Safe Transitions Best Practice Measures for Nursing Homes

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

www.healthcentricadvisors.org

Providence, RI

MEASURE:

Safe transitions best practice measures for nursing homes

MEASURES:

The best practice measures for nursing homes are eleven (11) process measures:

1. Interventions implemented for residents at highest risk for unplanned transfer
2. Clinical information sent with emergency department referrals
3. Real-time verbal information provided to emergency department or hospital clinicians, if needed
4. Medication reconciliation completed after emergency department or hospital discharge
5. Structured communication used for clinical questions to physicians
6. End-of-life care discussed with residents
7. Effective education provided to residents prior to nursing home discharge
8. Written discharge instructions provided to residents prior to nursing home discharge
9. Follow-up appointment scheduled prior to nursing home discharge
10. Summary clinical information provided to outpatient physician(s) at discharge
11. Residents have access to medication after nursing home discharge

PURPOSE:

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

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

POPULATION:

Varies by measure, but generally includes all patients in or recently transitioned from nursing homes

CARE SETTING:

Nursing homes, including skilled nursing and/or long-term care facilities

RECIPROCAL MEASURES:

In addition to the best practices for nursing homes, 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. 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 (nursing homes) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures (and the other Safe Transitions Best Practice Measures) may not be generalizable to other states and regions, but can inform the development of local standards.

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MEASURES DEVELOPED: 2009

MEASURES LAST REVIEWED: January 2023

MEASURE:

Interventions implemented for residents at highest risk for unplanned transfer

MEASURE SET:

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

MEASURE DESCRIPTION:

This measure estimates the frequency with which nursing homes implement interventions for residents at highest risk for unplanned transfer. Given the frailty and medical co-morbidities of the nursing home population, all residents are at higher risk than most other individuals for transfers to the emergency department (ED) and hospital. Identifying nursing home residents at the highest risk for unplanned transfer allows for implementation of targeted interventions.

Individuals in nursing homes obtain care from a diverse group of providers and experience frequent transitions between care settings. Research has demonstrated that that hospitalizations are everyday occurrences among both short- and long-stay residents, and transfers may take place without extensive discussion among staff, for a variety of complex reasons outlined below.[1] Coordinated care, ready access to clinical information and timely communication is especially important for this population and may reduce readmissions and improve quality of care.[2]

Risk factors for unplanned transfers may include: history of non-adherence with recommended treatment; severe depression; acute change in mental, emotional or behavioral status; history of falls; and recent hospitalizations. The Kaiser Family Foundation has identified the following additional factors: limited on-site nursing home capacity for medical issues, physician preference for care in inpatient facility, liability concerns for facilities, physician or facility financial incentives, lack of advance care planning, reluctance of family members to second guess physician's decision to hospitalize and behavioral health issues.[1]

NUMERATOR:

Documentation of implementation of interventions to address identified risks

DENOMINATOR:

Nursing home residents meeting highest risk criteria

EXCLUSIONS: None

RISK ADJUSTMENT: None

DEFINITIONS

High-risk: Risk factors may include (but are not limited to):

- History of non-adherence with recommended treatment,
- Severe depression,
- Acute change in mental, emotional, or behavioral status,
- Patient and family preferences for hospitalization,
- Physician preferences for hospitalization,
- History of falls (≥ 2 in the past year or any fall with an injury in the past year), and
- ≥ 2 hospitalizations in the prior 12 months.

Interventions: Targeted strategies to reduce residents' specific risks for unplanned transfer.

Unplanned transfer: Transport of a resident from a nursing home to an acute care facility, such as a hospital emergency department, for management of an escalating medical or surgical problem.

NOTES:

High-risk characteristics may be identified during initial or ongoing assessments.

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:	Nursing homes, including skilled nursing and/or long-term care facilities
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 nursing home residents, including those receiving skilled services

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 (nursing homes) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures (and the other Safe Transitions Best Practice Measures) may not be generalizable to other states and regions, but can inform the development of local standards.

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MEASURE DEVELOPED: 2009

MEASURE LAST REVIEWED: January 2023

MEASURE:

Clinical information sent with emergency department referrals

MEASURE SET:

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

MEASURE DESCRIPTION:

This measure estimates the frequency with which nursing homes send clinical information to the emergency department (ED), when referring a resident 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.[3] The Transitions of Care Consensus Conference recommends timely communication that includes both providers (sending and receiving) involved in a patient's care.[1]

ED clinicians express a desire to have pertinent, up-to-date clinical information accompany patients arriving from nursing homes.[4] 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 nursing home provider's specific concerns are adequately addressed.

NUMERATOR:

Documentation of provision of clinical information and contact information by the nursing home to the ED either:

- At the time of resident referral, or
- Within one hour of resident referral, if the resident is sent emergently

DENOMINATOR:

All residents referred to the ED

EXCLUSIONS: None

RISK ADJUSTMENT: None

DEFINITIONS

Clinical information:	Written information that includes the resident's baseline status, main reason for referral to the ED, expectation, advance directives (if present), problem list, medication list, and applicable labs.
Contact information:	A phone number connecting the ED to nursing home staff who can address the ED clinician's clinical question.
Emergently:	Clinical deterioration that occurs unexpectedly and requires immediate transfer to the ED.

NOTES:

The clinical information can be transmitted from the nursing home to the ED with the patient or via fax, email or other electronic means.

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:	Nursing homes, including skilled nursing and/or long-term care facilities
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 nursing home residents referred to ED

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 (nursing homes) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures (and the other Safe Transitions Best Practice Measures) may not be generalizable to other states and regions, but can inform the development of local standards.

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MEASURE DEVELOPED: 2009

MEASURE LAST 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 nursing homes (Best Practice #3)

MEASURE DESCRIPTION:

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

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes, and the Transitions of Care Consensus Conference recommends timely communication that includes both providers (sending and receiving) involved in a patient's care.[5] Although clinicians in the ED and nursing home settings recognize the importance of communication during care transitions, both groups acknowledge that communication is often inadequate between these settings.[6]

NUMERATOR:

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

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

DENOMINATOR:

All residents whose care requires phone calls from the ED or hospital to the nursing home for time-sensitive clinical questions

EXCLUSIONS: None

RISK ADJUSTMENT: None

DEFINITIONS

ED or hospital clinician:	Physician, Nurse Practitioner, Physician Assistant, or nurse who is taking care of the resident.
Nursing home 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 resident'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:	Nursing homes, including skilled nursing and/or long-term care facilities
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 nursing home residents, including those receiving skilled services

MEASURE HISTORY:

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MEASURE DEVELOPED: 2009

MEASURE LAST REVIEWED: January 2023

MEASURE:

Medication reconciliation completed after emergency department or hospital discharge

MEASURE SET:

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

MEASURE DESCRIPTION:

This measure estimates the frequency with which nursing homes perform medication reconciliation after their residents are discharged from the emergency department (ED) or hospital.

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 nursing home providers identify potential medication errors and understand which medications to stop, start or adjust after a resident visits an ED or hospital. Studies demonstrate that medication errors or discrepancies are relatively common at hospital discharge (occurring among 14% of elderly patients) and are associated with a higher risk of poor outcomes and hospital readmission.[10]

NUMERATOR:

Documentation of medication reconciliation within 24 hours of transfer from the hospital or ED to the nursing home

DENOMINATOR:

All residents discharged from the hospital or ED

EXCLUSIONS: None

RISK ADJUSTMENT: None

DEFINITIONS

Medication reconciliation:	The process of: 1) reviewing the patient's discharge medication regimen (name, dose, route, frequency, and purpose) and 2) comparing the discharge medication regimen to their prior medication regimen to identify and resolve any discrepancies.

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:	Nursing homes, including skilled nursing and/or long-term care facilities
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 nursing home residents discharged from the hospital or ED

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.

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MEASURE DEVELOPED: 2009

MEASURE LAST REVIEWED: January 2023

MEASURE:

Structured communication used for clinical questions to physicians

MEASURE SET:

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

MEASURE DESCRIPTION:

This measure estimates the frequency with which nursing home clinicians use structured communication for clinical questions to physicians about nursing home residents. Given the frailty and medical co-morbidities of the nursing home population, effective communication is especially important in providing quality care for these residents and a failure of this communication may lead to adverse events.[1]

Tools for structured communication, such as SBAR[11], provide a foundation for more effective and consistent transfer of information within a nursing home and from the nursing home to a hospital or emergency department, when a resident is transferred. 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

DENOMINATOR:

All verbal communication with physicians

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.

NOTES:

Facilities 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:	Nursing homes, including skilled nursing and/or long-term care facilities
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 nursing home residents, including those receiving skilled services

MEASURE HISTORY:

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

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MEASURE DEVELOPED: 2009

MEASURE LAST REVIEWED: January 2023

MEASURE:

Advance care planning discussed with residents

MEASURE SET:

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

MEASURE DESCRIPTION:

This measure estimates the frequency with which nursing home staff discuss advance care planning with residents and their families. This best practice goes beyond routine discussions about code status that may occur during the admissions process.

While residents may have advance directive documents, often these items are not well understood or discussed among residents, families and medical providers. It is not always clear who is responsible to speak on the resident's behalf around end-of-life care or who should take the lead in updating advance directives. This ambiguity can lead to confusion during medical emergencies and ultimately may result in undesired hospitalizations.[12]

Transfers at the end-of-life can severely diminish quality of life. Any transfer should occur in the context of the resident's expressed wishes or those of the resident's surrogate decision maker.[13] Advance care planning may help avoid unwanted transfers or unwanted treatments by exploring the resident's goals and values so that any offered medical care can be aligned with an individual resident's wishes.

It may also be helpful to shift the focus of advance care planning discussions away from completion of advance directives; instead, nursing homes may wish to use these discussions to prepare residents and their families to participate with clinicians to make the best possible in-the-moment medical decisions.[14] In other words, these discussions can prepare residents for the types of decisions and conflicts that may occur in the future, without requiring them to specify exactly what treatments they would want.

NUMERATOR:

Documentation of resident, family, or caregiver's participation in advance care planning discussions

DENOMINATOR:

All residents

EXCLUSIONS:

Residents who:

- Decline this discussion,
- Are unable to participate, or
- Do not have family or informal caregiver willing or able to participate.

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS

Informal caregiver: A person who provides care and support to the resident.

Advance care planning: Conversations and decision-making, based on personal beliefs and values, about the health care an individual would want to receive if they became unable to speak for themselves, and who they would want to participate on their behalf in the decision-making process. ACP may include completion of written advance directives.

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:	Nursing homes, including skilled nursing and/or long-term care facilities
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 nursing home residents, including those receiving skilled services

MEASURE HISTORY:

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MEASURE DEVELOPED: 2009

MEASURE LAST REVIEWED: January 2023

MEASURE:

Effective education provided to residents prior to nursing home discharge

MEASURE SET:

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

MEASURE DESCRIPTION:

This measure estimates the frequency with which nursing home residents 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,[15] 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 for the emergency department, although applicable to multiple settings, which indicates patient comprehension of such information is low and may impact post-discharge follow-up care and medication adherence.[16]

NUMERATOR:

Documentation that *all* of the following occurred prior to discharge:

- Provision of education to the resident, family, or informal caregiver
- Evidence that understanding of the education provided was assessed
- An opportunity for the resident to ask questions

DENOMINATOR:

All nursing home residents who are discharged home

EXCLUSIONS:

Residents who:

- Are transferred to an acute care setting, or
- Leave against medical advice, without allowing sufficient time to provide education.

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS

Informal caregiver:	A family member or other person who provides care and support to the patient.
Effective education:	Education that incorporates testing of the resident's understanding (e.g., use of a teach-back method).
Patient education:	Includes, at minimum, the reason for the nursing home stay, any changes to medications and the reason for the change, condition-specific "red flags" that should prompt the resident to seek medical attention and whom the resident should call, activity and other limitations, and recommended follow-up appointments and tests.

NOTES:

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

This best practice includes short-stay residents receiving skilled services, as well as long-stay residents transitioning back into the community.

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

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:	Nursing homes, including skilled nursing and/or long-term care facilities
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 nursing home residents who are discharged home

MEASURE HISTORY:

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

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MEASURE DEVELOPED: 2009

MEASURE LAST REVIEWED: January 2023

MEASURE:

Written discharge instructions provided to residents prior to nursing home discharge

MEASURE SET:

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

MEASURE DESCRIPTION:

This measure estimates the frequency with which nursing home residents are provided with written discharge instructions.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes.[17] Residents discharged home are expected to self-manage their follow-up, and provision of written discharge instructions ensures that residents and their families have information to refer to. It may also be helpful to downstream providers, if residents are coached to bring this information to follow-up appointments.

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

NUMERATOR:

Documentation that written discharge instructions were provided to the resident, family, or caregiver prior to discharge

DENOMINATOR:

All nursing home residents who are discharged home

EXCLUSIONS:

Residents who:

- Are transferred to an acute care setting, or
- Leave against medical advice, without allowing sufficient time to provide instructions.

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS

Informal caregiver:	A family member or other person who provides care and support to the patient.
Discharge instructions:	Includes, at minimum, the information provided verbally as part of effective education (the reason for the nursing home stay, any changes to medications and the reason for the change, condition-specific "red flags" that should prompt the resident to seek medical attention and whom the resident should call, activity and other limitations, and recommended follow-up appointments and tests), as well as nursing home contact information.
Nursing home contact information:	A phone number that connects discharged residents to a clinician who can answer questions about their nursing home stay or follow-up care.

NOTES:

This best practice includes short-stay residents receiving skilled services, as well as long-stay residents transitioning back into the community.

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

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:	Nursing homes, including skilled nursing and/or long-term care facilities
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 nursing home residents who are discharged home

MEASURE HISTORY:

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

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

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MEASURE DEVELOPED: 2009

MEASURE LAST REVIEWED: January 2023

MEASURE:

Follow-up appointment scheduled prior to nursing home discharge

MEASURE SET:

Safe transitions best practice measures for nursing homes (Best Practice #9)

MEASURE DESCRIPTION:

This measure estimates the frequency with which residents have a follow-up appointment scheduled with their primary care provider (PCP) or a relevant specialist before they leave the nursing home.

Although improved communication between the nursing home and community-based PCPs can help to close knowledge gaps during the nursing home stay, many PCPs (or specialists, as appropriate) do not fully assume responsibility for residents discharged from nursing homes until the follow-up appointment.

The follow-up appointment is important for the provider to: 1) assume professional responsibility for patient care, 2) assess and facilitate adherence to discharge instructions and medications, and 3) provide an opportunity for patients to ask questions. Scheduling during the nursing home stay ensures that residents leave the nursing home with the date and time of their follow-up appointments included with their discharge instructions.

NUMERATOR:

Documentation that both of the following occurred prior to discharge:

- An outpatient primary care provider (PCP) or specialist visit, as appropriate, was scheduled to occur within 14 days of the nursing home discharge date (unless timeframe otherwise specified and documented in the medical record), and
- Information about the follow-up appointment was provided to the resident, family, or caregiver

DENOMINATOR:

All nursing home residents who are discharged home

EXCLUSIONS:

Residents who:

- Are transferred to an acute care setting,
- Leave against medical advice without allowing sufficient time for an appointment to be scheduled, or
- Decline to have a follow-up appointment scheduled for any reason.

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS

Informal caregiver:	A family member or other person who provides care and support to the patient.
Information about the follow-up appointment:	Date, time, location, and contact information for questions or to reschedule.

NOTES:

Scheduling appointments should involve the resident, family, or caregiver, in order to identify an appointment time that is feasible for the resident and minimizes the risk of no-shows at the physician office.

If the resident has no known PCP, then this process should include assigning the resident to a PCP and scheduling a new patient appointment.

This best practice includes short-stay residents receiving skilled services, as well as long-stay residents transitioning back into the community.

Although patients who leave against medical advice are excluded from this measure, it is often still possible to schedule an appointment before they leave the skilled nursing facility. When it is not possible to do so, the appointment may be scheduled after they leave and the appointment information provided by telephone or by mail.

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:	Nursing homes, including skilled nursing and/or long-term care facilities
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 nursing home residents, including those receiving skilled services

MEASURE HISTORY:

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

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

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MEASURE DEVELOPED: 2009

MEASURE LAST REVIEWED: January 2023

MEASURE:

Summary clinical information provided to outpatient physician(s) at discharge

MEASURE SET:

Safe transitions best practice measures for nursing homes (Best Practice #10)

MEASURE DESCRIPTION:

This measure estimates the frequency with which nursing home staff send summary clinical information about the patient's stay to primary care providers (PCPs) and relevant specialists when their patients are discharged from the nursing home.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes.[18] Effective transfer of information allows outpatient physicians to immediately assume care of discharged patients without spending time on record requests or repeat testing and without defaulting (in the absence of information) to referring patients to the ED. Outpatient physicians also need this information to understand the rationale for recommended follow-up and medication changes, in order to facilitate the treatment plan, or to modify it.[19]

NUMERATOR:

Documentation that the following was sent to physician office(s), within 24 hours of resident discharge:

- A brief narrative of the nursing home stay,
- A medication list, and
- Nursing home contact information

DENOMINATOR:

All nursing home residents who are discharged home

EXCLUSIONS:

Residents who:

- Are transferred to an acute care setting, or
- Do not have an outpatient physician (and declined to have a new patient appointment scheduled).

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS

Contact information:	A phone number that connects the outpatient physician to nursing home staff who can address the physician's question.
Outpatient physician:	The patient's PCP and relevant specialists, if applicable.
Sent:	Transmitted from the nursing home to the outpatient physician office via fax, email or other electronic means.

NOTES:

This best practice includes short-stay residents receiving skilled services, as well as long-stay residents transitioning back into the community.

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:	Nursing homes, including skilled nursing and/or long-term care facilities
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 nursing home residents who are discharged home

MEASURE HISTORY:

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

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

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MEASURE DEVELOPED: 2009

MEASURE LAST REVIEWED: January 2023

MEASURE:

Residents have access to medication after nursing home discharge

MEASURE SET:

Safe transitions best practice measures for nursing homes (Best Practice #11)

MEASURE DESCRIPTION:

This measure estimates the frequency with which nursing homes facilitate residents' access to needed medications after discharge.

By facilitating residents' access to medications after nursing home discharge, nursing homes may prevent adverse effects due to residents missing medication doses in the time period between nursing home discharge and the first follow-up appointment with an outpatient physician. Many outpatient physicians may be unaware of medication changes that occurred while their patient was hospitalized or in a nursing home, and they may be reluctant to prescribe a medication not in their records without seeing the patient first.[20] Additionally, if residents do not have an adequate supply of medications after nursing home discharge, they may revert to prior prescriptions still on file at their pharmacy or old medications and dosing regimens, which may no longer be medically indicated or safe.

NUMERATOR:

Documentation that either of the following occurred prior to nursing home discharge:

- The resident received enough medications to last until the end of the intended treatment course or until the first outpatient follow-up appointment, or
- The resident received prescriptions for a 30-day supply (or to the end of the treatment course, if sooner) of all medications

DENOMINATOR:

All nursing home residents who are discharged home

EXCLUSIONS:

Residents who:

- Are transferred to an acute care setting,
- Leave against medical advice without allowing sufficient time to provide medications or prescriptions, or
- Do not take any medications.

RISK ADJUSTMENT: None – see exclusions

DEFINITIONS: None

NOTES:

It is not intended that nursing homes provide more medications than is their standard practice, but instead that they help residents avoid missing medication doses between nursing home discharge and resumption of care by an outpatient physician.

If a resident has been consistently receiving a medication that can result in physical dependency (e.g., opioids, benzodiazepines) and the nursing home does not plan to provide this medication or a prescription after discharge, the nursing home will need to 1) taper this medication off prior to the resident's discharge or 2) arrange for an outpatient physician to immediately assume prescribing responsibilities.

This best practice includes short-stay residents receiving skilled services, as well as long-stay residents transitioning back into the community.

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

CLASSIFICATION:

National Quality Strategy Priorities:	Promoting effective communication and coordination of care Ensuring that each person and family are engaged as partners in their care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Nursing homes, including skilled nursing and/or long-term care facilities
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 nursing home residents who are discharged home

MEASURE HISTORY:

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

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MEASURE DEVELOPED: 2009

MEASURE LAST UPDATED: June 2022

[1] Kaiser Family Foundation. To Hospitalize or Not to Hospitalize? Medical Care for Long-Term Care Facility Residents. October 2010. Available: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8110.pdf, 11 November 2013.

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