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

**Measure Number** (*if previously endorsed*)**:** 0291

**Measure Title**: Emergency Department Transfer Communication Measure

**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**: 11/23/2019

|  |
| --- |
| **Instructions**  *Complete 1a.1 and 1a.2 for all measures. If instrument-based measure, complete 1a.3.*  *Complete* ***EITHER 1a.2, 1a.3 or 1a.4*** *as applicable for the type of measure and evidence.*  *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.*   * 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. * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

|  |
| --- |
| **Note: The information provided in this form is intended to aid the Standing 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:   * Outcome: [**3**](#Note3) Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias. * 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. * For measures derived from patient reports, evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful. * Process measures incorporating Appropriate Use Criteria: See NQF’s guidance for evidence for measures, in general; guidance for measures specifically based on clinical practice guidelines apply as well.   **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 Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org) and/or modified GRADE.  **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

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.* (*A PRO-based performance measure is not a survey instrument. Data may be collected using a survey instrument to construct a PRO measure.)*

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

Process: documentation of sending information to a receiving facility

Appropriate use measure: documentation of info sent.

Structure: Click here to name the structure

Composite: Click here to name what is being measured

**1a.2** **LOGIC MODEL** Diagram or briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient’s health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

Care is provided

Patient enters ED

Care is documented

Decision is made to transfer patient

Communication occurs with receiving facility

Patient is transferred

Patient’s status and test results from prior hospital are understood, medication changes are noted, leading to better continuity of care, fewer repeated tests, better diagnosis and safer ongoing care.

Documentation is sent to receiving hospitals within 60 minutes

**1a.3** **Value and Meaningfulness:**  **IF** this measure is derived from patient report, provide evidence that the target population values the measured ***outcome, process, or structure*** and finds it meaningful. (Describe how and from whom their input was obtained.)

**\*\*RESPOND TO ONLY ONE SECTION BELOW -EITHER 1a.2, 1a.3 or 1a.4) \*\***

**1a.2** **FOR OUTCOME MEASURES including PATIENT REPORTED OUTCOMES - Provide empirical data demonstrating the relationship between the outcome (or PRO) to at least one healthcare structure, process, intervention, or service.**

**1a.3.****SYSTEMATIC REVIEW(SR) OF THE EVIDENCE (for intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measures, including those that are instrument-based) If the evidence is not based on a systematic review go to section 1a.4) If you wish to include more than one systematic review, add additional tables.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1a.4 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.*

**1a.4.1** **Briefly SYNTHESIZE the evidence that supports the measure.**

**1a.4.1** **Briefly SYNTHESIZE the evidence that supports the measure.**

Background of the Measure: In 2003, an expert panel convened by the University of Minnesota Rural Health Research Center and Stratis Health identified ED care as an important quality assessment measurement category for rural hospitals. While emergency care is important in all hospitals, it is particularly critical in rural hospitals where the size of the hospital and geographic realities make organizing triage, stabilization, and transfer of patients more important.

In 2018, as part of the Rural Quality Improvement Technical Assistance (RQITA) program, Stratis Health, in partnership with the University of Minnesota Rural Health Research Center, convened a Technical Expert Panel (TEP) to review, revise, and update the EDTC measures and the related specifications manual. The Panel members represented national experts in hospital ED physicians and nurses, quality measurement, electronic health records, and data analytics. The TEP met three times via conference call to review the measure specifications and discussion was framed around three primary issues and challenges including EDTC in a "wired" world, appropriate population for transfers, and clinical relevance of specific data elements. The TEP recommended significant changes to help streamline and modernize the measure including reducing the total number of data elements from 27 to 8, updating the definition of ‘sent’ to better address communication via EHR or HIE, and clarifying specific definitions of individual data elements.

Communication between providers promotes continuity of care and may lead to improved patient outcomes. These measures were piloted by rural hospitals in Hawaii, Iowa, Maine, Minnesota, Missouri, Nebraska, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Utah, Washington, West Virginia, Wisconsin, and Wyoming; projects took place from October 2005 through July 2014. Results of the pilot projects indicated room for improvement in ED care and transfer communication. Aggregate project results are available at http://www.flexmonitoring.org/wp-content/uploads/2014/02/ds8.pdf and http://flexmonitoring.org/documents/FlexDataSummaryReport3.pdf.

This measure is being implemented by critical access hospitals (CAHs) in the Medicare Beneficiary Quality Improvement Project (MBQIP) because small rural hospitals frequently transfer a higher proportion of emergency department (ED) patients than larger urban facilities. It is an important goal of MBQIP to help hospitals improve care transitions, including ED transfers, in order to reduce preventable hospital readmissions and adverse events in hospitals. Currently, 86% of the 1,318 CAHs participating in MBQIP are reporting EDTC-All.

In 2014, over 100 CAHs across eight states participated in a one-year special innovation project through the Centers for Medicare and Medicaid Services (CMS) led by Stratis Health. A case study discussing implementation of EDTC in Minnesota was also done by the Flex Monitoring Team (FMT), a Federal Office of Rural Health Policy (FORHP) funded consortium of research centers, in 2014. EDTC became a required MBQIP measure in 2015, and reporting rates among CAHs nationwide have risen dramatically since that time. Every EDTC sub-measure and the composite EDTC-All measure has consistently improved between Q1 2015 and Q3 2016. Most markedly, EDTC-All has risen from 51.8% to 74.3% (a 22.5 percentage point increase). Reporting rates and measure scores have improved.

Communication problems are a major contributing factor to adverse events in hospitals, accounting for 65% of sentinel events tracked by The Joint Commission. In addition, research indicates that deficits exist in the transfer of patient information between hospitals and primary care physicians in the community, and between hospitals and long-term facilities. Transferred patients are excluded from the calculation of most national quality measures, such as those used in Hospital Compare. The Hospital Compare Web site was created to display rates of Process of Care measures using data that are voluntarily submitted by hospitals.

The Joint Commission has adopted National Patient Safety Goal 2, "Improve the Effectiveness of Communication Among Caregivers." This goal required all accredited hospitals to implement a standardized approach to hand- off communications, including nursing and physician handoffs from the emergency department (ED) 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. (Note: The National Patient Safety Goals are reviewed and modified periodically. In 2013 a communication goal focuses on the communication of test results.) http://www.jointcommission.org/assets/1/6/HAP\_NPSG\_Chapter\_2014.pdf Limited attention has been paid to the development and implementation of quality measures specifically focused on patient transfers between EDs and other health care facilities. Examples are patients transferred between an ED and a skilled nursing facility with their often vulnerable and fragile populations. These measures are important for all health care facilities, but especially so for small rural hospitals that transfer a higher proportion of ED patients.

While many aspects of hospital quality are similar for urban and rural hospitals (e.g., providing heart attack patients with aspirin), the urban/rural contextual differences result in differences in emphasis on quality measurement. Because of its role in linking residents to urban referral centers, important aspects of rural hospital quality include triage-and-transfer decision making about when to provide a particular type of care, transporting patients, and coordinating information flow to specialists beyond the community. Because of their size, rural hospitals are less likely to be able to provide more specialized services, such as cardiac catheterization or trauma surgery. Rural residents often need to travel greater distances than urban residents to get to a hospital initially. In addition, their initial point of contact is less likely to have specialized services and staff found in tertiary care centers, so they are also more likely to be transferred. These size and geographic realities increase the importance of organizing triage, stabilization, and transfer in rural hospitals which, in turn, suggest that measurement of these processes is an important issue for rural hospitals.

The ED Transfer Communication measure aims to provide a means of assessing how well key patient information is communicated from an ED to any healthcare facility. 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 the field tests suggest that significant opportunity

**2019 additions to background literature support**

There is widespread agreement that patients receiving care from multiple providers across the care spectrum are at risk for poor quality care, adverse events, higher expenditures and incomplete medication management. There are no randomized control studies that directly examine the impact of structured communication between Critical Access Hospitals (CAHs) that transfer patients to facilities for other acute and non-acute care. Studies demonstrate that transfer patients experience higher cost of care and poorer outcomes

“Patient transfers between hospitals are becoming more common in the United States. Disease-specific studies have reported varying outcomes associated with transfer status. However, even as national quality improvement efforts and regulations are being actively adopted, forcing hospitals to become financially accountable for the quality of care provided, surprisingly little is known about transfer patients or their outcomes at a population level.” (Hernandez-Boussard et al., 2017)

Communication, efficiency and appropriateness are key factors advanced as impacting the quality and safety of non-emergency transport services. The safety of transferred patients is sometimes compromised by poor standardization and failures in the communication process.(Hains et al., 2011)Patient care during inter-facility transfer depends not only on the expertise provided by the receiving facility, but also on timely and accurate patient information received from the transferring institution.(Szary et al., 2010)

In a large national study of academic health center 2011-2012 discharges inter hospital transfer (IHT) patients are at a higher risk of inpatient mortality after controlling for patient characteristics and risk of mortality measures (odds ratio: 1.36, 95% conﬁdence interval: 1.29–1.43).(Sokol-Hessner et al., 2016)

Transfer patients in the lowest risk group have longer length of hospital stay and ICU stays. (Golestanian et al., 2007) They cost more solely due to their transfer status. What about being transferred sets them up for these higher costs? Could it be communication with the transferring hospital?

Transfer patients use more resources and have worse outcomes than nontransfer patients. They have statistically significant longer length of stays (13 to 4.5), more non-routine dispositions (53% to 68%), higher risk-adjusted inpatient mortality (4.6% to 2.1%), and higher risk-adjusted Patient Safety Indicators (PSI) In 4 of 5 indicators. Most CMS sponsored hospital quality measures do not include transferred patients. “Carefully constructed national quality measures for transfer of care should be designed and validated.”(Hernandez-Boussard et al., 2017)

“This expanding evidence base demonstrates that serious deficiencies in quality exist for patients undergoing transitions across sites of care. Qualitative studies produced consistent results, demonstrating that patients are often unprepared for their self-management role in the next care setting, receive conflicting advice regarding chronic illness management, are often unable to reach an appropriate health care practitioner who has access to their care plan when questions arise, and have minimal input into their care plan. Quantitative studies documented that quality and patient safety are compromised during the vulnerable period when patients transition between different settings because of high rates of medication errors, incomplete or inaccurate information transfer, and lack of appropriate follow-up care. During care transitions, patients receive medications from different prescribers, who rarely have access to patients’ comprehensive medication lists. Collectively, these types of problems conspire to increase rates of recidivism to high intensity care settings when patients’ care needs are not met, leading to greater health care costs.” (Coleman et al., 2006)

Hernandez-Boussard et al., ‘s population-wide study provides timely analyses of the characteristics of this particularly vulnerable and sizable inpatient population. Opportunity exists for improvement on these processes.” (Hernandez-Boussard et al., 2017)

Szary’s prospective study quantified compliance with inter-facility transfer communication and revealed an opportunity for improvement. Introduction of a simple written template to enhance communication between providers improved the quality of transfer information. (Szary et al., 2010)

**1a.4.2 What process was used to identify the evidence?**

**Routine PubMed Searches.**

**1a.4.3.** **Provide the citation(s) for the evidence.**

Selected References:

Baldwin LM, MacLehose RF, Hart LG, Beaver SK, Every N, Chan L. Quality of care for acute myocardial infarction in rural and urban US hospitals. J Rural Health 2004 Spring;20(2):99-108.

Cortes TA, Wexler S, Fitzpatrick JJ. The transition of elderly patients between hospitals and nursing homes. Improving nurse-tonurse communication. J Gerontol Nurs 2004 Jun;30(6):10-5; quiz 52-3. [5 references]

Ellerbeck EF, Bhimaraj A, Perpich D. Organization of care for acute myocardial infarction in rural and urban hospitals in Kansas. J Rural Health 2004 Fall;20(4):363-7.

Joint Commission on Accreditation of Healthcare Organizations. Sentinel events statistics. [Internet]. [Accessed 2007 Jul 18].

Klingner J, Moscovice I, Washington Rural Healthcare Quality Network and Stratis Health, Minnesota Quality Improvement Organization. Rural hospital emergency department quality measures: aggregate data report. Minneapolis (MN): University of Minnesota, Division of Health Services Research & Policy; 2007 Mar. 12 p. (Flex Monitoring Team data summary report; no. 3).

Klingner J, Moscovice I. Development and testing of emergency department patient transfer communication measures. J Rural Health 2012 Jan;28(1):44-53. [16 references]

Kripalani S, Lefevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. JAMA 2007 Feb 28;297(8):831-41. [133 references]

Newgard CD, McConnell KJ, Hedges JR. Variability of trauma transfer practices among non-tertiary care hospital emergency departments. Acad Emerg Med 2006 Jul;13(7):746-54.

University of Minnesota Rural Health Research Center, Stratis Health (Minnesota's Quality Improvement Organization), HealthInsight (Nevada and Utah's Quality Improvement Organization). Refining and field testing a relevant set of quality measures for rural hospitals. Final report submitted to the Centers for Medicare & Medicaid Services under contract no. 500-02-MN01. Bloomington (MN): Stratis Health; 2005 Jun 30. US Department of Health and Human Services. Hospital Compare Web site. [Web site]. [Accessed 2011 Feb 25].

Wakefield DS, Ward M, Miller T, Ohsfeldt R, Jaana M, Lei Y, Tracy R, Schneider J. Intensive care unit utilization and interhospital transfers as potential indicators of rural hospital quality. J Rural Health 2004 Fall;20(4):394-400.

Westfall 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. Ann Fam Med 2006 Mar-Apr;4(2):153-8.

<http://www.stratishealth.org/providers/ED_Transfer_Resources.html>

**New references for 2019 submission**

Coleman, E. A., Parry, C., Chalmers, S., & Min, S.-J. (2006). The care transitions intervention: Results of a randomized controlled trial. *Archives of Internal Medicine*, *166*(17), 1822–1828. https://doi.org/10.1001/archinte.166.17.1822

Golestanian, E., Scruggs, J. E., Gangnon, R. E., Mak, R. P., & Wood, K. E. (2007). Effect of interhospital transfer on resource utilization and outcomes at a tertiary care referral center. *Critical Care Medicine*, *35*(6), 1470–1476. https://doi.org/10.1097/01.CCM.0000265741.16192.D9

Hains, I. M., Marks, A., Georgiou, A., & Westbrook, J. I. (2011). Non-emergency patient transport: What are the quality and safety issues? A systematic review. *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care*, *23*(1), 68–75. https://doi.org/10.1093/intqhc/mzq076

Hernandez-Boussard, T., Davies, S., McDonald, K., & Wang, N. E. (2017). Interhospital Facility Transfers in the United States: A Nationwide Outcomes Study. *Journal of Patient Safety*, *13*(4), 187–191. https://doi.org/10.1097/PTS.0000000000000148

Sokol-Hessner, L., White, A. A., Davis, K. F., Herzig, S. J., & Hohmann, S. F. (2016). Interhospital transfer patients discharged by academic hospitalists and general internists: Characteristics and outcomes. *Journal of Hospital Medicine*, *11*(4), 245–250. https://doi.org/10.1002/jhm.2515

Szary, N. M., Sarwal, A., Boshard, B. J., & Hall, L. W. (2010). Transfer of care communication: Improving communication during inter-facility patient transfer. *Missouri Medicine*, *107*(2), 127–130.

**Brief article review of new citations: 2019**

For each study you review, state the study design, report sample size and report the main result.

1. Szary NM, Sarwal A, Boshard BJ, Hall LW. Transfer of Care Communication: Improving Communication during Inter-Facility Patient Transfer. Missouri Medicine March/April 2010 102:2

Study Design: Pre Post prospective study quantified compliance with inter-facility transfer communication requested information. Intervention was a template of requested information used by the receiving hospital when contacted by the sending hospital. Observations did not differentiate between sources of transfers.

Sample Size: 60 pre observations, 43 post observations. Observations of information provided by sending facilities were made by resident physicians, at the University of Missouri 223 bed hospital in Columbia Missouri, who were receiving those transfers.

Main Result: Significant improvement was seen in the reception of Medication lists (P<0.01), and Imaging (P<0.01). Improvement in Lab data was documented (P<0.11). No significant increase was observed in discharge summaries.

Limitations: Small sample.

1. [Golestanian E](https://www.ncbi.nlm.nih.gov/pubmed/?term=Golestanian%20E%5BAuthor%5D&cauthor=true&cauthor_uid=17440423)1, [Scruggs JE](https://www.ncbi.nlm.nih.gov/pubmed/?term=Scruggs%20JE%5BAuthor%5D&cauthor=true&cauthor_uid=17440423), [Gangnon RE](https://www.ncbi.nlm.nih.gov/pubmed/?term=Gangnon%20RE%5BAuthor%5D&cauthor=true&cauthor_uid=17440423), [Mak RP](https://www.ncbi.nlm.nih.gov/pubmed/?term=Mak%20RP%5BAuthor%5D&cauthor=true&cauthor_uid=17440423), [Wood KE](https://www.ncbi.nlm.nih.gov/pubmed/?term=Wood%20KE%5BAuthor%5D&cauthor=true&cauthor_uid=17440423).

**Effect of interhospital transfer on resource utilization and outcomes at a tertiary care referral center.** [Crit Care Med.](https://www.ncbi.nlm.nih.gov/pubmed?term=(effect%20of%20transfer%20on%20resource)%20AND%20golestanian) 2007 Jun;35(6):1470-6.

Design: Observational cohort study. Comparing Acute Physiology and Chronic Health Evaluation (APACHE) III score, actual and predicted ICU and hospital lengths of stay, actual and predicted ICU and hospital mortality, and costs per admission.

Sample Size:4569 patients admitted to a tertiary ICU from 1997 to 2000.

Main Result: Crude comparison of directly admitted and transfer patients revealed that transfer patients had significantly higher APACHE III scores (mean, 60.5 vs. 49.7, p < .001), ICU mortality (14% vs. 8%, p < .001), and hospital mortality (22% vs. 14%, p < .001). Transfer patients also had longer ICU lengths of stay (mean, 6.0 vs. 3.8 days, p < .001) and hospital lengths of stay (mean, 20 vs. 15.9 days, p < .001). Stratified by disease severity using the APACHE III model, there was no difference in either ICU or hospital mortality between the two populations. However, in the transfer group with the lowest predicted mortality of 0-20%, ICU and hospital lengths of stay were significantly higher. In crude cost analysis, transfer patients' costs were $9,600 higher per ICU admission compared with nontransfer patients (95% confidence interval, $6,000-$13,400). Risk stratification revealed that the higher per-patient cost was entirely confined to the transfer patients with the lowest predicted mortality.

1. Interhospital Facility Transfers in the United States: A Nationwide Outcomes Study

Tina Hernandez-Boussard, PhD, MPH, MS\*, Sheryl Davies, BA†, Kathryn McDonald, MA†, and N. Ewen Wang, M

J Patient Saf . 2017 December ; 13(4): 187–191. doi:10.1097/PTS.0000000000000148

Study Design: Retrospective observational study of in-hospital adverse events and discharge deposition for transfer patients vs nontransfer patients using Nationwide Inpatient Sample (NIS).

Sample Size: 1,397,712 transfer patients and 31,692,211 nontransfer patients for a total of 33,089,923 patients.

Main Result: We identified 1,397,712 transfer patients and 31,692,211 nontransfer patients. Age, sex, race, and payer were significantly associated with odds of transfer ( P < 0.05). Transfer patients had higher risk-adjusted inpatient mortality (4.6 versus 2.1, P < 0.01), longer length of stay (13.3 versus 4.5, P < 0.01), and fewer routine disposition discharges (53.6 versus 68.7, P < 0.01). In-hospital adverse events were significantly higher in transfer patients compared with nontransfer patients ( P < 0.05). With hospital accountability and value-based payments constituting an integral part of health care reform, documenting the quality of care delivered to transfer patients is essential before accurate quality assessment improvement efforts can begin in this patient population.

Our results suggest that transfer patients have inferior outcomes compared with nontransfer patients. Although they are clinically complex patients and assessing accountability as between the transferring and receiving hospitals is methodologically difficult, transfer patients must nonetheless be included in quality benchmark data to assess the potential impact this population has on hospital outcome profiles. With hospital accountability and value-based payments constituting an integral part of health care reform, documenting the quality of care delivered to transfer patients is essential before accurate quality assessment improvement efforts can begin in this patient population.

1. Interhospital Transfer Patients Discharged by Academic Hospitalists and General Internists: Characteristics and Outcomes

Lauge Sokol-Hessner, MD1\*, Andrew A. White, MD2, Katherine F. Davis, RN3, Shoshana J. Herzig, MD, MPH1, Samuel F. Hohmann, PhD3

Journal of Hospital Medicine Vol 11 | No 4 | April 2016

Study Design: Retrospective cohort study that compares interhospital transfers (IHT) with those admitted from the emergency department to an academic health system.

Sample Size: 885,392 adult inpatients discharged from 158 academic health centers and affiliated hospitals from April 1, 2011 to March 31,2012.

Main Result: IHT patients are at a higher risk of inpatient mortality after controlling for patient characteristics and risk of mortality measures.

1. The Care Transitions Intervention

Results of a Randomized Controlled Trial

Eric A. Coleman, MD, MPH; Carla Parry, PhD, MSW; Sandra Chalmers, MPH; Sung-joon Min, PhD

ARCH INTERN MED/VOL 166, SEP 25, 2006 WWW.ARCHINTERNMED.CO

Study Design: Randomized control trial from September 1 2002 to Aug 31 2003 of patients moving across different health care settings who received communication tools, assertiveness encouragement, and “transition” coaching.

Sample Size: 750 community dwelling adults over age 65 who were admitted to the study hospital for 1 of 11 conditions.

Main Result: Coaching for chronically ill elders to ensure that their needs are met may reduce rates of subsequent rehospitalization.

1. Non-emergency patient transport: What are the quality and safety issues? A systematic review. Hains, I. M., Marks, A., Georgiou, A., & Westbrook, J. I. (2011). *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care*, *23*(1), 68–75. https://doi.org/10.1093/intqhc/mzq076

Study design: Systematic Review

Sample: Twelve articles from 7 countries.

Main Results: Communication, efﬁciency and appropriateness are key factors that are advanced as impacting on the quality and safety of non-emergency transport services. Standardization of the non-emergency transport process shows promise in reducing risk and increasing efﬁciency. Applying information and communication technology to improve the quality of transport services has received little attention despite its potential beneﬁts. Patient outcomes in relation to quality and safety of transport services are rarely measured. Available evidence suggests that safety of non-emergency patient transfers is sometimes compromised due to poor standar