**National Quality Forum—Evidence (subcriterion 1a)**

**Measure Number** (*if previously endorsed*)**:** 0292

**Measure Title**: administrative communication

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** Click here to enter composite measure #/ title

**Date of Submission**: 1/20/2014

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| **Instructions**  *For composite performance measures:*  *A separate evidence form is required for each component measure unless several components were studied together.*  *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*   * Respond to all questions as instructed with answers immediately following the question. All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Maximum of 10 pages (*incudes questions/instructions*; minimum font size 11 pt; do not change margins). ***Contact NQF staff if more pages are needed.*** * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

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| **Note: The information provided in this form is intended to aid the Steering Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF’s evaluation criteria.**   1a. Evidence to Support the Measure Focus The measure focus is evidence-based, demonstrated as follows:   * Health outcome: [**3**](#Note3) a rationale supports the relationship of the health outcome to processes or structures of care. Applies to patient-reported outcomes (PRO), including health-related quality of life/functional status, symptom/symptom burden, experience with care, health-related behavior. * Intermediate clinical outcome: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4)that the measured intermediate clinical outcome leads to a desired health outcome. * Process: [**5**](#Note5) a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured process leads to a desired health outcome. * Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured structure leads to a desired health outcome. * Efficiency: [**6**](#Note6) evidence not required for the resource use component.   **Notes**  **3.** Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.  **4.** The preferred systems for grading the evidence are the U.S. Preventive Services Task Force (USPSTF) [grading definitions](http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm) and [methods](http://www.uspreventiveservicestaskforce.org/methods.htm), or Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org/publications/index.htm).  **5.** Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.  **6.** Measures of efficiency combine the concepts of resource use and quality (see NQF’s [Measurement Framework: Evaluating Efficiency Across Episodes of Care](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx); [AQA Principles of Efficiency Measures](http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc)). |

**1a.1.This is a measure of**: (*should be consistent with type of measure entered in De.1*)

Outcome

Health outcome: Click here to name the health outcome

Patient-reported outcome (PRO): Click here to name the PRO

*PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors*

Intermediate clinical outcome (*e.g., lab value*): Click here to name the intermediate outcome

Process: transfer communication from ED to receiving facility

Structure: Click here to name the structure

Other: Click here to name what is being measured

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**HEALTH OUTCOME/PRO PERFORMANCE MEASURE**  *If not a health outcome or PRO, skip to* [*1a.3*](#Section1a3)

**1a.2.** **Briefly state or diagram the path between the health outcome (or PRO) and the healthcare structures, processes, interventions, or services that influence it.**

**1a.2.1.** **State the rationale supporting the relationship between the health outcome (or PRO) to at least one healthcare structure, process, intervention, or service (*i.e., influence on outcome/PRO*).**

*Note: For health outcome/PRO performance measures, no further information is required; however, you may provide evidence for any of the structures, processes, interventions, or service identified above.*

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**intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measure**

**1a.3.****Briefly state or diagram the path between structure, process, intermediate outcome, and health outcomes**. Include all the steps between the measure focus and the health outcome.

The communication of essential healthcare information is necessary for continuity of care. Continuity of care results in better health outcomes, more efficient use of resources and improve patient satisfaction.

**1a.3.1.** **What is the source of the systematic review of the body of evidence that supports the performance measure?**

Clinical Practice Guideline recommendation – ***complete sections*** [***1a.4***](#Section1a4)***, and*** [***1a.7***](#Section1a7)

US Preventive Services Task Force Recommendation – ***complete sections*** [***1a.5***](#Section1a5) ***and*** [***1a.7***](#Section1a7)

Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)

Other – ***complete section*** [***1a.8***](#Section1a8)

*Please complete the sections indicated above for the source of evidence. You may skip the sections that do not apply.*

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**1a.4. CLINICAL PRACTICE GUIDELINE RECOMMENDATION**

**1a.4.1.** **Guideline citation** (*including date*) and **URL for guideline** (*if available online*):

**1a.4.2.** **Identify guideline recommendation number and/or page number** and **quote verbatim, the specific guideline recommendation**.

**1a.4.3.** **Grade assigned to the quoted recommendation with definition of the grade:**

**1a.4.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: If separate grades for the strength of the evidence, report them in section 1a.7.*)

**1a.4.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.4.1*)**:**

**1a.4.6. If guideline is evidence-based (rather than expert opinion), are the details of the quantity, quality, and consistency of the body of evidence available (e.g., evidence tables)?**

Yes **→ *complete section*** [***1a.7***](#Section1a7)

No **→ *report on another systematic review of the evidence in sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)***; if another review does not exist, provide what is known from the guideline review of evidence in*** [***1a.7***](#Section1a7)

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**1a.5.** **UNITED STATES PREVENTIVE SERVICES TASK FORCE RECOMMENDATION**

**1a.5.1.** **Recommendation citation** (*including date*) and **URL for recommendation** (*if available online*):

**1a.5.2.** **Identify recommendation number and/or page number** and **quote verbatim, the specific recommendation**.

**1a.5.3.** **Grade assigned to the quoted recommendation with definition of the grade**:

**1a.5.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: the* *grading system for the evidence should be reported in section 1a.7.*)

**1a.5.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.5.1*)**:**

***Complete section*** [***1a.7***](#Section1a7)

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**1a.6. OTHER SYSTEMATIC REVIEW OF THE BODY OF EVIDENCE**

**1a.6.1.** **Citation** (*including date*) and **URL** (*if available online*):

**1a.6.2.** **Citation and** **URL for methodology for evidence review and grading** (*if different from 1a.6.1*)**:**

***Complete section*** [***1a.7***](#Section1a7)

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**1a.7. FINDINGS FROM SYSTEMATIC REVIEW OF BODY OF THE EVIDENCE supporting the measure**

*If more than one systematic review of the evidence is identified above, you may choose to summarize the one (or more) for which the best information is available to provide a summary of the quantity, quality, and consistency of the body of evidence. Be sure to identify which review is the basis of the responses in this section and if more than one, provide a separate response for each review.*

**1a.7.1.** **What was the specific structure, treatment, intervention, service, or intermediate outcome addressed in the evidence review?**

**1a.7.2.** **Grade assigned for the quality of the quoted evidence with definition of the grade**:

**1a.7.3. Provide all other grades and associated definitions for strength of the evidence in the grading system.**

**1a.7.4.** **What is the time period covered by the body of evidence? (*provide the date range, e.g., 1990-2010*). Date range**: 2004-2007

**QUANTITY AND QUALITY OF BODY OF EVIDENCE**

**1a.7.5.****How many and what type of study designs are included in the body of evidence**? (*e.g., 3 randomized controlled trials and 1 observational study*)

**1a.7.6.** **What is the overall quality of evidence across studies in the body of evidence**? (*discuss the certainty or confidence in the estimates of effect particularly in relation to study factors such as design flaws, imprecision due to small numbers, indirectness of studies to the measure focus or target population*)

**ESTIMATES OF BENEFIT AND CONSISTENCY ACROSS STUDIES IN BODY OF EVIDENCE**

**1a.7.7.** **What are the estimates of benefit—magnitude and direction of effect on outcome(s) across studies in the body of evidence**? (*e.g., ranges of percentages or odds ratios for improvement/ decline across studies, results of meta-analysis, and statistical significance*)

**1a.7.8.** **What harms were studied and how do they affect the net benefit (benefits over harms)?**

**UPDATE TO THE SYSTEMATIC REVIEW(S) OF THE BODY OF EVIDENCE**

**1a.7.9.** **If new studies have been conducted since the systematic review of the body of evidence, provide for each new study: 1) citation, 2) description, 3) results, 4) impact on conclusions of systematic review**.

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**1a.8 OTHER SOURCE OF EVIDENCE**

*If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.*

**Evidence to support the measurement focus.**

In previous work, a model for measuring rural hospital quality was developed, with a focus on the special issues posed by the rural hospital context (Moscovice et al. 2004). The development of rural relevant hospital quality measures was completed over several steps. With the assistance of expert panels consisting of rural hospital and hospital quality measurement experts, an initial core set of quality measures relevant to rural hospitals with fewer than 50 beds was identified. Established hospital quality measures were examined and the list consolidated.

The team evaluated existing quality indicator and performance measurement systems to assess their relevance for rural hospitals. Existing quality indicator and performance measurement systems (e.g., those developed by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), Agency for Healthcare Research and Quality (AHRQ), National Quality Forum (NQF), Centers for Medicare and Medicaid Services (CMS) and four rural-oriented performance measurement systems, Apples to Apples, Rural Wisconsin Health Cooperative, Maryland Hospital Association QI Project, Georgia Hospital Association CARE were reviewed. Four criterions were used to evaluate rural hospital quality measures included:

* Prevalence in rural hospitals with less than 50 beds
* Ease of data collection effort in rural hospitals with less than 50 beds
* Internal usefulness for rural hospitals with less than 50 beds
* External usefulness for rural hospitals with less than 50 beds.

The research partners further refined this draft set of existing quality measures to fit the rural context and identified emergency department care as both an important quality assessment measurement category for rural hospitals and missing from existing measurement sets.

The following referenced articles describe the ongoing use of expert panels to review the measures value, structure, elements and results.

**Rural Relevant Quality Measures for Critical Access Hospitals**

The Journal of Rural Health **29** (2013) 159–171\_c 2012 National Rural Health Association

Michelle M. Casey, MS;**1** Ira Moscovice, PhD;**1** Jill Klingner, RN, PhD;**1*,*2** & Shailendra Prasad, MBBS, MPH**1*,*3**

1 Rural Health Research Center, Division of Health Policy and Management, School of Public Health, University of Minnesota, Minneapolis, Minnesota

2 Labovitz School of Business and Economics, University of Minnesota-Duluth, Duluth, Minnesota

3 Department of Family Medicine and Community Health, University of Minnesota, Minneapolis, Minnesota

**Implementation of Emergency Department Transfer Communication Measures in Minnesota Critical Access Hospitals (Currently in revise and resubmit phase for JRH.)**

Jill Klingner, RN, PhD1,2; Ira Moscovice, PhD1; Michelle Casey, MS1; Alex McEllistrem Evenson, MA1

Throughout the field studies, strong emphasis was placed on obtaining expert and hospital staff insights. Evaluation of the measures, data collection, report usefulness, and the overall process was requested from hospital representatives at many points. Hospital, network, QIO and consulting staff were asked to maintain a log of comments regarding the project including suggestions for improvements. Feedback forms and contact information for participants involved in this project were provided during training sessions. Each time a hospital was contacted, comments were requested regarding the project. Hospitals were invited to call the QIO, network, consulting or University staff at any time with questions, comments, or concerns. Three expert panels were convened to review data and measurement definitions and specifications.

**EVIDENCE SUPPORTING THE VALUE OF MONITORING USE OF SERVICE**

Patients who are transferred from an Emergency Department to another acute facility are excluded from the calculation of most national quality measures, such as the Hospital Compare measures. In addition, limited attention has been paid to the development and implementation of quality measures specifically focused on patient transfers between Emergency Departments and other facilities. This type of measure is important for all healthcare facilities, but is especially important for small rural hospitals, which transfer a higher proportion of Emergency Department patients to other hospitals than do larger urban facilities (Newgard CD 2006, Wakefield DS 2004, Ellerbeck EF 2004, Baldwin LM 2004, Westfall JM 2006).

Communication problems are a major contributing factor to adverse events in hospitals, accounting for 65% of sentinel events tracked by the Joint Commission (JCAHO 2007).In addition, research indicates that deficits exist in the transfer of patient information between hospitals and primary care physicians in the community (Kripalani S 2007), and between hospitals and long term facilities (Cortes T 2004). The Joint Commission has adopted National Patient Safety Goal #2, “Improve the Effectiveness of Communication Among Caregivers.” Requirement 2E for this goal requires all accredited hospitals to implement a standardized approach to hand-off communications, including nursing and physician hand-offs from the emergency department to inpatient units, other hospitals, and other types of health care facilities. The process must include a method of communicating up-to-date information regarding the patient’s care, treatment and services, condition and any recent or anticipated changes (JCAHO-2 2007).

The proposed Emergency Department Transfer Communication measures aim to provide a means of assessing how well key patient information is communicated from an Emergency Department to a referral hospital. They are applicable to patients with a wide range of medical conditions (e.g., acute myocardial infarction, heart failure, pneumonia, respiratory compromise and trauma) and are relevant for both internal quality improvement purposes and external reporting to consumers and purchasers. The results of our field tests described later suggest that significant opportunity exists for improvement on these measures.

TheEmergency Department Transfer Communication Measure Set incorporates conceptual elements from the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the Continuity of Care Record (CCR). This measure was developed by the University of Minnesota Rural Health Research Center working in partnership with Stratis Health, the Minnesota Quality Improvement Organization.

The Emergency Department Transfer Communication Measures are a set of measures that assess whether documentation regarding 27 patient care elements was sent with a transferred patient or within 60 minutes of departure. The set consists of seven measures: 1) administrative communications, 2) patient information, 3) vital signs, 4) medication history and administration, 5) physician documentation, 6) nursing documentation, and 7) tests and procedures. Each element receives a score of 0 when documentation is not available in the patient record and a score of 1 when the documentation is available. Each of the seven measures is scored by summing the 0-1 scores for all elements that are part of the measure.

**1a.8.1** **What process was used to identify the evidence?**

Systematic literature review

**1a.8.2.** **Provide the citation and summary for each piece of evidence.**

Patient safety studies have identified the Emergency Department as the location within a hospital that has the highest percentage of preventable and negligent adverse events.1-2 Increasing attention is being paid to prevention of medical errors in Emergency Department settings, but considerable work still needs to be done to develop performance measures for Emergency Department care.3-4

Patients who are transferred from an Emergency Department to another facility are excluded from the calculation of most national quality measures, such as the Hospital Compare measures. In addition, limited attention has been paid to the development and implementation of quality measures specifically focused on patient transfers between Emergency Departments and other facilities. This type of measure is important for all healthcare facilities, but is especially important for small rural hospitals, which transfer a higher proportion of Emergency Department patients to other facilities than do larger urban facilities.5-9

1Leape, L., Brennan, T., Laird, N. et al. The Nature of Adverse Events in Hospitalized Patients. Results of the Harvard Medical Practice Study II. *New England Journal of Medicine* 324:377-384, 1991.

2Thomas, E., Studdert, D., Burstin, H. et al. Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado. *Medical Care* 38:261-271, 2000.

3Schenkel, S. Promoting Patient Safety and Preventing Medical Error in Emergency Departments. *Academic Emergency Medicine* 7:1204-1222, 2000.

4Welch, S., Augustine, J., Camago, C. and Reese, C. Emergency Department Performance Measures and Benchmarking Summit. *Academic Emergency Medicine*, 13(10):1074-1080, 2006.

5Newgard CD, McConnell KJ, Hedges JR. Variability of trauma transfer practices among non-tertiary care hospital emergency departments. . *Academic Emergency Medicine* 13:746-754, 2006.

6Wakefield DS, Ward M, Miller T, et al. Intensive care unit utilization and interhospital transfers as potential indicators of rural hospital quality. *Journal of Rural Health*. 20:394-400, 2004.

7Ellerbeck EF, Bhimaraj A, Perpich D. Organization of care for acute myocardial infarction in rural and urban hospitals in Kansas. *Journal of Rural Health*. 20:363-367, 2004.

8Baldwin LM, MacLehose RF, Hart LG et al. Quality of care for acute myocardial infarction in rural and urban US hospitals. *Journal of Rural Health*, 20:99-108, 2004.

9Westfall JM, Van Vorst RF, McGloin J, Selker HP. Triage and diagnosis of chest pain in rural hospitals: Implementation of the ACI-TIPI in the High Plains Research Network. *Annals of Family Medicine*. 4:153-158, 2006.

10Joint Commission on Accreditation of Healthcare Organizations. Sentinel Events Statistics. Available at: [http://www.jointcommission.org/SentinelEvents /Statistics/](http://www.jointcommission.org/SentinelEvents%20/Statistics/). Accessed July 18, 2007.

11Kripalani, S., LeFevre, F., Phillips, C. et al. Deficits in Communication and Information Transfer between Hospital-Based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care*. JAMA* 297(8):831-841, 2007.

12Cortes T., Wexler S. and Fitzpatrick J. The transition of elderly patients between hospitals and nursing homes. Improving nurse-to-nurse communication. *Journal of Gerontological Nursing.* 30(6):10-5, 2004.

13Joint Commission on Accreditation of Healthcare Organizations. 2008 National Patient Safety Goals. Available at: [http://www.jointcommission.org/PatientSafety/ NationalPatientSafetyGoals/08\_hap\_npsgs.htm](http://www.jointcommission.org/PatientSafety/%20NationalPatientSafetyGoals/08_hap_npsgs.htm). Accessed July 18, 2007.

The following paragraphs describe three of the current projects which use these measures:

* 1. As part of the Minnesota Statewide Quality Reporting and Measurement System established by state health care reform legislation in 2008,[[1]](#endnote-1) the Critical Access Hospitals (CAHs) in Minnesota were required to report data on the ED patient transfer communication measures to the Minnesota Department of Health starting in February 2012.10 This study examines the implementation of the ED patient transfer communications measures in the 79 CAHs in Minnesota in 2011-2013. Attached is an abstract of a submitted article describing the project.
  2. The measures are currently being used in 8 states as a pilot prior to inclusion in the Phase 3 of the Medicare Beneficiary Quality Improvement project (MBQIP).

Project Overview: The Critical Access Hospital (CAH) Emergency Department Transfer

Communication QIO special project is intended to build QIO capacity to support and improve the care delivered by CAHs focusing on transfer communication from the CAH emergency department.

This 12-month QIO special innovation project will provide and pilot test QIO resources for supporting CAHs to be trained to collect and report the ED Transfer Communication measures, identify gaps and opportunities for improvement, and begin planning for improving the transfer communication process and results. Eight QIOs are participating, supporting CAH participation in the following states: Iowa, Missouri, Nebraska, Maine, Oklahoma, West Virginia, Wisconsin, Wyoming.  Stratis Health, the Minnesota QIO, is coordinating and providing tools, training, and resources for each QIO to utilize in working with the participating CAHs in their respective states.  The project timeline is 8/1/13  - 7/31/14.  CAHs will begin collecting data in late 2013.

* 1. The project aligns with the HRSA funded federal Office of Rural Health Policy's (ORHP) Medicare Rural Hospital Flexibility Program (Flex) priorities in the Medicare Beneficiary Quality Improvement Project (MBQIP).  The ED Transfer Communication measure will be included in phase three of MBQIP, which launches in 2014.   QIOs are expected to work collaboratively with their state Flex offices.

1. [↑](#endnote-ref-1)