NATIONAL QUALITY FORUM

ED Transitions of Care: Measure Compendium

Contents

Provider Communication

Subdomain	Measure Title	Description	Measure Type	Measure Relevance
Key Information	Medication reconciliation completed after emergency department (ED) or hospital discharge (Safe transitions best practice measures for community physician offices -Best Practice #7)	This measure estimates the frequency with which community physician offices perform medication reconciliation after their patients are discharged from the ED or hospital.	Process	Directly
Key Information	Transitions of Care (TRC)	The percentage of discharges for members 18 years of age and older who had each of the following during the measurement year. Four rates are reported for this measure. The four rates are: 1. Notification of Inpatient Admission: Documentation of primary care practitioner (PCP) notification of inpatient admission on the day of admission or the following day. 2. Receipt of Discharge Information: Documentation of PCP receipt of discharge information on the day of discharge or the following day. 3. Patient Engagement After Inpatient Discharge: Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided by the PCP within 30 days after discharge. 4. Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).	Process	Directly
Key Information	Confirmation of receipt of discharge information sent to hospital (Safe transitions best practice measures	This measure estimates the frequency with which community physician offices confirm receipt of the discharge information sent to them by the hospital.	Process	Potentially

	for community physician offices - Best Practice #4)			
Key Information	Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings	The IMPACT Act requires a quality measure on the transfer of health information and care preferences when an individual transitions between post-acute care (PAC) and hospitals, other PAC providers, or home. This process-based quality measure estimates the percent of patient or resident stays or episodes where information was sent from the previous provider/home at admission or the start/resumption of care. In addition, this quality measure assesses the modes of information transfer from one care provider to the subsequent provider/home.	Process	Potentially
Key Information	Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	The IMPACT Act requires a quality measure on the transfer of health information and care preferences when an individual transitions between post-acute care (PAC) and hospitals, other PAC providers, or home. This process-based quality measure estimates the percent of patient or resident stays or episodes where information was sent from the PAC provider to the subsequent provider/home at discharge or end of care. In addition, this quality measure assesses the modes of information transfer from one care provider to the next.	Process	Potentially
Key Information	Perioperative Composite (Group measure as defined by Am. Coll. of Surgeons)	Percentage of patients who are taken to the operating room for an elective surgical intervention under regional anesthesia, monitored anesthesia care (MAC), and/or general anesthesia who have an updated history and physical (H&P), documentation that recent laboratory values were reviewed, and documentation of the site and side of surgery in the medical record within the 24 hours prior to surgery.	Process	Indirectly

Key Information	NQF Measure #0558: HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a complete post discharge continuing care plan, all the components of which are transmitted to the next level of care provider upon discharge. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-6: Post Discharge Continuing Care Plan Created) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-6 (Post Discharge Continuing Care Plan Created).	Process	Indirectly
Modality	Closing the referral loop: receipt of specialist report	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred; an eMeasure.	Process	Directly
Modality	Real-time verbal information provided to ED or hospital clinicians, if needed (Safe transitions best practice measure set-Best Practice #2)	This measure estimates the frequency with which community physician offices respond to ED and hospital clinicians' time-sensitive verbal requests for clinical information at the time of the initial call or within one hour.	Process	Directly
Modality	NQF Measure #0488: Adoption of Health Information Technology	Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted and be using a certified/qualified electronic health record (EHR).	Structure	Indirectly

Modality	NQF Measure #0486: Adoption of Medication e-prescribing	Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting.	Structure	Indirectly
Modality	Intraoperative Timeout Safety Checklist (Group measure as defined by Am. Coll. of Surgeons)	Percentage of patients age 18 or older who are taken to the operating room for an elective or emergent surgical intervention under regional, MAC, and/or general anesthesia for whom an intraoperative safety checklist is performed prior to incision that includes the patient's name, the procedure to be performed, laterality, confirmation of site marking, allergies, confirmation of the administration of preoperative antibiotic prophylaxis and VTE prophylaxis if appropriate, anticipated equipment, placement of Bovie pad, correct patient positioning, and display of essential imaging.	Process	Indirectly
Timeliness	Clinical information provided to emergency department (ED) or hospital clinicians (Safe transitions best practice measures for community physician offices -Best Practice #3)	This measure estimates the frequency with which community physician offices respond to ED and hospital clinicians' requests for clinical information within 2 hours of the request.	Process	Directly
Timeliness	NQF Measure #0291: Emergency Transfer Communication (% of patients transferred to another healthcare facility)	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that REQUIRED information was communicated to the receiving facility prior to departure OR WITHIN 60 MINUTES OF TRANSFER	Process	Directly
Timeliness	NQF Measure #0293: Medication Information	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that medication information was communicated to the receiving FACILITY within 60 minutes of departure	Process	Directly

Timeliness	NQF Measure #0296: Nursing Information	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that nursing information was communicated to the receiving FACILITY within 60 minutes of departure.	Process	Directly
Timeliness	NQF Measure #0294: Patient Information	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that patient information was communicated to the receiving FACILITY within 60 minutes of departure	Process	Directly
Timeliness	NQF Measure #0295: Physician Information	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that physician information was communicated to the receiving FACILITY within 60 minutes of departure	Process	Directly
Timeliness	NQF Measure #0297: Procedures and Tests	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that procedure and test information was communicated to the receiving FACILITY within 60 minutes of departure	Process	Directly
Timeliness	NQF Measure #0292: Vital Signs	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that the entire vital signs record was communicated to the receiving FACILITY within 60 minutes of departure	Process	Directly
Timeliness	Care Coordination after Asthma-Related Emergency Department Visit	Proportion of emergency department (ED) visits not resulting in an inpatient admission for patients of any age who visit the ED for asthma for which the ED notifies the patient's primary care provider or his or her relevant specialist about the patient's visit to the ED within 24 hours of discharge	Process	Potentially
Timeliness	Care Coordination after Asthma-Related Emergency Department Visit: EP (Eligible Professional) Follow-up	Proportion of emergency department (ED) visits not resulting in an inpatient admission for patients of any age who visit the ED for asthma and for which the patient's primary care provider, relevant specialist, or a designated	Process	Potentially

		staff member followed up with the patient within 72 hours of receiving notification of the patient's ED visit from the ED.		
Timeliness	NQF Measure #0648: Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Process	Indirectly
Efficiency	Clinical information sent with emergency department (ED) referrals (Safe transitions best practice measure set-Best Practice #1)	This measure estimates the frequency with which community physician offices send clinical information to the ED, when referring a patient for evaluation.	Process	Directly
Education	NQF Measure #1919: Cultural Competency Implementation Measure	The Cultural Competence Implementation Measure is an organizational survey designed to assist healthcare organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed® cultural competency practices prioritized for the survey. The target audience for this survey includes healthcare organizations across a range of health care settings, including hospitals, health plans, community clinics, and dialysis organizations. Information from the survey can be used for quality improvement, provide information that can help health care organizations establish benchmarks and assess how they compare in relation to peer organizations, and for public reporting.	Structure	Indirectly

Patient and Family Communication

Subdomain	Measure Title	Description	Measure Type	Measure Relevance
Key Information	NQF Measure #2605: Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge. Four rates are reported: • The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge. • The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge. • The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge. • The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.	Process	Directly
Key Information	Follow-Up After Emergency Department Visit for People With Multiple Chronic Conditions	The percentage of emergency department (ED) visits for members 18 years and older who have multiple chronic conditions and had a follow-up service within 7 days of the ED visit.	Process	Directly

Key Information	Percentage of patients with an emergency department visit or inpatient admission for an asthma exacerbation who are discharged from the emergency department OR inpatient setting with an asthma discharge plan	This measure is used to assess the percentage of patients age five years and older with an emergency department visit or inpatient admission for an asthma exacerbation who are discharged from the emergency department or inpatient setting with an asthma discharge plan.	Process	Directly
Key Information	NQF Measure #0649: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements	Process	Directly
Key Information	NQF Measure #0646: Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	Process	Potentially
Key Information	NQF Measure #0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements	Process	Potentially
Key Information	NQF Measure #0326: Advance Care Plan	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record	Process	Indirectly

		that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.		
Key Information	NQF Measure #0552: HBIPS-4: Patients discharged on multiple antipsychotic medications.	The proportion of patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-5 (Patients discharged on multiple antipsychotic medications with appropriate justification).	Process	Indirectly
Key Information	NQF Measure #0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	The proportion of patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-6: Post Discharge Continuing Care Plan and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired	Process	Indirectly

		measure with HBIPS-4 (Patients discharged on multiple antipsychotic medications).		
Key Information	NQF Measure #0136: Heart Failure (HF): Detailed discharge instructions	Percentage of heart failure patients discharged home with written instructions or educational material given to patient or caregiver at discharge or during the hospital stay addressing all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen.	Process	Indirectly
Modality	High-risk patients contacted via phone after emergency department (ED) or hospital discharge (Safe transitions best practice measures for community physician offices -Best Practice #5)	This measure estimates the frequency with which community physician offices call high-risk patients within 72 hours of patients' discharge from the ED or hospital.	Process	Directly
Modality	Patient Electronic Access (Provider)	For an EHR reporting period in 2016, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period.	Process	Indirectly
Education	Dementia: Caregiver Education and Support	Percentage of patients, regardless of age, with a diagnosis of dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional resources for support within a 12 month period	Process	Indirectly

Education	Patient Specific Education (Hospital)	Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.	Process	Indirectly
Shared Accountability	Postoperative Plan Communication with Patient and Family (Group measure as defined by Am. Coll. of Surgeons)	Percentage of patients who are taken to the operating room for an elective or emergent surgical procedure under regional anesthesia, MAC, and/or general anesthesia who had documented postoperative communication regarding the surgery and plan for care after discharge with the patient and the patient's family	Process	Indirectly

Engagement of Broader Community

Subdomain	Measure Title	Description	Measure Type	Measure Relevance
Linkages and Synchronization	Patient Electronic Access (Hospital)	More than 50 percent of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH are provided timely access to view online, download and transmit to a third party their health information.	Process	Directly
Linkages and Synchronization	Electronic Prescribing (eRx) (Provider)	Generate and transmit permissible discharge prescriptions electronically (eRx).	Process	Indirectly
Linkages and Synchronization	NQF Measure #0487: EHR with EDI prescribing used in encounters where a prescribing event occurred	Of all patient encounters within the past month that used an electronic health record (EHR) with electronic data interchange (EDI) where a prescribing event occurred, how many used EDI for the prescribing event.	Structure	Indirectly
Linkages and Synchronization	Health Information Exchange (Hospital)	The eligible hospital or CAH (Critical Access Hospital) who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.	Process	Indirectly
Linkages and Synchronization	Health Information Exchange (Provider)	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.	Process	Indirectly
Linkages and Synchronization	Postoperative Care Coordination and Follow-up with Primary/Referring Provider (Group measure as defined by Am. Coll. of Surgeons)	Percentage of patients age 18 or older who are taken to the operating room for an elective or emergent surgical intervention under regional, MAC, and/or general anesthesia who had documented post-operative communication regarding the surgery with the patient's primary care physician or referring physician within the 30 days following surgery.	Process	Indirectly
Linkages and Synchronization	Post-Discharge Review of Patient Goals of Care (Group	Percentage of patients who are taken to the operating room for an elective surgical procedure under regional anesthesia, MAC, and/or	Process	Indirectly

	measure as defined by Am. Coll. of Surgeons)	general anesthesia who had documented postoperative communication reviewing original goals of care expressed preoperatively and updating goals of care as appropriate occurring after discharge up until 90 days following discharge date.		
Linkages and Synchronization	Rhode Island Physician Health Information Technology Survey	To measure physicians' use and integration of health information technology and electronic medical records in their office or hospital clinical practice.	Process	Indirectly
Linkages and Synchronization	NQF Measure #0489: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/ Certified EHR System as Discrete Searchable Data Elements	Documents the extent to which a provider uses certified/qualified electronic health record (EHR) system that incorporates an electronic data interchange with one or more laboratories allowing for direct electronic transmission of laboratory data into the EHR as discrete searchable data elements.	Structure	Indirectly
Quality and Availability of Services	Protocol for inter-facility transfer	This measure is used to assess whether the trauma system has a protocol to guide the transfer of injured patients age 18 years and older from a lower-level facility to a higher-level facility.	Structure	Directly
Quality and Availability of Services	NQF Measure #0045: Communication with the physician or other clinician managing on-going care post fracture for men and women aged 50 years and older	Percentage of adults 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication.	Process	Indirectly
Quality and Availability of Services	NQF Measure #0557: HBIPS-6 Post discharge continuing care plan created	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a post discharge continuing care plan created. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence	Process	Indirectly

		Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-7 (Post Discharge Continuing Care Plan Transmitted).		
Quality and Availability of Services	NQF Measure #2455: Heart Failure: Post-Discharge Appointment for Heart Failure Patients	Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified)	Process	Indirectly
Quality and Availability of Services	NQF Measure #0576: Follow-Up After Hospitalization for Mental Illness (FUH)	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the patient received follow-up within 30 days of discharge • The percentage of discharges for which the patient received follow-up within 7 days of discharge.	Process	Indirectly
Quality and Availability of Services	Postoperative Care Plan (Group measure as defined by Am. Coll. of Surgeons)	Percentage of patients age 18 or older who are taken to the operating room for an elective or emergent surgical intervention under regional, MAC, and/or general anesthesia who have a documented plan of care at the beginning of the postoperative phase of care that addresses: mobilization, pain management, diet, resumption of preoperative medications, management of drains/catheters/invasive lines, and wound care	Process	Indirectly

Quality and Availability of Services	Resumption Protocol (Group measure as defined by Am. Coll. of Surgeons)	Percentage of patients age 18 or older who are taken to the operating room for an elective or emergent surgical intervention under regional, MAC, and/or general anesthesia who have a documented plan during a post-discharge follow-up encounter updating patient improvements in mobility, pain control, diet, resumption of home medications, wound care, and management of cutaneous/invasive devices (drains, IV lines, etc.).	Process	Indirectly

Achievement of Outcomes

Subdomain	Measure Title	Description	Measure Type	Measure Relevance
Healthcare Utilization & Costs	Follow-up visits conducted after patient discharge from the hospital (Safe transitions best practice measures for community physician offices -Best Practice #6)	This measure estimates the frequency with which community physician offices conduct office visits with patients discharged from hospital.	Process	Potentially
Healthcare Utilization & Costs	NQF Measure #0644: Patients with a transient ischemic event ER visit that had a follow up office visit.	Patient(s) with a recent emergency room encounter for a transient cerebral ischemic event that had any physician visit within 14 days of the acute event.	Process	Potentially
Healthcare Utilization & Costs	NQF Measure #2881: Excess days in acute care (EDAC) after hospitalization for acute myocardial infarction (AMI)	This measure assesses days spent in acute care within 30 days of discharge from an inpatient hospitalization for acute myocardial infarction (AMI) to provide a patient-centered assessment of the post-discharge period. This measure is intended to capture the quality of care transitions provided to discharged patients hospitalized with AMI by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: emergency department (ED) visits, observation stays, and unplanned readmissions at any time during the 30 days post-discharge. In order to aggregate all three events, we measure each in terms of days. In 2016, CMS will begin annual reporting of the measure for patients who are 65 years or older, are enrolled in fee-for-service (FFS) Medicare, and are hospitalized in non-federal hospitals	Outcome	Indirectly

Healthcare Utilization & Costs	NQF Measure #2880: Excess days in acute care (EDAC) after hospitalization for heart failure	This measure assesses days spent in acute care within 30 days of discharge from an inpatient hospitalization for heart failure to provide a patient-centered assessment of the post-discharge period. This measure is intended to capture the quality of care transitions provided to discharged patients hospitalized with heart failure by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: emergency department (ED) visits, observation stays, and unplanned readmissions at any time during the 30 days post-discharge. In order to aggregate all three events, we measure each in terms of days. In 2016, CMS will begin annual reporting of the measure for patients who are 65 years or older, are enrolled in fee-for-service (FFS) Medicare, and are hospitalized in non-federal hospitals.	Outcome	Indirectly
Healthcare Utilization & Costs	NQF Measure #2882: Excess days in acute care (EDAC) after hospitalization for pneumonia	This measure assesses days spent in acute care within 30 days of discharge from an inpatient hospitalization for pneumonia to provide a patient-centered assessment of the post-discharge period. This measure is intended to capture the quality of care transitions provided to discharged patients hospitalized with pneumonia by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: emergency department (ED) visits, observation stays, and unplanned readmissions at any time during the 30 days post-discharge. In order to aggregate all three events, we measure each in terms of days. In 2016, the Center for Medicare and Medicaid Services (CMS) will begin annual reporting of the measure for patients who are 65 years or	Outcome	Indirectly

		older, are enrolled in fee-for-service (FFS) Medicare, and are hospitalized in non-federal hospitals.		
Patient Experience	NQF Measure #0228: 3-Item Care Transition Measure (CTM-3)	The CTM-3 is a hospital level measure of performance that reports the average patient reported quality of preparation for self-care response among adult patients discharged from general acute care hospitals within the past 30 days.	Outcome: PRO (patient-reported outcome)	Potentially
Patient Experience	Communication about Treating Pain Post-Discharge	The following questions (or a subset of questions) would replace the current Pain Management measure in the HCAHPS Survey with a new measure(s). The following items were tested in early 2016. CMS is currently analyzing the results, as well as discussing these potential new pain management items with focus groups and hospital staff. Multi-item measure (composite): DP1: "Before you left the hospital, did someone talk with you about how to treat pain after you got home?" DP2: "Before you left the hospital, did hospital staff give you a prescription for medicine to treat pain?" DP3: "Before giving you the prescription for pain medicine, did hospital staff describe possible side effects in a way you could understand?"	Outcome	Potentially
Patient Experience	NQF Measure #1904: Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey that includes the following domains: Patient-provider communication; Complementary and alternative medicine; Experiences of discrimination due to race/ethnicity, insurance, or	Outcome	Indirectly

		language; Experiences leading to trust or distrust, including level of trust, caring and confidence in the truthfulness of their provide; and Linguistic competency (Access to language services). Samples for the survey are drawn from adults who have at least one provider´s visit within the past year. Measures can be calculated at the individual clinician level, or at the group (e.g., practice, clinic) level. We have included in this submission items from the Core Clinician/Group CAHPS instrument that are required for these supplemental items to be fielded (e.g., screeners, stratifies). Two composites can be calculated from the item set: 1) Providers are caring and inspire trust (5 items), and 2) Providers are polite and considerate (3 Items).		
Patient Experience	NQF Measure #0166: HCAHPS	HCAHPS (NQF #0166) is a 32-item survey instrument that produces 11 publicly reported measures: 7 multi-item measures (communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, discharge information and care transition); and 4 single-item measures (cleanliness of the hospital environment, quietness of the hospital environment, overall rating of the hospital, and recommendation of hospital)	Outcome	Indirectly

Patient Experience	Postoperative Review of Patient Goals of Care (Group measure as defined by Am. Coll. of Surgeons)	Percentage of patients who are taken to the operating room for an elective surgical procedure under regional anesthesia, MAC, and/or general anesthesia who had documented postoperative communication reviewing original goals of care expressed preoperatively and updating goals of care as appropriate.	Process	Indirectly
Patient Experience	Surgical Plan and Goals of Care (Preoperative Phase) (Group measure as defined by Am. Coll. of Surgeons)	Percentage of patients who have been given the purpose for the recommended procedure AND goals of care discussion has been documented in the medical record.	Process	Indirectly
Safety Outcomes	NQF Measure #0293: Medication Information	Percentage of patients transferred to another HEALTHCARE FACILITY whose medical record documentation indicated that medication information was communicated to the receiving FACILITY within 60 minutes of departure	Process	Directly
Safety Outcomes	Medication reconciliation completed after emergency department (ED) or hospital discharge (Safe transitions best practice measures for community physician offices -Best Practice #7)	This measure estimates the frequency with which community physician offices perform medication reconciliation after their patients are discharged from the ED or hospital.	Process	Directly
Safety Outcomes	Medication reconciliation post-discharge (AMRP)	This measure is used to assess the percentage of discharges from January 1 to December 1 of the measurement year for patients 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.	Process	Potentially
Safety Outcomes	Medication reconciliation post-discharge (MRP)	This measure is used to assess the percentage of discharges from January 1 to December 1 of the	Process	Potentially

		measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).		
Safety Outcomes	NQF Measure #0097: Medication Reconciliation Post-Discharge	The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.	Process	Potentially
Safety Outcomes	NQF Measure #0553: Care for Older Adults- Medication Review	Percentage of adults 66 years and older who had a medication review during the measurement year; a review of all a patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	Process	Indirectly
Safety Outcomes	NQF Measure #2456: Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adult patient. The time frame is the hospitalization period.	Outcome	Indirectly
Safety Outcomes	NQF Measure #0554: Medication Reconciliation Post-Discharge (MRP)	The percentage of discharges during the first 11 months of the measurement year (e.g., January 1–December 1) for patients 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.	Process	Indirectly

Safety Outcomes	Medication Reconciliation (Hospital)	The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.	Process	Indirectly
Safety Outcomes	Medication Reconciliation (Provider)	The eligible provider (EP) who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.	Process	Indirectly

Measure Concepts

Domain	Concept	Description
Provider Communication	Quality of information on transfer to and from ED	Multi-tiered and multi-location dependent measure. The denominator would be total number of transfers FROM the ED to a specific location (ie. home, floor, NH or other long-term care facility or rehab) and the numerator would be the number of transfers with appropriate communication within 1 - 24 hrs, 2 – 48 hrs, 3 – 72 hrs, 4 - > 72 hrs. Additionally, the reverse would be true, a denominator of number of transfers TO the ED and the numerator would be number of transfers with appropriate communication within 1 – 1 hr, 2 – 2 hrs, 3 – 4 hrs, 4 - > 4 hrs. This would help to determine which location is most at need for improvement in communication and in which direction with regard to flow of that information.
Provider Communication	Collaborative Medication Reconciliation	Measure number of patients at discharge who's medication list is reconciled with their pharmacist. This may also include sharing of new Rx with pharmacist to update patient's pharmacy list. Source: https://innovations.ahrq.gov/profiles/collaborative-medication-reconciliation-significantly-reduces-errors-and-readmissions
Provider Communication	Record Name of Patients PCP on ED admission	Measure percent of patients who provide the name of their primary care provider to ED and it is documented in ED chart.
Provider Communication	Send Summary of Clinical Information to PCP on ED Discharge	Measure number of patients who's PCP reviews a clinical summary of patient's chief complaint, diagnosis, provider note, and any prescription modifications after a visit to ED.
Provider Communication	Provider up/down stream communication	Share clinical summary information with PCP, HCP (healthcare professional), downstream receiving. Including all of the medication and procedural info
Provider Communication	Is there a transition discussion or documentation that occurred during a referral into the ED?	This is relevant for settings that don't commonly transmit information (i.e. nursing homes, urgent care centers, many doctors' offices)

Provider Communication	Are specific elements of a high quality ED transition communicated during a referral into the ED?	a. Patient identifying information b. Clinical status (if known) c. Relevant prior history / context d. Expectations of the sending provider e. Patient / family preferences
Provider Communication	What was the quality of the information sent during a referral to the ED?	a. Appropriate modality b. Appropriate timeliness c. Accuracy of information
Provider Communication	Do providers receive appropriate education on ED transitions in care?	This can measure ED providers and/or other setting e.g. nursing home, urgent care, doctors office
Patient and Family Communication	Patient decision support	Measure nurse triage use rates to determine amount of support provided to patients who are deciding whether or not to visit the ED. Source: https://innovations.ahrq.gov/profiles/church-health-system-partnership-facilitates-transitions-hospital-home-urban-low-income
Patient and Family Communication	Provide Effective Education Pre Discharge / Transition	ED nurse provider educates patient and family about condition, medications, other treatments, post-discharge plans, and follow up ordered by the physician
Patient and Family Communication	Discharge Instructions	Provide patient with appropriate discharge instructions that are at patients' literacy level and take into account patients' social economic status.
Patient and Family Communication	Is there a transition discussion or documentation that occurred after a patient was discharged from the ED?	For patients who require specific post-ED care.

Engagement of Broader Community	Reducing Readmissions through a community Approach	Creating partnerships with key community stakeholders builds a stronger post-discharge network for the ED patient who may have healthcare needs after the ED encounter. Although the project initially targeted reducing inpatient readmissions, we have seen tremendous success in reducing recurrent ED visits for patients, especially for patients needing assistance understanding post-discharge instructions, exhibiting medication compliance barriers, or those with complex social issues hindering their ability to follow through with discharge recommendations.
Engagement of Broader Community	Is there a system in place within a sending facility to administer standardized ED transitions in care for referrals?	Structural measure to asses system in place to support ED transitions.
Engagement of Broader Community	Is there a system in place within the ED to receive standardized ED transitions and integrate them into the EHR?	Structural measure to asses system in place to support ED transitions.
Engagement of Broader Community	Are specific elements of a high quality ED transition communicated after an ED visit?	Specific information to place of referral: a. Patient identifying information b. ED care and test results c. Specific follow-up needs
Engagement of Broader Community	What is the quality of the information sent after an ED visits? (easier to measure than referrals in)	a. Appropriate modality b. Appropriate timeliness c. Accuracy of information d. Information completeness
Engagement of Broader Community	Was there a follow-up visit with a primary care physician (or specialist) within a requested date (or a standardized date)?	

Achievement of Outcomes	Education and Accessibility	A random sampling for patients are either handed surveys upon discharge or are mailed after their transition has occurred and asked to rate their level of experience overall and with regard to education on their diagnosis. The denominator would be the total number of surveys returned and completed for each question and the numerator would be the response given (rating on a scale of 1-3).
Achievement of Outcomes	Medication Reconciliation at and after discharge	Medication reconciliation at and after discharge.
Achievement of Outcomes	A survey on provider experiences in ED transitions in care	To assess provider satisfaction / experience with ED transitions of care.
Achievement of Outcomes	A survey on patient experiences in ED transitions in care	To assess patient and family satisfaction / experience with ED transitions of care.
Achievement of Outcomes	Complications related to poor ED transitions in care (e.g. delayed diagnoses)	To assess quality of ED transition as it relates to complications associated with transition.

NATIONAL QUALITY FORUM

ED Transitions of Care: Measure Compendium

Appendix: Measure Relevance Criteria

The measures in this compendium were identified by searching trusted measure sources such as NQF's measure inventory (Quality Positioning System - QPS), CMS' measure inventory, AHRQ National Quality Measures Clearinghouse, National Guidelines Clearinghouse, Health Indicators Warehouse, The Joint Commission, and previous NQF endorsement projects. This list of measures was then sorted by relevance (directly relevant, potentially relevant, indirectly relevant, and not relevant). NQF determined the relevancy of each measure using the following criteria:

Directly relevant metrics are structure, care process, or outcome measures specifically focused on ED transitions in care. For example, one measure looked at the percentage of patients discharged from an emergency department to another setting (ambulatory care, home health, etc.) who received a transition record at the time of discharge with specified informational elements. This measure directly impacts providers and patients by providing guidance on essential communication practices to support a quality transition.

Potentially relevant metrics are measures of structure, care process or outcome that measure the quality of a transition in care, but may not directly focus on the ED. Or alternatively, these are metrics that are directly relevant to the ED transitions but do not directly specifically measure ED transitions. For example, one measure focuses on the percentage of patients discharged for whom a discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse. While this measure supports a quality transition, it is specific to a process that, if put in place, could impact the quality of a transition.

Indirectly relevant metrics measure a structure, care process, or outcome that is related to a transitions in care without a clear, specific link to the ED. For instance, measures that focus on interoperability or health information technology support transitions of care, but are not linked directly to the ED.