

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

MEASURE SET:**Safe transitions best practice measures for urgent care centers****MEASURES:**

The best practice measures for urgent care centers 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 completion of visit
4. Summary clinical information provided to home care provider upon completion of visit
5. Summary clinical information provided to the emergency department when referring a patient for evaluation
6. Modified medication reconciliation performed upon completion of visit
7. Effective education provided to patients upon completion of visit
8. Written discharge instructions provided to patients upon completion of visit

PURPOSE:

The best practice measures are intended to improve provider-to-provider communication and patient activation during patient transitions between any two settings. Urgent care centers 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:

All patients seen in the urgent care center and/or walk-in clinics

CARE SETTING:

Urgent care center

RECIPROCAL MEASURES:

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

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

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 Improvement Organization for Rhode Island, 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 (urgent care centers) 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.

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LAST UPDATED:

08 March 2018

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

Safe transitions best practice measures for urgent care centers (Best Practice #1)

MEASURE DESCRIPTION:

This measure estimates the frequency with which urgent care centers ask patients for the name of their primary care provider (PCP). Asking for the name of the patient's PCP 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

Results from a 2008 national survey indicate that communication between urgent care centers and other healthcare providers is inconsistent: a third of urgent care clinicians reported they did not send information to patients' regular physicians, even if that physician were known.² Many urgent care patients do not have PCPs—as many as 38% in one study.² Identifying these patients will allow for referrals, possibly leading to improved follow up, as well as avoidance of unnecessary healthcare utilization (e.g., duplicate testing or hospital admission).

NUMERATOR:

Documentation of one of the following:

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

DENOMINATOR:

All patients seen in the urgent care center

EXCLUSIONS:

None

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

Primary care provider: The clinician identified by the patient as their usual source of care or regular physician or the PCP designated in the medical record.

NOTES:

If a patient does not have a PCP, is unsure of the name, or is 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 urgent care center to ask this question with every patient, at every visit, since this information is subject to change over time.

If the patient does not have a PCP or identifies a specialist as their PCP, the urgent care center should offer to refer the patient to a PCP.

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:	Urgent care center
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 seen in the urgent care center

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, 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 (urgent care centers) and their community partners (e.g., PCPs) 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 for Urgent Care Centers) 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:

08 March 2018

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

Safe transitions best practice measures for urgent care centers (Best Practice #2)

MEASURE DESCRIPTION:

This measure estimates the frequency with which urgent care centers 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.³ Community-based home care providers may not be aware of their patients' urgent care center 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 visit while the patient is in the urgent care center, they can contact the urgent care clinician to assist with preventing unwanted hospital 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 urgent care center

EXCLUSIONS:

None

RISK ADJUSTMENT:

None

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 the patient does not have a current home care provider, is unsure of the name or is 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:	Urgent care center
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 seen in the urgent care center

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, 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 (urgent care centers) and their community partners (e.g., PCPs) 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 for Urgent Care Centers) 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:

08 March 2018

MEASURE:**Summary clinical information provided to primary care provider upon completion of visit****MEASURE SET:**

Safe transitions best practice measures for urgent care centers (Best Practice #3)

MEASURE DESCRIPTION:

This measure estimates the frequency with which urgent care centers provide primary care providers (PCPs) with summary clinical information about their patients' urgent care 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 One 2008 national survey found that about half of urgent care clinicians reported sending a copy of the patient's chart when the PCP is known. Others may call or send a consult note and a third do not communicate at all.⁵

Such communication is particularly important during and after urgent care center visits. To ensure appropriate clinical follow-up, information from the encounter should be readily available to the patient's PCP.

NUMERATOR:

Documentation of the following sent to the PCP office within 24 hours of the completion of the patient's visit:

- Medical diagnosis
- Updated medication list with reason for any changes
- Results of diagnostic tests and presence of pending tests
- Name of urgent care clinician who saw the patient and contact information
- Discharge instructions, including name of emergency department (ED) to which patient was referred, if applicable
- Recommended follow-up, and
- Name of informal caregiver (such as family) and contact information.

DENOMINATOR:

All patients seen in the urgent care center

EXCLUSIONS:

Patients without a known PCP

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

Diagnostic tests: Imaging, EKGs, laboratory studies, or other tests performed as part of the urgent care evaluation.

Primary care provider: The clinician identified by the patient as their regular doctor or the PCP designated in the medical record. This may include a PCP, specialist, mid-level practitioner, office location, or clinic, and the summary clinical information can be sent to any of the above to meet the measure.

Sent: Transmitted from the urgent care clinician to the PCP office via fax, email or other electronic means.

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

Discharge Instructions: Should include, at a minimum:

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

Urgent care contact information: Phone number the primary care provider can call for more information about the urgent care visit and recommended follow-up, if needed.

NOTES:

If diagnostic test results have not returned by the time the summary is transmitted, the urgent care center should indicate that there are pending tests and send results when available.

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.

Summary clinical information should be sent to the PCP and to any relevant specialists identified by the patient.

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:	Urgent care center
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 upon completion of urgent care center visit

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, 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 (urgent care centers) and their community partners (e.g., PCPs) 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 for Urgent Care Centers) 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:

08 March 2018

MEASURE:**Summary clinical information provided to home care provider upon completion of visit****MEASURE SET:**

Safe transitions best practice measures for urgent care centers (Best Practice #4)

MEASURE DESCRIPTION:

This measure estimates the frequency with which urgent care centers provide home care providers with summary clinical information about their patients' urgent care 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.⁶ Information transfer to the next care provider helps receiving or downstream clinicians prepare for patient intake and ensure continuity of care. Such communication is particularly important during and after urgent care center visits. To ensure appropriate clinical follow-up, information from the encounter should be readily available to the patient's home care provider.

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 visit while the patient is in the urgent care center, they can contact the urgent care clinician to assist with preventing unwanted hospital admissions or diagnostic studies and other interventions, for which patients could be financially responsible.

NUMERATOR:

Documentation of the following sent to the home care provider within 24 hours of the completion of the patient's visit:

- Medical diagnosis
- Updated medication list with reason for any changes
- Results of diagnostic tests and presence of pending tests
- Name of urgent care clinician who saw the patient and contact information
- Discharge instructions, including name of emergency department to which patient was referred, if applicable
- Recommended follow-up, and
- Name of informal caregiver (such as family) and contact information.

DENOMINATOR:

All patients seen in the urgent care center

EXCLUSIONS:

Patients without a known home care provider

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

Diagnostic tests: Imaging, EKGs, laboratory studies, or other tests performed as part of the urgent care evaluation.

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.

Sent:	Transmitted from the urgent care clinician to the home care provider office via fax, email or other electronic means.
Informal caregiver:	A family member or other person who provides care and support to the patient.
Discharge Instructions:	Should include, at a minimum: <ul style="list-style-type: none">• The information provided verbally as part of effective education including:<ul style="list-style-type: none">- Urgent care 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 urgent care clinician and urgent care contact information.
Urgent care contact information:	Phone number the home care provider can call for more information about the urgent care visit and recommended follow-up, if needed.

NOTES:

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

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 summary clinical information here is the same as the information sent to primary care providers 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:	Urgent care center
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 seen in an urgent care center who are receiving home care services

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, 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 (urgent care centers) and their community partners (e.g., PCPs) 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 for Urgent Care Centers) 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:

08 March 2018

MEASURE:**Summary clinical information provided to the emergency department when referring a patient for evaluation****MEASURE SET:**

Safe transitions best practice measures for urgent care centers (Best Practice #5)

MEASURE DESCRIPTION:

This measure estimates the frequency with which urgent care centers provide emergency departments (EDs) with summary clinical information about the urgent care center visit when a patient is referred to the ED from the urgent care center.

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. Information transfer to the next facility helps receiving or downstream providers prepare for patient intake and ensure continuity of care. Such communication is particularly important when a patient is referred to the ED from an urgent care center for further evaluation, given the inherent acuity of the medical issue and the uncertainty in either the diagnosis or the management plan.

NUMERATOR:

Documentation that there was a verbal conversation with the ED AND that the following was sent to the ED clinician with the patient or at the time of patient referral:

- Reason for referral and specific concern to be addressed
- Results of diagnostic tests and presence of pending tests
- Name of informal caregiver (such as family) and contact information.
- Name of urgent care clinician who saw the patient and contact information

DENOMINATOR:

All patients seen in the urgent care center who are referred to the ED

EXCLUSIONS:

None

RISK ADJUSTMENT:

None

DEFINITIONS

Diagnostic tests: Imaging, EKGs, laboratory studies, or other tests performed as part of the urgent care evaluation.

Sent: Transmitted from the urgent care clinician to the ED with the patient or via fax, email or other electronic means.

Urgent care contact information: Phone number the ED clinician can call for more information about the urgent care visit, if needed.

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

Verbal conversation with the ED: A phone call from the urgent care center clinician to the ED triage staff or an ED clinician to give information about the patient and the reason for referral.

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:	Urgent care center
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 seen in the urgent care center who are referred to the ED

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, 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 (urgent care centers) and their community partners (e.g., PCPs) 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 for Urgent Care Centers) 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:

08 March 2018

MEASURE:**Modified medication reconciliation preformed upon completion of visit****MEASURE SET:**

Safe transitions best practice measures for urgent care centers (Best Practice #6)

MEASURE DESCRIPTION:

This measure estimates the frequency with which patients in the urgent care center receive modified medication reconciliation upon completion of visit.

Medication errors are common, and studies have shown that medication reconciliation is associated with decreased risk for adverse drug events.^{7,8,9} 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 an urgent care visit. Recognizing the unique clinical environment of the emergency department, the Joint Commission has modified the medication reconciliation requirements delineated in their patient safety goals, and these modified guidelines can reasonably be extended to the urgent care setting, as well.

NUMERATOR:

Documentation of modified medication reconciliation prior to completion of visit

DENOMINATOR:

All patients seen in the urgent care center

EXCLUSIONS:

Patients referred to the emergency department (ED)

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

Modified medication reconciliation:	The process of: 1) identifying which medications the patient should stop, start, or adjust dose of after the urgent care visit; and 2) providing both the patient and their primary care provider with a written list of medications, along with the reason for any changes.
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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. Some urgent care centers 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. High-risk medications might include opioids, diabetic agents, anticoagulants, and antipsychotic medications.

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:	Urgent care center
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 seen in the urgent care center

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, 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 (urgent care center) and their community partners (e.g., PCPs) 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 for Urgent Care Centers) 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:

08 March 2018

MEASURE:**Effective education provided to patients upon completion of visit****MEASURE SET:**

Safe transitions best practice measures for urgent care center (Best Practice #7)

MEASURE DESCRIPTION:

This measure estimates the frequency with patients in the urgent care center 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 emergency department, which indicates patient comprehension of such information is low and may impact post-visit follow-up care and medication adherence¹¹.

NUMERATOR:

Documentation that all of the following occurred upon completion of the patient's visit:

- 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 seen in the urgent care center

EXCLUSIONS:

Patients referred to the emergency department (ED)

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 urgent care 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:	Urgent care center
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 seen in the urgent care center

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, 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 (urgent care centers) and their community partners (e.g., PCPs) 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 for Urgent Care Centers) 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:

08 March 2018

MEASURE:**Written discharge instructions provided to patients upon completion of visit****MEASURE SET:**

Safe transitions best practice measures for urgent care centers (Best Practice #8)

MEASURE DESCRIPTION:

This measure estimates the frequency with which patients in the urgent care center are provided with written discharge instructions upon completion of the visit.

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 urgent care center 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 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.”¹³

NUMERATOR:

Documentation that written discharge instructions were provided to the patient or informal caregiver (such as family) upon completion of visit

DENOMINATOR:

All patients seen in the urgent care center

EXCLUSIONS:

Patients referred to the emergency department (ED)

RISK ADJUSTMENT:

None – see exclusions

DEFINITIONS

Discharge Instructions: Should include, at a minimum:

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

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

Urgent care contact: Phone number the patient can call for more information about the urgent care information: visit 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.

Written discharge instructions should engage the broader community, when applicable, and include information on available resources that address social determinants of health and may support a transition of care¹⁴. These resources may include meals-on-wheels, heating assistance, and 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:	Urgent care center
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 seen in the urgent care center

MEASURE HISTORY:

This measure was developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, 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) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (urgent care centers) and their community partners (e.g., PCPs) 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 for Urgent Care Centers) 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:

08 March 2018

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 Developing data: Integration within the healthcare system. *The Journal of Urgent Care Medicine* 2009 Mar;3(6):40

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- ⁴ 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.
- ⁵ Developing data: Integration within the healthcare system. *The Journal of Urgent Care Medicine* 2009 Mar;3(6):40.
- ⁶ 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.
- ⁷ Mueller SK, Sponsler KC, Kripalani S, Schnipper JL. Hospital-based medication reconciliation practices: a systematic review. *Arch Intern Med.* 2012;172(14):1057.
- ⁸ Mills PR, McGuffie AC. Formal medicine reconciliation within the emergency department reduces the medication error rates for emergency admissions. *Emerg Med J.* 2010 Dec;27(12):911-5.
- ⁹ Caglar S, Henneman PL, Blank FS, Smithline HA, Henneman EA. Emergency department medication lists are not accurate. *J Emerg Med.* 2011; 40: 613-616.
- 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.
- ¹¹ Samuels-Kalow ME, Stack AM, Porter SC. Effective discharge communication in the emergency department. *Ann Emerg Med.* 2012; 60(2):152-9.
- ¹² ² 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.
- ¹⁴ National Quality Forum. Emergency Department Transitions of Care: A Quality Measurement Framework. 2017, pg 41.