NATIONAL QUALITY FORUM

Emergency Department Quality of Transitions of Care 2016-2017

Expert Panel Orientation
January 4, 2017

Welcome and Introductions

National Quality Forum Project Staff

- Marcia Wilson, PhD, MBA, Senior Vice President
- Kyle Cobb, MS, Senior Director
- Kirsten Reed, Project Manager
- Vanessa Moy, MPH, Project Analyst
- Jesse Pines, MD, Consultant

Expert Panel

- Stephen Cantrill, MD, FACEP (Co-Chair)
- Janet Niles, RN, MS, CCM (Co-Chair)
- Billie Bell, RN
- Donna Carden, MD
- Lisa Deal, Pharm.D., BCPS, BSN, RN
- James Dunford, MD, FACEP
- Tricia Elliott, MBA, CPHQ
- Susan (Nikki) Hastings, MD, MHS
- Joseph Karan
- Julie Massey, MD, MBA
- Aleesa Mobley, PhD, RN, APN
- Elif Oker, MD
- Andrea Pearson, MD
- Marc Price, DO
- Karin Rhodes, MD, MS
- Kristin Rising, MD, MS
- Brenda Schmitthenner, MPA
- Amy Starmer, MD, MPH
- Adam Swanson, MPP
- Arjun Venkatesh, MD, MBA, MHS
- Sam West
- Margaret Weston, MSN, RN, CPHQ
- Christine Wilhelm, MBA
- Stephanie Witwer, PhD, RN, NEA-BC

Agenda

- Welcome and Introductions
- Opening Remarks
- Overview of NQF
- Role of the Expert Panel, Co-Chairs, NQF staff
- Project Objectives and Timeline
- Environmental Scan Methodology
- Open Discussion
- Next steps

Opening Remarks

Background

- The Office of the Assistant Secretary for Preparedness and Response's (ASPR) Emergency Care Coordination Center (ECCC) leads the U.S. government's efforts to create an emergency care system that is
  - *patient- and community centered;*
  - *integrated into the broader healthcare system;*
  - *high quality; and*
  - *prepared to respond in times of public health emergencies.*
- U.S. emergency departments (ED) have about 130 million patient visits annually and these visits often represent critical inflection points in a patient's health trajectory
- Health care providers often do not receive information on patients' prior care when patients transition from one healthcare setting to another, and patients often do not know how to manage the data they are given
- Ineffective coordination of care may contribute to poor outcomes in patient safety, quality of care, and health outcomes

Project Goals

- **To synthesize evidence through stakeholder meetings and research to determine the viability of a bidirectional transitions of care quality measurement framework for transitions into and out of the ED**
  - *Stakeholder engagement is critically important since optimally managing acute complaints and exacerbations of chronic conditions involves coordination with numerous stakeholders in the health care system, including the patient*
- Improving the management of ED transitions of care has the potential to improve person-centered care, value, and cost efficiency

Overview of National Quality Forum

National Quality Forum: A Unique Role

Mission: To lead national collaboration to improve health and healthcare quality through measurement

- Established in 1999 as a non-profit, non-partisan, membership-based organization
  - *Multistakeholder*
  - *Consensus-based entity*
  - *Transparency in all activities*

NQF: Our Integrated Approach

Activities in Multiple Measurement Areas

- **Performance Measure Endorsement**
  - *600+ NQF-endorsed measures across multiple clinical areas*
  - *20 empaneled standing expert committees*

- **Measure Applications Partnership (MAP)**
  - *Advises U.S. Department of Health and Human Services on selecting measures for 20+ federal programs, Medicaid, and health exchanges*

- **Measurement Science**
  - *Cross-cutting issues in performance measures, e.g., attribution, variation in measures, sociodemographic status (SDS) risk adjustment*
  - *Development of frameworks to guide and prioritize needed measure development, e.g., home and community based services, interoperability, telehealth*
    - *Emergency Department Quality of Transitions of Care*

Activities in Multiple Measurement Areas

- **Measure Incubator**
  - *Accelerates the process to close measurement gaps*
  - *Facilitates efficient measure development and testing through collaboration*
    - » *Matches measure topics, measure developers, data and funding*

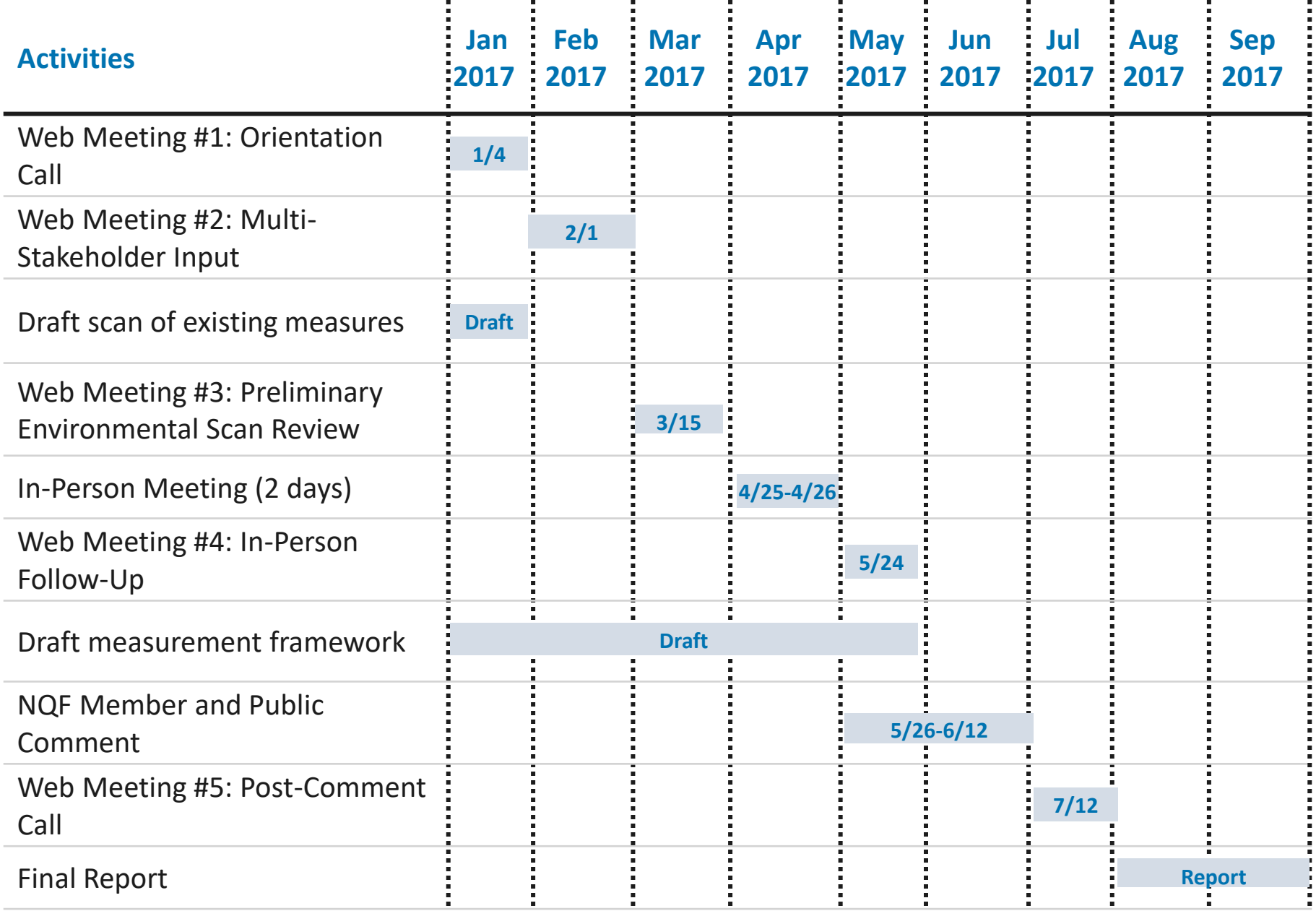
- **National Quality Partners**
  - *Galvanizes NQF member organizations around critical health and healthcare topics*
  - *Spurs action on issues of national importance, e.g., early elective deliveries, antibiotic stewardship, advanced illness*

NQF: Lead. Prioritize. Collaborate.

Project Objectives & Timeline

Project Goals & Objectives

- Goal: Establish a prioritized measure concept list to guide development of performance measures in support of enhancing the quality of ED transitions of care.
- Objectives:
  - *Develop a framework that addresses the current landscape of quality measures to inform future development focus.*
  - *Ensure the patient perspective is incorporated in the framework and prioritized measure concepts.*
  - *Assess the potential of translating existing measures to support project goal.*


Activities
Jan 2017
Feb 2017
Mar 2017
Apr 2017
May 2017
Jun 2017
Jul 2017
Aug 2017
Sep 2017
Web Meeting #1: Orientation Call
1/4
Web Meeting #2: Multi-Stakeholder Input
2/1
Draft scan of existing measures
Draft
Web Meeting #3: Preliminary Environmental Scan Review
3/15
In-Person Meeting (2 days)
4/25-4/26
Web Meeting #4: In-Person Follow-Up
5/24
Draft measurement framework
Draft
NQF Member and Public Comment
5/26-6/12
Web Meeting #5: Post-Comment Call
7/12
Final Report
Report

Final Product

- Defining Quality Transitions of Care for the Emergency Department: key definitions
  - *What are the key components that define quality in transitions of care?*
- Understanding the current measure landscape
- Identifying gaps in measurement: key concepts for quality transitions of care
- Establishing a framework
- Prioritized list of measure concepts
  - *Challenges, barriers, opportunities*
  - *special considerations - populations, conditions, etc.*

Roles of the Expert Panel, Co-chairs, & NQF staff

Expert Panel and Co-Chairs

- Serve as experts working with NQF staff to achieve the goals of the project
- Engage in meeting discussions and provide valuable feedback on the project
- Co-Chairs:
  - *Assist in facilitating Expert Panel meetings and reach consensus on all decisions*
  - *Keep the Expert Panel on track to meet project goals without hindering critical discussion/input*
  - *Assist NQF in anticipating questions and identifying additional information that may be useful to the Expert Panel*

NQF Project Team Staff

- **Work with the Panel to achieve project goals:**
  - *Organize staff meetings and conference calls*
  - *Guide the Expert Panel*
  - *Ensure communication and collaboration among all project participants and external stakeholders*
  - *Respond to NQF member and public queries about the project*
  - *Maintain documentation of project activities, draft and edit reports and project materials and publish final project report*

NQF Members and the Public at Large

- **NQF membership and the public will engage in the work by:**
  - *Reviewing the draft reports and providing feedback to NQF and the Expert Panel through public commenting periods*
  - *Participating in web meetings and in-person meetings during opportunities for public comment*

Environmental Scan Methodology

Environmental Scan Overview

- Conduct a comprehensive environmental scan to determine the viability of bidirectional transitions of care quality measure as patients move from their usual source of care to the ED and back to their usual care
- The objectives of the scan include:
  - *Identify existing measures, concept measures, gaps in measurement, and measures in development*
    - » transitions of care
    - » related complaint/symptom based measurement approaches
  - *Identify a priority measure concept list*
    - » discussion of barriers, strengths, and weaknesses of concepts

Measure Review

- Identify existing measures, measure concepts, and measures in development through searches by using key terms
  - *Care processes (i.e., discharge planning, handoffs, care coordination, communication, transitions of care)*
  - *Care settings (i.e., SNF, home health, long-term care, emergency department, inpatient)*
  - *Chief complaints (i.e., abdominal pain, brain injury, chest pain)*
  - *High risk populations (i.e., geriatrics, children, SMI, substance abuse, multiple chronic conditions)*

What We Found

	Domains				
Relevance	**Care Settings**	**Care Processes**	**High Risk Populations**	**Chief Complaint**	**Total**
Directly relevant	6	20	2	0	28
Potentially relevant	4	11	7	2	24
Indirectly Relevant	5	10	13	8	36
Not Relevant	1	8	6	26	41
Total	**16**	**49**	**28**	**36**	**129**

Example: Directly relevant

Title: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care) (#0649)	
Description	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
Numerator	Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements: •Summary of major procedures and tests performed during ED visit, AND •Principal clinical diagnosis at discharge which may include the presenting chief complaint, AND •Patient instructions, AND •Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care, AND •List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each
Denominator	All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self care) or home health care
Developer	PCPI Foundation

Example: Potentially relevant

Title: Medication Reconciliation Post-Discharge (#0097)	
Description	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.
Numerator	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
Denominator	All discharges from an in-patient setting for patients who are 18 years and older.
Developer	NCQA

Example: Indirectly relevant

Title: Adoption of Medication e-prescribing (#0486)	
Description	Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting.
Numerator	All prescriptions created during the encounter were generated using an e-prescribing system (G8443) that is capable of ALL of the following: 1. Generating a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBM) if available 2. Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts for e-prescribing including undesirable or unsafe situations, such as potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions. 3. Providing information related to the availability of lower cost, therapeutically appropriate alternatives (if any). 4. Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan.
Denominator	All patient encounters.
Developer	CMS

Literature Review

- Identify key terms and issues applicable to emergency department transitions of care through literature and ideas to facilitate what should be included in the measurement framework.
- Information sources:
  - *PubMed*
  - *Grey Literature (i.e., academic or policy literature that is not commercially published)*
  - *Measures Inventory*
  - *Key informant interviews*
  - *Previous NQF work*

Key Informants

- To expand on the advice and expertise of the expert panel to fill potential gaps in knowledge about specific aspects of transitions of care
- To supplement the information and data found within the literature review and measure review, we will also conduct a series of key informant interviews to obtain information and details on transitions of care we could not obtain through the literature

Expert Panel Strategic Discussion

Literature Review

- **Definition of transitions of care:**

"Transitions of Care refer to the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change. Specifically, they can occur:

1. *Within settings; e.g., primary care to specialty care, or intensive care unit (ICU) to ward.*
2. *Between settings; e.g., hospital to sub-acute care, or ambulatory clinic to senior center.*
3. *Across health states; e.g., curative care to palliative care or hospice, or personal residence to assisted living.*
4. *Between providers; e.g., generalist to a specialist practitioner, or acute care provider to a palliative care specialist."*

National Transitions of Care Coalition
http://www.ntocc.org/Portals/0/PDF/Resources/TransitionsOfCare_Measures.pdf

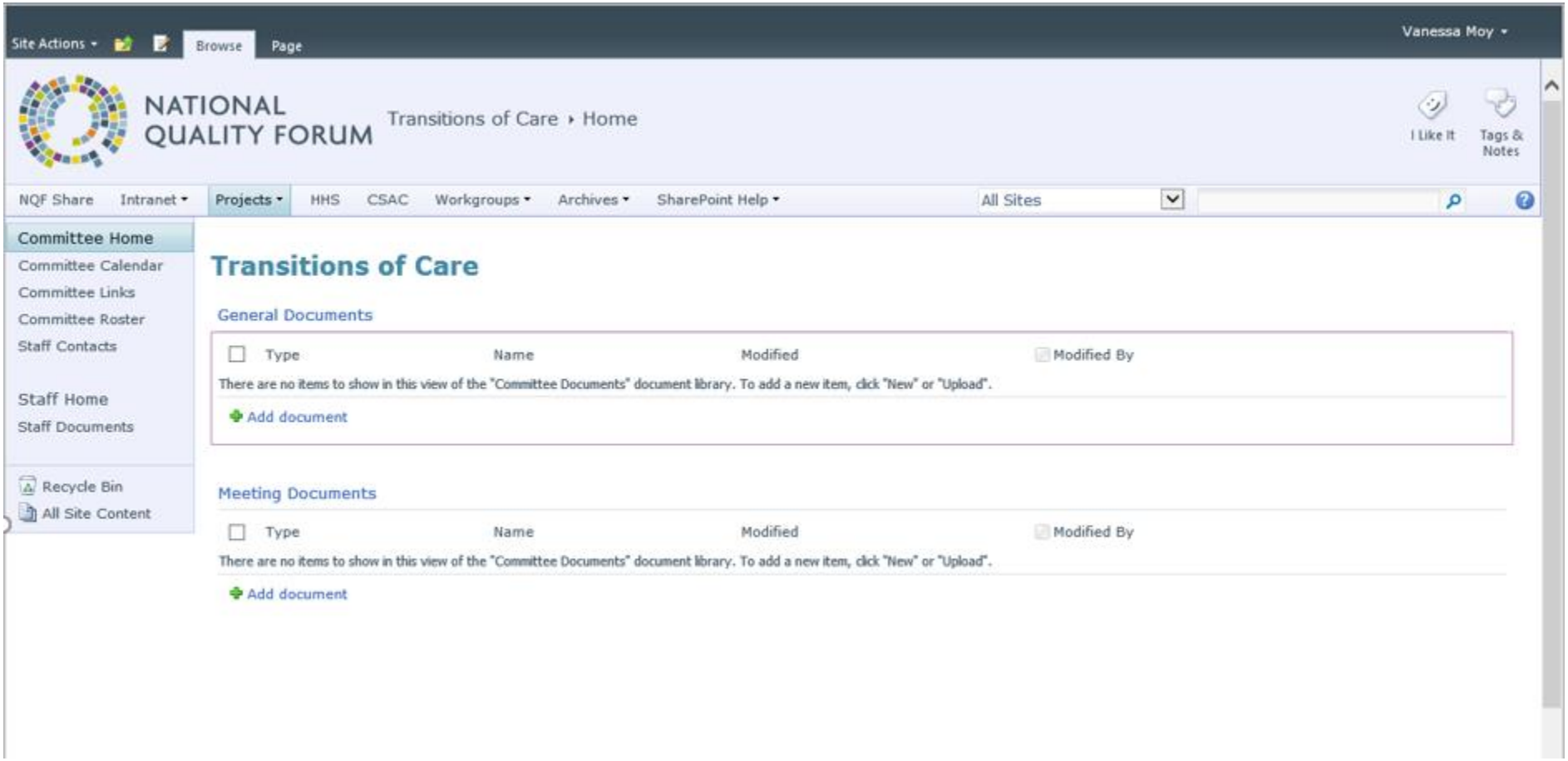
Expert Panel Discussion

- What are the most important areas of ED transitions we should focus on?
  - *Should this project include internal ED provider hand-offs, ED to hospitalist?*
  - *Should we include measures where ED visits are an outcome of other care processes or transitions?*
  - *Are there ED transitions that are more amenable to quality measurement?*
  - *What are the best ways to assess quality in a transition?*

Expert Panel Discussion

- What are the elements of a bad, good, adequate transition? How can these elements be measured?
  - *How the transition was conducted. Are there structures or processes that promote better transitions in care?*
  - *What is the transition medium? (electronic; face-to-face; telephone)*
  - *Are there specific conditions and patients that are handled better than others?*

SharePoint Overview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Transitions of Care › Home
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NQF Share
Intranet
Projects
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CSAC
Workgroups
Archives
SharePoint Help
All Sites
Committee Home
Committee Calendar
Committee Links
Committee Roster
Staff Contacts
Staff Home
Staff Documents
Recycle Bin
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Add document
Meeting Documents
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There are no items to show in this view of the "Committee Documents" document library. To add a new item, click "New" or "Upload".
Add document


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Committee Calendar
Committee Links
Committee Roster
Staff Contacts
Staff Home
Staff Documents
Recycle Bin
All Site Content
Title
Location
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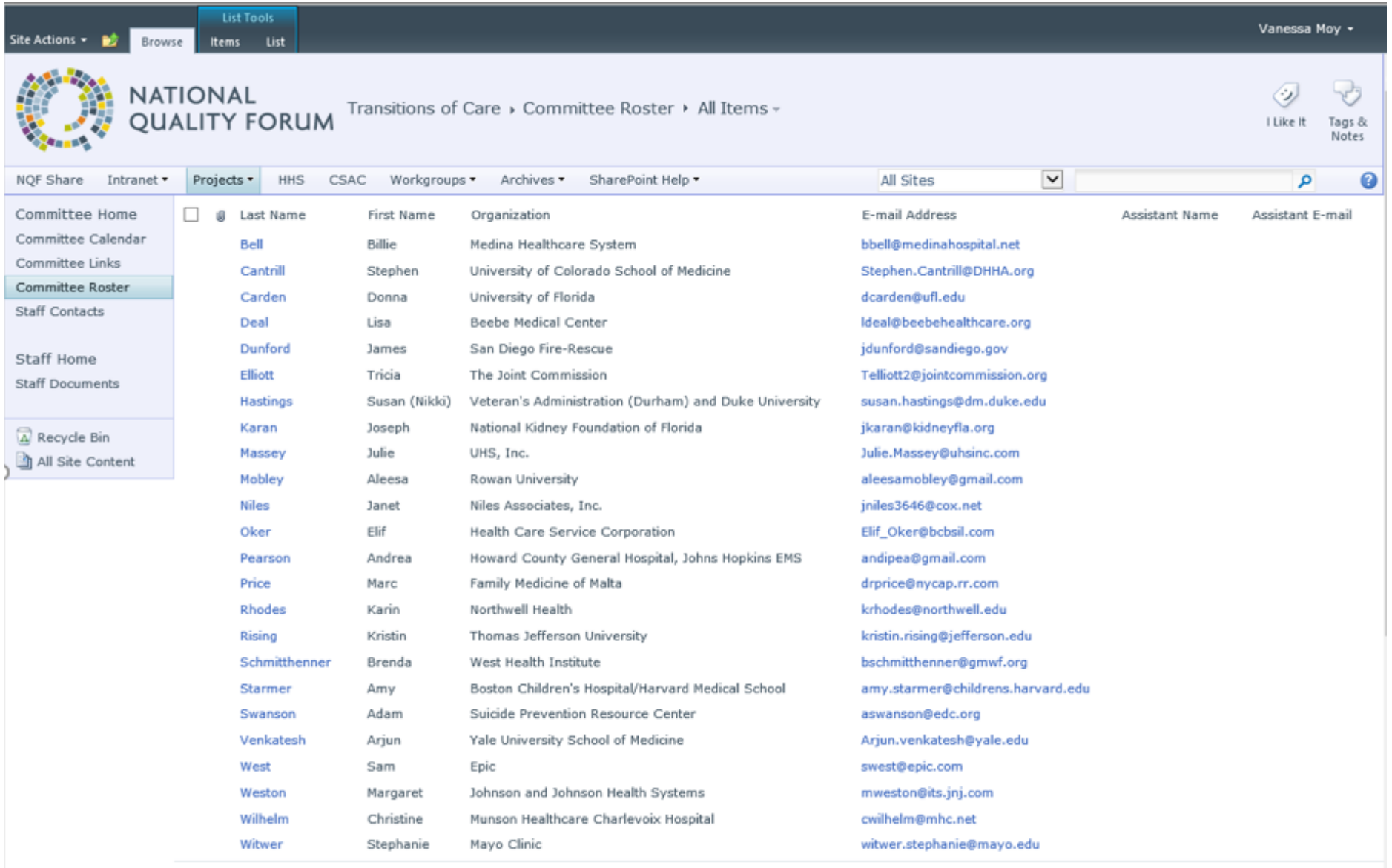
All Day Event
Web Meeting #1: Orientation 1/4/2017 1:00 PM 1/4/2017 3:00 PM
Web Meeting #2: Stakeholder Input 2/1/2017 1:00 PM 2/1/2017 3:00 PM
Web Meeting #3: Preliminary Environmental Scan Review 3/15/2017 1:00 PM 3/15/2017 3:00 PM
In-Person Meeting: Day 1 4/25/2017 8:00 AM 4/25/2017 5:00 PM
In-Person Meeting: Day 2 4/26/2017 8:00 AM 4/26/2017 5:00 PM
Web Meeting #4: In-Person Follow Up 5/24/2017 1:00 PM 5/24/2017 3:00 PM
Web Meeting #5: Post-Comment Call 7/12/2017 1:00 PM 7/12/2017 3:00 PM
Add new event



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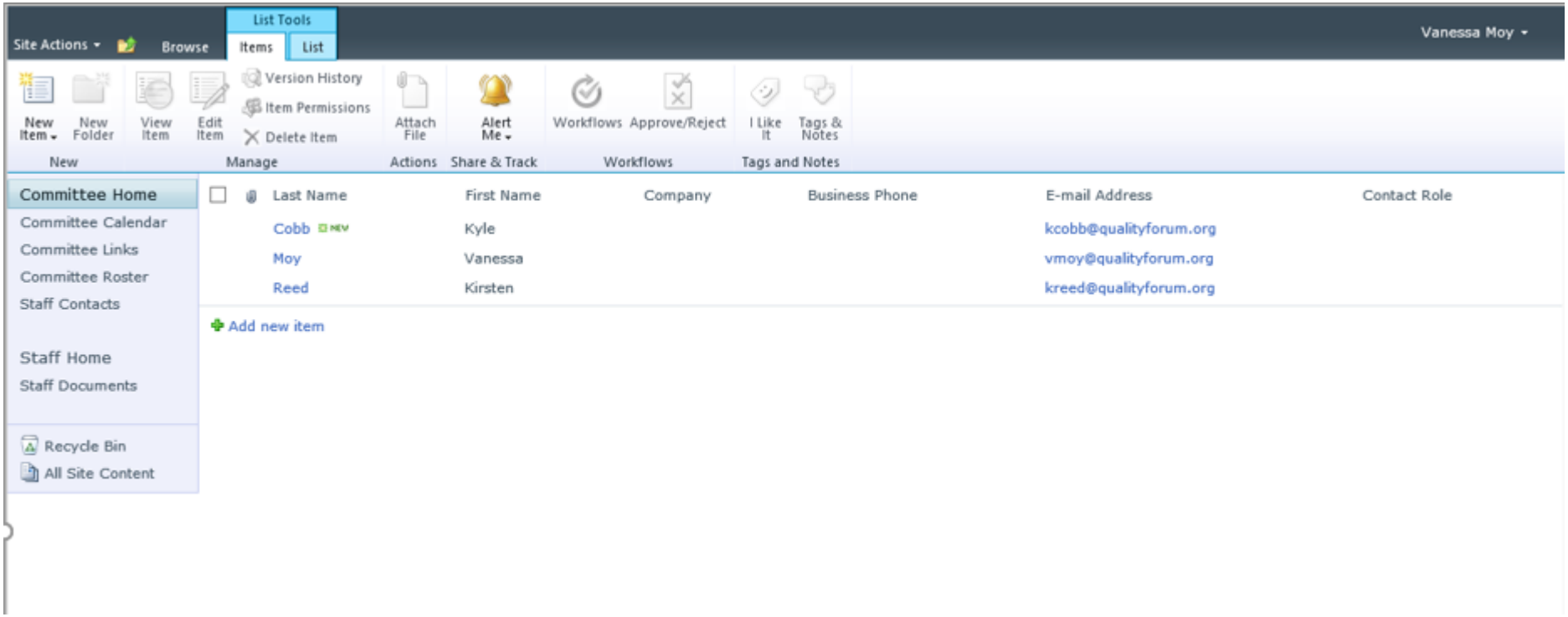
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Version History
Item Permissions
Delete Item
Attach File
Alert Me
Workflows
Approve/Reject
I Like It
Tags & Notes
New
Manage
Actions
Share & Track
Workflows
Tags and Notes
Committee Home
Committee Calendar
Committee Links
Committee Roster
Staff Contacts
Staff Home
Staff Documents
Recycle Bin
All Site Content
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First Name
Company
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Kirsten
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Add new item

Public Comment

Questions?

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- NQF Phone: 202-783-1300
- Project page: http://www.qualityforum.org/Emergency_Department_Quality_of_Transitions_of_Care.aspx
- SharePoint: http://share.qualityforum.org/Projects/Transitions%20of%20Care/SitePages/Home.aspx

Thank you.