

# Safe Transitions Best Practice Measures for Home Health Agencies

---

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

**MEASURE:****Safe transitions best practice measures for home health agencies****MEASURES:**

The best practice measures for home health agencies are eleven (11) process measures:

1. Risk assessment for hospital admission completed
2. Targeted interventions implemented for high-risk patients
3. Patients educated about seeking assistance for worsening symptoms
4. Medication reconciliation completed at the start of care assessment, re-certification, resumption of services and after doctor or emergency department visits
5. Medication adherence and regimen changes assessed at each home visit
6. Follow-up appointments completed within 14 days of hospital or skilled nursing facility discharge
7. Structured communication used for clinical questions to physicians
8. Real-time verbal information provided to emergency department or hospital clinicians, if needed
9. Clinical information sent with emergency department referrals
10. Summary clinical information provided to outpatient physician(s) at discharge
11. Responses to patient questions provided in a timely manner

**PURPOSE:**

The best practice measures are intended to improve provider-to-provider communication and patient activation during patient transitions between any two settings. Home health agencies 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 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. Other processes included here are based on national campaigns and standards.

**POPULATION:**

Varies by measure, but generally includes all patients in home health care

**CARE SETTING:**

Home health agencies

**RECIPROCAL MEASURES:**

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

1. Community physician offices
2. Emergency departments
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 (home health agencies) 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.

**MEASURE INFORMATION:**

Lynne Chase  
*Quality Director, Healthcentric Advisors*  
[lchase@healthcentricadvisors.org](mailto:lchase@healthcentricadvisors.org)

**CONSULTING SERVICES:**

Kara H. Butler, MBA, MHSA  
*Director, Administrative Services, Healthcentric Advisors*  
[kbutler@healthcentricadvisors.org](mailto:kbutler@healthcentricadvisors.org)

**MEASURES DEVELOPED:** 2009**MEASURES LAST REVIEWED:** January 2023

**MEASURE:****Risk assessment for hospital admission completed****MEASURE SET:**

Safe transitions best practice measures for home health agencies (Best Practice #1)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which home health agencies complete risk assessments for hospital admission for all patients. Hospital admissions are a significant source of patient and family stress, high costs and poor quality of life.<sup>1</sup> Given the frailty and medical co-morbidities of the home health population, all patients are at higher risk than most other individuals for hospital admission. Identifying patients at the highest risk for admission allows for implementation of targeted interventions, possibly preventing an unnecessary hospitalization.

Risk factors to be identified in the assessment for hospital admission may include: recent decline in mental, emotional or behavioral status; history of falls (more than two in the past year or any fall with an injury in the past year); frailty indicators (e.g., weight loss, declines in physical function, self-reported exhaustion); recent hospitalizations; and polypharmacy (five or more medications).

**NUMERATOR:**

During start of care assessment and at re-certification, documentation of:

- Risk status,
- Patient without an identified caregiver, or
- Patient with cognitive impairment

**DENOMINATOR:**

All patients

**EXCLUSIONS:** None

**RISK ADJUSTMENT:** None

**DEFINITIONS**

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

**Cognitive impairment:** Documented diagnosis of cognitive impairment or dementia; or decreased ability to participate in care due to mental status, as assessed by the home health clinician.

**High-risk status:** Identified during risk assessment. High risk factors may include:

- Recent decline in the past 3 months in mental, emotional, or behavioral status,
- History of falls ( $\geq 2$  in the past year or any fall with an injury in the past year),
- Frailty indicators (e.g., weight loss, decline in physical function, self-reported exhaustion) or difficulty complying with medical instructions (e.g., medications, diet).
- $\geq 2$  hospitalizations in the prior 6 months and/or  $\geq 2$  or more emergency department visits.
- Polypharmacy (5+ medications),
- Other factors as appropriate (e.g., socioeconomic status, health literacy, and medications like anticoagulants, diabetic agents, and opioids).

**Re-certification:** Occurs 60 days after the first visit.

**Risk assessment:** Completion of a risk assessment (such as OASIS items M1032 and M1034) that captures high-risk criteria for hospital admission could potentially be used.

Start of care assessment: Occurs at the first clinical visit to the patient's home.

**NOTES:** None

**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:	Home health agencies
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 home health care

**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) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (home health agencies) 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.

**MEASURE INFORMATION:**

Lynne Chase  
Quality Director, Healthcentric Advisors  
[lchase@healthcentricadvisors.org](mailto:lchase@healthcentricadvisors.org)

**MEASURE DEVELOPED:** 2009

**CONSULTING SERVICES:**

Kara H. Butler, MBA, MHSA  
Director, Administrative Services, Healthcentric Advisors  
[kbutler@healthcentricadvisors.org](mailto:kbutler@healthcentricadvisors.org)

**MEASURE LAST REVIEWED:** January 2023

**MEASURE:****Targeted interventions implemented for high-risk patients****MEASURE SET:**

Safe transitions best practice measures for home health agencies (Best Practice #2)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which home health agencies implement interventions for patients at highest risk for hospital admission. Given the frailty and medical co-morbidities of the home health population, all patients are at higher risk than most other individuals for hospital admission. Identifying patients at the highest risk for admission allows for implementation of targeted interventions, possibly preventing an unnecessary hospitalization.<sup>2</sup>

Targeted interventions may include: front-loaded visits; telehealth; rehabilitation services; or scheduled calls on days with no visits.

**NUMERATOR:**

Documentation of implementation of targeted interventions for high-risk patients within 24 hours of the start of care assessment and re-certification

**DENOMINATOR:**

All high-risk patients

**EXCLUSIONS:** None

**RISK ADJUSTMENT:** None

**DEFINITIONS**

**Interventions:** Targeted strategies to reduce patients' specific risks for hospital admission, for example:

- Front-loaded visits,
- Telehealth,
- Rehabilitation services, or
- Scheduled calls on days with no visits

**High-risk status:** Identified during risk assessment. High risk factors may include:

- Recent decline in the past 3 months in mental, emotional, or behavioral status,
- History of falls ( $\geq 2$  in the past year or any fall with an injury in the past year),
- Frailty indicators (e.g., weight loss, decline in physical function, self-reported exhaustion) or difficulty complying with medical instructions (e.g., medications, diet).
- $\geq 2$  hospitalizations in the prior 6 months and/or  $\geq 2$  or more emergency department visits.
- Polypharmacy (5+ medications),
- Other factors as appropriate (e.g., socioeconomic status, health literacy, and medications like anticoagulants, diabetic agents, and opioids).

**Re-certification:** Occurs 60 days after the first visit.

**Start of care assessment:** Occurs at the first clinical visit to the patient's home.

**NOTES:** None

**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:	Home health agency
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 home health care

**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) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (home health agencies) 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.

**MEASURE INFORMATION:**

Lynne Chase  
Quality Director, Healthcentric Advisors  
[lchase@healthcentricadvisors.org](mailto:lchase@healthcentricadvisors.org)

**MEASURE DEVELOPED:** 2009

**CONSULTING SERVICES:**

Kara H. Butler, MBA, MHSA  
Director, Administrative Services, Healthcentric Advisors  
[kbutler@healthcentricadvisors.org](mailto:kbutler@healthcentricadvisors.org)

**MEASURE LAST REVIEWED:** January 2023

**MEASURE:****Patients educated about seeking assistance for worsening symptoms****MEASURE SET:**

Safe transitions best practice measures for home health agencies (Best Practice #3)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which home health agencies educate patients, and their families and caregivers, about seeking assistance for worsening symptoms. Early recognition of changes that indicate a worsening condition allows for interventions and treatments that may help to prevent unnecessary hospitalizations. Self-management skills can enable patients, and their families and caregivers, to recognize “red flag” symptoms that should prompt reaching out for help.<sup>3</sup> Assessment of the patient’s understanding of the education provided is a key part of this process and may be accomplished using strategies like “teach-back.”<sup>4</sup>

**NUMERATOR:**

Documentation that all three of the following occurred at the start of care assessment and re-certification:

- A home health agency phone number was provided to the patient, family, or caregiver, and
- The patient, family, or caregiver was educated about when and how to seek assistance for worsening symptoms (“red flags”) and
- Evidence that the patient, family, or caregiver’s understanding of the education provided was assessed

**DENOMINATOR:**

All home health patients

**EXCLUSIONS:** None

**RISK ADJUSTMENT:** None

**DEFINITIONS**

Informal Caregiver:	A family member or other person who provides care and support to the patient.
Home health agency phone number:	A phone number that connects the patient, family, or caregiver: (1) to a clinician who can answer questions about their care, or (2) to an answering service through which a clinician will return the call within 30 minutes.
Re-certification:	Occurs 60 days after the first visit.
Start of care assessment:	Occurs at the first clinical visit to the patient’s home.

**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:	Home health agency
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 home health care

**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) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (home health agencies) 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.

**MEASURE INFORMATION:**

Lynne Chase  
Quality Director, Healthcentric Advisors  
[lchase@healthcentricadvisors.org](mailto:lchase@healthcentricadvisors.org)

**MEASURE DEVELOPED:** 2009**CONSULTING SERVICES:**

Kara H. Butler, MBA, MHSA  
Director, Administrative Services, Healthcentric Advisors  
[kbutler@healthcentricadvisors.org](mailto:kbutler@healthcentricadvisors.org)

**MEASURE LAST REVIEWED:** January 2023

**MEASURE:**

**Medication reconciliation completed at the start of care assessment, re-certification, resumption of services and after doctor or emergency department visits**

**MEASURE SET:**

Safe transitions best practice measures for home health agencies (Best Practice #4)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which home health agencies perform medication reconciliation at the start of care assessment, re-certification, resumption of services and after a doctor or emergency department (ED) visit.

Medication errors are common, and studies have shown that medication reconciliation is associated with decreased risk for adverse drug events.<sup>5,6,7</sup> Medication reconciliation is a Joint Commission patient safety goal and can help home health providers identify potential medication errors. This process also allows home health providers to understand which medications to stop, start or adjust after a patient experiences a transition in their care. Studies demonstrate that medication errors 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.<sup>8</sup>

**NUMERATOR:**

Documentation of medication reconciliation at the start of care assessment, re-certification, resumption of services, and after doctor or ED visits

**DENOMINATOR:**

Patients receiving skilled nursing services or medication management services

**EXCLUSIONS:** None

**RISK ADJUSTMENT:** None

**DEFINITIONS**

**Medication reconciliation:** The process of 1) reviewing the patient's current medication regimen (name, dose, route, frequency, and purpose) and comparing it with what the patient is actually taking (including non-prescription medications) to identify and resolve any discrepancies; and 2) providing an updated list to the patient.

**Re-certification:** Occurs 60 days after the first visit.

**Resumption of services:** Restart of home health care services after interruption for hospital utilization.

**Start of care assessment:** Occurs at the first clinical visit to the patient's home.

**NOTES:** None

**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:	Home health agency
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 home health care

**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) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (home health agencies) 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.

**MEASURE INFORMATION:**

Lynne Chase  
Quality Director, Healthcentric Advisors  
[lchase@healthcentricadvisors.org](mailto:lchase@healthcentricadvisors.org)

**MEASURE DEVELOPED:** 2009

**CONSULTING SERVICES:**

Kara H. Butler, MBA, MHSA  
Director, Administrative Services, Healthcentric Advisors  
[kbutler@healthcentricadvisors.org](mailto:kbutler@healthcentricadvisors.org)

**MEASURE LAST REVIEWED:** January 2023

**MEASURE:****Medication adherence and regimen changes assessed at each home visit****MEASURE SET:**

Safe transitions best practice measures for home health agencies (Best Practice #5)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which home health agencies assess medication adherence and regimen changes at each home visit.

Successful medication management is an important factor in reducing hospitalizations.<sup>9</sup> Studies estimate that one in five patients discharged from the hospital to home experience an adverse event within just three weeks, and that two-thirds of these adverse events are drug-related events that may have possibly been avoided.<sup>10</sup> Assessing adherence at each visit may help identify adverse effects, difficulty in obtaining a particular medication or unaddressed concerns about a regimen. Inquiring about regimen changes helps the home health provider maintain an up-to-date medication list and can identify new potential errors or drug interactions.<sup>11</sup>

**NUMERATOR:**

Documentation of assessment of medication adherence and medication regimen changes at each home visit

**DENOMINATOR:**

Patients receiving skilled nursing services or medication management services

**EXCLUSIONS:** None

**RISK ADJUSTMENT:** None

**DEFINITIONS**

Re-certification: Occurs 60 days after the first visit.  
Resumption of services: Restart of home health care services after interruption for hospital utilization.  
Start of care assessment: Occurs at the first clinical visit to the patient's home.

**NOTES:** None

**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:	Home health agencies
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 home health care

**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) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (home health agencies) 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.

**MEASURE INFORMATION:**

Lynne Chase  
Quality Director, Healthcentric Advisors  
[lchase@healthcentricadvisors.org](mailto:lchase@healthcentricadvisors.org)

**MEASURE DEVELOPED:** 2009**CONSULTING SERVICES:**

Kara H. Butler, MBA, MHSA  
Director, Administrative Services, Healthcentric Advisors  
[kbutler@healthcentricadvisors.org](mailto:kbutler@healthcentricadvisors.org)

**MEASURE LAST REVIEWED:** January 2023

**MEASURE:****Follow-up appointments completed within 14 days of hospital or skilled nursing facility discharge****MEASURE SET:**

Safe transitions best practice measures for home health agencies (Best Practice #6)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which patients complete any follow-up appointment with their primary care provider or a specialist within 14 days of hospital or skilled nursing facility discharge.

Although improved communication among home health agencies, nursing homes and community-based primary care providers can help to transmit important clinical information when patients are discharged, many primary care providers (or specialists) do not fully assume responsibility for recently discharged patients until a follow-up appointment occurs.

The follow-up appointment is important for the provider to: 1) assume professional responsibility for patient care, 2) assess and facilitate adherence to discharge instructions and medications, and 3) elicit any patient questions. Aiming to complete this appointment within 14 days of hospital or skilled nursing facility discharge minimizes gaps in care and helps to ensure that problems developing after discharge are identified and treated promptly.

**NUMERATOR:**

Documentation that patient completed a physician follow-up appointment within 14 days of hospital or skilled nursing facility discharge

**DENOMINATOR:**

All patients discharged from a hospital or skilled nursing facility

**EXCLUSIONS:**

Patients who decline to have a physician visit scheduled for any reason

**RISK ADJUSTMENT:** None – see exclusions

**DEFINITIONS**

**Discharge:** Patient discharged from hospital outpatient observation, hospital inpatient admission, or a skilled nursing facility.

**Physician follow-up appointment:** An office visit with an outpatient primary care provider, relevant specialist, or the physician signing the home health orders.

**NOTES:**

For patients seen in the emergency department and discharged home, consider reviewing discharge instructions and assisting with any recommended physician follow-up visits.

**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:	Home health agency
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 home health care

**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) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (home health agencies) 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.

**MEASURE INFORMATION:**

Lynne Chase  
Quality Director, Healthcentric Advisors  
[lchase@healthcentricadvisors.org](mailto:lchase@healthcentricadvisors.org)

**MEASURE DEVELOPED:** 2009

**CONSULTING SERVICES:**

Kara H. Butler, MBA, MHSA  
Director, Administrative Services, Healthcentric Advisors  
[kbutler@healthcentricadvisors.org](mailto:kbutler@healthcentricadvisors.org)

**MEASURE LAST REVIEWED:** January 2023

**MEASURE:****Structured communication used for clinical questions to physicians****MEASURE SET:**

Safe transitions best practice measures for home health agencies (Best Practice #7)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which home health agencies use structured communication for clinical questions to physicians about home health patients. Given the frailty and medical co-morbidities of the home health population and the busy workday of most primary care providers, efficient and effective communication is especially important. Home health agencies need a framework to quickly and accurately convey information about worrisome signs or symptoms that may lead to an emergency department visit if not promptly addressed.<sup>1</sup>

Tools for structured communication, such as SBAR<sup>12</sup>, provide a foundation for more effective and consistent transfer of information from a home health nurse to a provider in a community physician office. Nurses and physicians are trained to communicate in different ways; use of structured communication can help to bridge these different communication styles and ensure that patient information is shared in a concise format. Structured communication improves patient safety because clinicians can communicate with each other with a shared set of expectations.

**NUMERATOR:**

Documentation of use of structured communication, such as SBAR, and a “triage protocol”

**DENOMINATOR:**

All verbal communication with physician offices

**EXCLUSIONS:** None

**RISK ADJUSTMENT:** None

**DEFINITIONS**

- SBAR:** Situation-Background-Assessment-Recommendation; a communication framework for inter-provider discussions to ensure that high-urgency concerns are addressed efficiently. SBAR is one example of a structured communication tool.
- Triage protocol:** Formalized goals for expected response timeframes from a physician office, based on the urgency of the clinical question.

**NOTES:**

Home health agencies might find it helpful to develop a formal physician communication policy—a written policy that is part of new-hire and occasional recurring staff training.



**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:	Home health agency
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 home health care

**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) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (home health agencies) 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.

**MEASURE INFORMATION:**

Lynne Chase  
Quality Director, Healthcentric Advisors  
[lchase@healthcentricadvisors.org](mailto:lchase@healthcentricadvisors.org)

**MEASURE DEVELOPED:** 2009

**CONSULTING SERVICES:**

Kara H. Butler, MBA, MHSA  
Director, Administrative Services, Healthcentric Advisors  
[kbutler@healthcentricadvisors.org](mailto:kbutler@healthcentricadvisors.org)

**MEASURE LAST REVIEWED:** January 2023

**MEASURE:****Real-time verbal information provided to emergency department or hospital clinicians, if needed****MEASURE SET:**

Safe transitions best practice measures for home health agencies (Best Practice #8)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which home health agencies 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. The Transitions of Care Consensus Conference recommends timely communication between the sending and receiving providers involved in a patient's care.<sup>13</sup> Although many clinicians recognize the importance of communication during care transitions, all groups acknowledge that communication is often inadequate.<sup>14</sup>

**NUMERATOR:**

Documentation that if an ED or hospital clinician called the home health agency, one of the following occurred:

- A conversation between the ED or hospital clinician and a home health staff member at the time of the initial call, or
- A return phone call from a home health staff member within 1 hour of the ED or hospital clinician's phone call to the home health agency

**DENOMINATOR:**

All patients whose care requires phone calls from the ED or hospital to the home health agency for time-sensitive clinical conversations

**EXCLUSIONS:** None

**RISK ADJUSTMENT:** None

**DEFINITIONS**

ED or hospital clinician:	Physician, nurse practitioner, physician assistant or nurse who is taking care of the patient.
Home health 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 "requires" 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 quickly to inform the patient's care.

**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:	Home health agency
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 home health care

**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) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (home health agencies) 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.

**MEASURE INFORMATION:**

Lynne Chase  
Quality Director, Healthcentric Advisors  
[lchase@healthcentricadvisors.org](mailto:lchase@healthcentricadvisors.org)

**MEASURE DEVELOPED:** 2009**CONSULTING SERVICES:**

Kara H. Butler, MBA, MHSA  
Director, Administrative Services, Healthcentric Advisors  
[kbutler@healthcentricadvisors.org](mailto:kbutler@healthcentricadvisors.org)

**MEASURE LAST REVIEWED:** January 2023

**MEASURE:****Clinical information sent with emergency department referrals****MEASURE SET:**

Safe transitions best practice measures for home health agencies (Best Practice #9)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which home health agencies 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.<sup>15</sup> The Transitions of Care Consensus Conference recommends timely communication between the sending and receiving providers involved in a patient's care.<sup>1</sup>

ED clinicians express a desire to have pertinent, up-to-date clinical information accompany patients who are sent in with a specific concern by another healthcare provider.<sup>16</sup> 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 the home health nurse's specific concerns are adequately addressed.

**NUMERATOR:**

Documentation of provision of clinical and contact information by the referring home health agency to the ED and the outpatient physician office:

- ED: Within 1 hour of patient referral for ED evaluation, and
- Physician office: Within 1 hour of patient referral for ED evaluation or the next business day if the patient is referred following an after-hours phone call with the home health agency

**DENOMINATOR:**

All patients referred to the ED

**EXCLUSIONS:**

Patients who go to the ED without first notifying the home health agency

**RISK ADJUSTMENT:** None – see exclusions

**DEFINITIONS**

After-hours:	Outside of the standard home health agency business hours (e.g., 8:00am to 5:00pm, seven days a week).
Clinical information:	Verbal or written information that includes the clinical complaint/problem, main reason for referral to the ED, and medication list, when possible.
Contact information:	A phone number that connects the ED to home health agency staff who can address an ED clinician's question.
Outpatient physician:	The patient's primary care provider and the physician signing the home health orders, if different.
Provision:	Via email, phone, fax, remote access to medical record or other electronic means.

**NOTES:**

Home health agencies are not required to send this information to the outpatient physician office if a clinician from the office was involved in decision to refer the patient to the ED.

If the home health agency becomes aware of an ED visit in which the patient self-referred, the agency should also notify the physician office.

**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:	Home health agency
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 home health care

**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) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (home health agencies) 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.

**MEASURE INFORMATION:**

Lynne Chase  
Quality Director, Healthcentric Advisors  
[lchase@healthcentricadvisors.org](mailto:lchase@healthcentricadvisors.org)

**MEASURE DEVELOPED:** 2009

**CONSULTING SERVICES:**

Kara H. Butler, MBA, MHSA  
Director, Administrative Services, Healthcentric Advisors  
[kbutler@healthcentricadvisors.org](mailto:kbutler@healthcentricadvisors.org)

**MEASURE LAST REVIEWED:** January 2023

**MEASURE:****Summary clinical information provided to outpatient physician(s) at discharge****MEASURE SET:**

Safe transitions best practice measures for home health agencies (Best Practice #10)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which home health agencies send summary clinical information about the episode of care to primary care providers (PCPs) and relevant specialists when patients are discharged from home health services.

Timely and adequate information transfer is an important component of safe patient transitions and has been linked to improved patient experience and outcomes.<sup>17</sup> Because of their unique clinical role and work in patients' homes, home health nurses may elicit important symptoms, historical information or social issues that directly impact patients' health care but are unknown to the PCP. Effective transfer of this information, along with an updated medication list based on what is present in the patient's home, prevents important issues from being inadvertently dropped after home health care has been discontinued.

**NUMERATOR:**

Documentation that summary clinical information was sent to the physician office(s) within 72 hours of patient discharge from home health, including:

- Patient's current functional status
- Ongoing clinical or pertinent social issues
- A medication list and
- Home health agency contact information

**DENOMINATOR:**

All patients receiving skilled nursing services, skilled therapy services, or medication management services

**EXCLUSIONS:** None

**RISK ADJUSTMENT:** None

**DEFINITIONS**

**Contact information:** A phone number that connects the physician office to home health agency staff who can address the office's question.

**Outpatient physician:** The patient's PCP and the physician signing the home health orders, if different.

**Sent:** Transmitted from the home health agency to the physician office via fax, email or other electronic means.

**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:	Home health agency
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 home health care

**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) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (home health agencies) 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.

**MEASURE INFORMATION:**

Lynne Chase  
Quality Director, Healthcentric Advisors  
[lchase@healthcentricadvisors.org](mailto:lchase@healthcentricadvisors.org)

**MEASURE DEVELOPED:** 2009

**CONSULTING SERVICES:**

Kara H. Butler, MBA, MHSA  
Director, Administrative Services, Healthcentric Advisors  
[kbutler@healthcentricadvisors.org](mailto:kbutler@healthcentricadvisors.org)

**MEASURE LAST REVIEWED:** January 2023

**MEASURE:****Responses to patient questions provided in a timely manner****MEASURE SET:**

Safe transitions best practice measures for home health agencies (Best Practice #11)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which home health agencies respond to patient questions in a timely manner, when the agency is contacted outside of a home visit.

The Home Health Quality Improvement National Campaign<sup>18</sup> directs home health agencies to educate patients to call the agency first with questions or concerns—before the patient takes a potentially avoidable trip to the emergency department. In order to accomplish this goal, home health agencies must return patient phone calls in a timeframe that both meets patient expectations and is logistically feasible for the agency.<sup>19</sup> The process of instructing patients to call the home health agency first is typically done within the context of developing an overall emergency plan for the patient that details what types of symptoms need to be reported and to whom.

**NUMERATOR:**

Documentation of a response to patient, family, or caregiver questions that occur outside of a home visit:

- Via phone call within 30 minutes, and
- If necessary, via a visit within 24 hours

**DENOMINATOR:**

All patients

**EXCLUSIONS:** None**RISK ADJUSTMENT:** None**DEFINITIONS**

Information Caregiver: A family member or other person who provides care.

Response: A phone call or home visit from a home health staff member who can answer clinical questions about the patient's care.

**NOTES:** None**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:	Home health agency
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 home health care



**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) obtaining input (measure content and feasibility) and endorsement from the targeted provider group (home health agencies) 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.

**MEASURE INFORMATION:**

Lynne Chase  
Quality Director, Healthcentric Advisors  
[lchase@healthcentricadvisors.org](mailto:lchase@healthcentricadvisors.org)

**MEASURE DEVELOPED:** 2009**CONSULTING SERVICES:**

Kara H. Butler, MBA, MHSA  
Director, Administrative Services, Healthcentric Advisors  
[kbutler@healthcentricadvisors.org](mailto:kbutler@healthcentricadvisors.org)

**MEASURE LAST REVIEWED:** January 2023

© 2023 Healthcentric Advisors – All Rights Reserved.

<sup>1</sup> Taft SH, Pierce CA, Gallo CL. From hospital to home and back again: a study in hospital admissions and deaths for home care patients. *Home Health Care Management & Practice*. October 2005; 17: 467–80.

<sup>2</sup> Rodgers, J. M., & Schott, D. K. Front loading visits: A best practice measure to decrease re-hospitalization in heart failure patients. *Home Health Care Management and Practice*. February 2008. 20(2), 147–153.

<sup>3</sup> Sanderson, S., D. Anderson, and L. Dugan. "Patient Emergency Planning & Teletriage: The ACH Reduction Connection." *Home Health Care Management & Practice* 20.2 (2008): 125-34.

<sup>4</sup> Wick JY. "Checking for comprehension: mastering teach-back techniques." *Consult Pharm*. 2013 Sep; 28(9):550-4.

<sup>5</sup> Mueller SK, Sponsler KC, Kripalani S, Schnipper JL. Hospital - based medication reconciliation practices: a systematic review. *Arch Intern Med*. 2012;172(14):1057.

<sup>6</sup> 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.

<sup>7</sup> Caglar S, Henneman PL, Blank FS, Smithline HA, Henneman EA. Emergency department medication lists are not accurate. *J Emerg Med*. 2011; 40: 613 - 616.

<sup>8</sup> Coleman EA, Smith JD, Raha D, Min SJ. Posthospital medication discrepancies: prevalence and contributing factors. *Arch Intern Med*. 2005; 165(16):1842-7.

<sup>9</sup> Sanderson, S., D. Anderson, and L. Dugan. "Patient Emergency Planning & Teletriage: The ACH Reduction Connection." *Home Health Care Management & Practice* 20.2 (2008): 125-34.

<sup>10</sup> 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.

<sup>11</sup> Boling PA. Care transitions and home health care. *Clin Geriatr Med*. 2009;25(1):135–148.

<sup>12</sup> Leonard M, Graham S, Bonacum D. The Human Factor: The Critical Importance of Effective Teamwork and Communication in Providing Safe Care. *Quality and Safety in Health Care*. 2004;13:i85–i90

<sup>13</sup> 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.

<sup>14</sup> Gillespie SM, Gleason LJ, Karuza J, Shah MN. Health care providers' opinions on communication between nursing homes and emergency departments. *J Am Med Dir Assoc*. 2010;11:204–10.

<sup>15</sup> 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.

<sup>16</sup> Gillespie SM, Gleason LJ, Karuza J, Shah MN. Health care providers' opinions on communication between nursing homes and emergency departments. *J Am Med Dir Assoc*. 2010;11:204–10.

<sup>17</sup> 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.

<sup>18</sup> Home Health Quality National Initiative. Home Health Quality Improvement (HHQI) National Campaign. Available: <http://www.homehealthquality.org>, 2014.

<sup>19</sup> Sanderson, S., D. Anderson, and L. Dugan. "Patient Emergency Planning & Teletriage: The ACH Reduction Connection." *Home Health Care Management & Practice* 20.2 (2008): 125-34.