 hours of patient discharge from the hospital, or
- A follow-up appointment scheduled within 14 days of discharge (or the timeframe otherwise specified and documented in the hospital discharge instructions)

DENOMINATOR:

All patients discharged from the hospital

EXCLUSIONS:

Patients who:

- Are followed by their community physician's office while in the hospital,
- Are discharged to acute care, long-term care or skilled nursing facilities, or
- Decline a follow-up phone call and appointment.

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS

Community physician:	The primary care provider (PCP) or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a physician or advance practice provider, or be an office location, facility or clinic.
Follow-up appointment scheduled:	A community physician office visit scheduled either by the ED or hospital or the community physician's office.
Hospital discharge:	Includes both inpatient admissions and observation stays.
Informal caregiver:	A person, such as a family member, who provides care and support to the patient.
Outpatient clinician:	Physician, nurse practitioner, physician assistant or nurse at the community physician's office, which can be a PCP or specialist, and can be an office location, facility or clinic.
Outpatient follow-up:	A phone call or office visit with an outpatient clinician from the community physician's office, which can be an office location, facility or clinic.

Phone call:	An outpatient clinician phone call with the patient, family, or caregiver to assess the patient's condition and adherence to recommended care and to reinforce follow-up.

NOTES:

Patients discharged from the ED are not targeted by this measure for a number of reasons, including the fact that many patients self-refer to the ED (sometimes resulting in inappropriate ED utilization, for conditions that could have been addressed in an outpatient setting) and the fact that ED discharge disposition is highly variable (follow-up may not always be necessary or appropriate). Community physicians should use their discretion regarding the necessity of follow-up office visits for patients discharged from the ED.

There are transitional care management billing codes that are available to support physician follow-up (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf).

CLASSIFICATION:

National Quality Strategy Priorities:	Promoting effective communication and coordination of care Ensuring that each person and family are engaged as partners in their care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Community physician office
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:

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) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) 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:

Medication reconciliation completed after emergency department or hospital discharge

MEASURE SET:

Safe transitions best practice measures for community physician offices (Best Practice #6)

MEASURE DESCRIPTION:

This measure estimates the frequency with which community physician offices perform medication reconciliation after their patients are discharged from the emergency department (ED) or hospital.

Studies demonstrate that medication errors or discrepancies are relatively common at hospital discharge (occurring among 14% of elderly patients) and are associated with a higher risk of poor outcomes and hospital readmission.[9] Guidelines for post-hospital office visits stress the importance of medication reconciliation to identity and resolve any medication problems, helping to ensure patient safety and prevent excess utilization.[10]

NUMERATOR:

Documentation that an outpatient clinician performed medication reconciliation within 14 days of ED or hospital discharge, either in-person at the office or via phone

DENOMINATOR:

All patients discharged from the ED or hospital

EXCLUSIONS:

Patients who are discharged to acute care, long-term care or skilled nursing facilities

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS

Community physician:	The primary care provider (PCP) or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a physician or advance care provider, or be an office location, facility or clinic.
Hospital discharge:	Includes both inpatient admissions and observation stays.
Informal caregiver:	A person, such as a family member, who provides care and support to the patient
Medication reconciliation:	The process of: 1. Reviewing the patient's discharge medication regimen (name, dose, route, frequency, and purpose), 2. Comparing the discharge medication regimen with what the patient is currently taking (including non-prescription medications), as well as with their prior medication regimen, to identify and resolve any discrepancies, and 3. Providing an updated list to the patient or informal caregiver (such as family), with information about which medications the patient should start, stop, continue, or adjust the dose of and the reasons for any change.
Outpatient clinician:	Physician, nurse practitioner, physician assistant, nurse or certified nursing assistant at the community physician's office, which can be an office location, facility or clinic.

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.[11] A checklist for post-hospital discharge office visits is also available and recommends that outpatient

clinicians use a "teach back" mechanism to test patients' comprehension of their medications' purpose and instructions.[2]

Outpatient clinicians seeking to exceed the minimum standard set forth by this best practice may consider adopting medication reconciliation as an "always event" that is completed during every patient encounter, not only those immediately following ED or hospital utilization.

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:	Community physician office
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 or who visit the ED and are discharged home

MEASURE 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) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) 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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[1] 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.
[2] Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831–41.
[3] 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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[7] Project Better Outcomes for Older adults through Safer Transitions (BOOST). Available: www.hospitalmedicine.org/BOOST/, 11 Apr 2013.
[8] Coleman EA. The post-hospital follow-up visit: A physician checklist to reduce readmissions. Available: http://www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist, 11 Apr 2013.
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