

## **Measure # 78: Safe Transitions Best Practice Measures for Community Physician Offices**

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# Safe Transitions Best Practice Measures for Community Physician Offices



***Healthcentric Advisors***

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



**MEASURE SET:****Safe transitions best practice measures for community physician offices****MEASURES:**

The best practice measures for community physician offices are seven (7) process measures:

1. Clinical information sent with emergency department (ED) referrals
2. Real-time verbal information provided to ED or hospital clinicians, if needed
3. Clinical information provided to ED or hospital clinicians, if needed
4. Confirmation of receipt of discharge information sent to hospital
5. High-risk patients contacted via phone after ED or hospital discharge
6. Follow-up visits conducted after patient discharge from the hospital
7. Medication reconciliation completed after ED or hospital discharge

**PURPOSE:**

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

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

**POPULATION:**

Varies by measure, but generally includes patients currently in or recently discharged from the ED or the hospital

**CARE SETTING:**

Community physician offices

**RECIPROCAL MEASURES:**

In addition to the best practices for community physician offices, Healthcentric Advisors developed five (5) additional sets of setting-specific measures, for:

1. Emergency departments
2. Home health agencies
3. Hospitals
4. Nursing homes
5. Urgent care centers

**NOTES:**

Because these measures are intended to set minimum standards for all patients, no sampling guidelines are provided. Providers who cannot calculate the measures electronically may wish to implement a representative sampling frame to calculate performance on an ongoing basis.

Providers may also wish to implement small-scale pilots to measure baseline performance and implement targeted improvement strategies before expanding efforts facility wide.

For those seeking assistance, Healthcentric Advisors provides consultative services related to quality improvement, measurement and care transitions.

**MEASURE SET HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

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

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**LAST UPDATED:**

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**MEASURE:****Clinical information sent with emergency department (ED) referrals****MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #1)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices send clinical information to the ED, when referring a patient for evaluation.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes.<sup>1</sup> The Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care.<sup>1</sup> Although information is sparse regarding communication from primary care providers to the ED, a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between primary care providers and hospital physicians occurs infrequently, in only 3%-20% of cases.<sup>2</sup> ED clinicians express a desire to have pertinent, up-to-date clinical information accompany arriving patients.

**NUMERATOR:**

Documentation of provision of clinical information and contact information by the referring physician's office either:

- At the time of patient referral for ED evaluation, or
- Within one hour of patient referral for ED evaluation, if the patient is referred following an after-hours or weekend phone call with the community physician.

**DENOMINATOR:**

All patients referred for ED evaluation by their community physician

**EXCLUSIONS:**

Patients whose care is supervised/directed by their community physician while in the ED

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

Clinical information:	Verbal or written information that includes the main reason for referral to the ED, expectation, problem list, medication list and applicable labs or studies
Community physician:	Primary care provider (PCP) or specialist, such as cardiologist, who cares for the patient in an outpatient setting
Contact information:	Phone number that connects the ED to office staff who can address the ED clinician's clinical question
Patients referred for ED evaluation:	Patients sent to the ED by their community physician or another clinician in their physician's office for further evaluation of a clinical problem that may or may not lead to inpatient admission. This can occur either from the office or following a phone call during which the physician office directs the patient to the ED.

**NOTES:**

None

**CLASSIFICATION:**

National Quality Strategy Priorities:	Promoting effective communication and coordination of care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Community physician office
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

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

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**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

14 June 2013

<sup>1</sup> Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. *J Gen Intern Med.* 2009; 24(8):971-6.

<sup>2</sup> Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA.* 2007;297(8):831-41.

**MEASURE:**

**Real-time verbal information provided to emergency department or hospital clinicians, if needed**

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #2)

**MEASURE DESCRIPTION:**

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.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes, and the Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care.<sup>1</sup> Although information is sparse regarding primary care providers' response to requests from the ED for information, a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between primary care providers and hospital physicians occurs infrequently, in only 3%-20% of cases.<sup>2</sup>

ED and hospital clinicians indicate that they often have difficulty reaching their patients' primary care providers, when they have a time-sensitive need for clinical information to inform patient care. Reasons may include: lack of information about the patient's primary care provider; lack of contact information, if the primary care provider is known; and the inability to get past the "gatekeeper" and speak directly with a clinician in a timely manner.

**NUMERATOR:**

Documentation that if an ED or hospital clinician called the community physician office, one of the following occurred:

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

**DENOMINATOR:**

All patients whose care requires a phone call from the ED or hospital to the community physician's office for time-sensitive clinical conversations

**EXCLUSIONS:**

None

**RISK ADJUSTMENT:**

None

**DEFINITIONS**

Community physician:	The primary care provider (PCP) or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a primary care physician, specialist or mid-level practitioner, or be an office location, facility or clinic.
ED or hospital clinician:	Physician, nurse practitioner, physician's assistant or nurse who is taking care of the patient
Office staff member:	Clinical or clerical staff who can address the ED or hospital clinician's specific question
Time-sensitive clinical question:	Whether or not a patient's care "required" a conversation and in what timeframe is a subjective determination left to the ED or hospital clinician's discretion, with the understanding that outreach is intended to be limited to situations where information is needed to inform the patient's care

**NOTES:**

None

**CLASSIFICATION:**

National Quality Strategy Priorities:	Making care safer by reducing harm caused in the delivery of care Promoting effective communication and coordination of care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Community physician office
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

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

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**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

14 June 2013

<sup>1</sup> Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. *J Gen Intern Med.* 2009; 24(8):971-6.

<sup>2</sup> Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA.* 2007;297(8):831-41.

**MEASURE:**

**Clinical information provided to emergency department (ED) or hospital clinicians, if needed**

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #3)

**MEASURE DESCRIPTION:**

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.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes.<sup>1</sup> The Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care.<sup>1</sup> Although information is sparse regarding primary care providers' response to requests from the ED for information, a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between primary care providers and hospital physicians occurs infrequently, in only 3%-20% of cases.<sup>2</sup> ED clinicians report difficulty obtaining outpatient clinical information to inform patient care.

**NUMERATOR:**

Documentation of the community physician office's provision of clinical information within 2 hours of ED or hospital request

**DENOMINATOR:**

All ED or hospital patients whose care requires ED or hospital clinician outreach to obtain outpatient clinical information

**EXCLUSIONS:**

Patients:

- Without a known PCP, or
- Who are followed by their community physician's office while in the ED or hospital

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

Clinical information:	Verbal or written information that includes the information requested by the ED/hospital and may include clinical complaint/problem, main reason for referral to the ED, expectation, problem list, medication list and applicable labs or studies
Community physician:	The primary care provider (PCP) or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a primary care physician, specialist or mid-level practitioner, or be an office location, facility or clinic.
ED or hospital clinician:	Physician, nurse practitioner, physician's assistant or nurse who is taking care of the patient
Provision:	Via email, phone, fax, remote access to office medical record or other electronic means

**NOTES:**

None

**CLASSIFICATION:**

National Quality Strategy Priorities:	Making care safer by reducing harm caused in the delivery of care Promoting effective communication and coordination of care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Community physician office
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

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

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**MEASURE DEVELOPED:**

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**MEASURE LAST UPDATED:**

14 June 2013

<sup>1</sup> Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. *J Gen Intern Med.* 2009; 24(8):971-6.

<sup>2</sup> Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA.* 2007;297(8):831-41.

**MEASURE:****Confirmation of receipt of discharge information sent to hospital****MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #4)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices confirm receipt of the discharge information sent to them by the hospital.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes.<sup>1</sup> The Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care,<sup>1</sup> but a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between primary care providers and hospital physicians occurs infrequently, in only 3%-20% of cases.<sup>2</sup>

The Society of Hospital Medicine recommends that community physician offices confirm their receipt of discharge information.<sup>3</sup> This ensures that the hand-off between settings is complete.

**NUMERATOR:**

Documentation of the community physician office's confirmation of receipt of hospital discharge information

**DENOMINATOR:**

All patients discharged from the hospital

**EXCLUSIONS:**

Patients who:

- Are followed by their community physician while in the ED or hospital, or
- Are discharged to acute care, long-term care or skilled nursing.

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

**Confirmed receipt:** Communication back to the hospital to acknowledge that the office has received the discharge information that the hospital sent

**Discharge information:** In accordance with the Safe Transitions Best Practice Measures for Hospitals, the hospital is required to provide, at minimum: the reason for hospitalization; significant findings; procedures performed and care, treatment and services provided to the patient; the patient's condition at discharge; information provided to the patient and family; a list of reconciled medications; a list of acute medical issues and pending tests and studies that require follow-up.

This may be accomplished via written information, such as a standardized form, that includes: 1) a brief narrative of the hospital visit, or 2) a verbal hand-off between the hospital clinician and primary care provider.

**NOTES:**

None

**CLASSIFICATION:**

National Quality Strategy Priorities:	Promoting effective communication and coordination of care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Community physician office
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

**MEASURE HISTORY:**

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**MEASURE DEVELOPED:**

2009

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<sup>2</sup> Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA.* 2007;297(8):831-41.

<sup>3</sup> Project Better Outcomes for Older adults through Safer Transitions (BOOST). Available: [www.hospitalmedicine.org/BOOST/](http://www.hospitalmedicine.org/BOOST/), 11 Apr 2013.

**MEASURE:****High-risk patients contacted via phone after emergency department (ED) or hospital discharge****MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #5)

**MEASURE DESCRIPTION:**

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.

Patients are at risk for poor outcomes and increased healthcare utilization if they: are over the age of 80 years; have cancer, chronic obstructive pulmonary disease or congestive heart failure; have polypharmacy (8+ medications); or have experienced a hospitalization in the previous 6 months.<sup>1</sup> This risk could be exacerbated by poor health literacy, stress and other factors, making it important for the patient's outpatient clinician to ascertain the patient's condition and their adherence to recommended care and follow-up quickly after a healthcare episode.

The follow-up phone call may be particularly important if the patient's scheduled follow-up visit does not immediately follow ED or hospital discharge, to preemptively catch any potential problems and to ensure that the patient knows that their primary care provider is now responsible for their care, and how they can outreach with questions.

**NUMERATOR:**

Documentation of a follow-up phone call within 72 hours of patient discharge from the ED or hospital

**DENOMINATOR:**

All patients discharged from the ED or hospital who are characterized as high-risk

**EXCLUSIONS:**

Patients who:

- Are followed by their community physician's office while in the ED or hospital,
- Are discharged to acute care, long-term care or skilled nursing,
- Refuse a follow-up phone call, or
- Have an outpatient follow-up appointment within 72 hours of ED or hospital discharge

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

**Follow-up phone call:** An outpatient clinician phone call with the patient, family or informal caregiver (such as a family member) to assess the patient's condition and adherence to recommended care and to reinforce follow-up

**High-risk patients:** Patients with one or more of the following:

- Age 80 years or older,
- A diagnosis of cancer, chronic obstructive pulmonary disease or congestive heart failure,
- Polypharmacy (8+ medications), or
- A hospitalization in the previous 6 months

**Outpatient clinician:** Physician, nurse practitioner, physician assistant or nurse at the community physician's office, which can be an office location, facility or clinic

**NOTES:**

This measure can be met by completing BP #6: Percent of patients with follow-up visits conducted after discharge from the hospital.

**CLASSIFICATION:**

National Quality Strategy Priorities:	Promoting effective communication and coordination of care Ensuring that each person and family are engaged as partners in their care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Community physician office
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

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

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**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

14 June 2013

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<sup>1</sup> Project Better Outcomes for Older adults through Safer Transitions (BOOST). Available: [www.hospitalmedicine.org/BOOST/](http://www.hospitalmedicine.org/BOOST/), 11 Apr 2013.

**MEASURE:****Follow-up visits conducted after patient discharge from the hospital****MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #6)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices conduct office visits with patients discharged from hospital.

The post-hospital follow-up visit provides an opportunity for the community physician office to fully assume responsibility for patient care—which is transferred from the hospital to the office at the time of hospital discharge—and to ascertain the patient’s condition and their adherence to recommended care and follow-up. The visit is also an opportunity to activate and engage patients and their informal caregivers (such as family) in their care and to prevent any worsening signs or symptoms from resulting in an avoidable ED visit or hospital admission.<sup>1</sup>

**NUMERATOR:**

Documentation of one of the following:

- A community primary care provider phone call to the patient or informal caregiver within 72 hours of discharge, or
- A follow-up appointment scheduled within 14 days of discharge (or the timeframe otherwise specified and documented in the hospital discharge instructions)

**DENOMINATOR:**

All patients discharged from the hospital

**EXCLUSIONS:**

Patients who:

- Are followed by their community physician’s office while in the hospital,
- Are discharged to acute care, long-term care or skilled nursing, or
- Refuse a follow-up phone call and appointment.

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

Community physician:	The primary care provider (PCP) or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a primary care physician, specialist or mid-level practitioner, or be an office location, facility or clinic.
Follow-up appointment scheduled:	A community physician office visit scheduled either by the ED or hospital or the community physician’s office
Informal caregiver:	A person, such as a family member, who provides care and support to the patient
Outpatient clinician:	Physician, nurse practitioner, physician assistant or nurse at the community physician’s office, which can be a primary care provider or specialist, and can be an office location, facility or clinic
Outpatient follow-up:	A phone call or office visit with an outpatient clinician from the community physician’s office, which can be an office location, facility or clinic

Phone call: An outpatient clinician phone call with the patient, family, or caregiver to assess the patient's condition and adherence to recommended care and to reinforce follow-up

**NOTES:**

Patients discharged from the ED are not targeted by this measure for a number of reasons, including the fact that many patients self-refer to the ED (sometimes resulting in inappropriate ED utilization, for conditions that could have been addressed in an outpatient setting) and the fact that ED discharge disposition is highly variable (follow-up may not always be necessary or appropriate). Community physicians should use their discretion regarding the necessity of follow-up office visits for patients discharged from the ED.

This measure can be met for high-risk patients by completing BP #5: Percent of high-risk patients contacted via phone after ED or hospital discharge.

**CLASSIFICATION:**

National Quality Strategy Priorities:	Promoting effective communication and coordination of care Ensuring that each person and family are engaged as partners in their care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Community physician office
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

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

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**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

14 June 2013

<sup>1</sup> Coleman EA. The post-hospital follow-up visit: A physician checklist to reduce readmissions. Available: <http://www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist>, 11 Apr 2013.

**MEASURE:****Medication reconciliation completed after emergency department (ED) or hospital discharge****MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #7)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices perform medication reconciliation after their patients are discharged from the ED or hospital.

Studies demonstrate that medication errors or discrepancies are relatively common at hospital discharge (occurring among 14% of elderly patients) and are associated with a higher risk of poor outcomes and hospital readmission.<sup>1</sup> Guidelines for post-hospital office visits stress the importance of medication reconciliation to identify and resolve any medication problems, helping to ensure patient safety and prevent excess utilization.<sup>2</sup>

**NUMERATOR:**

Documentation that an outpatient clinician performed medication reconciliation within 14 days of ED or hospital discharge, either in-person at the office or via phone

**DENOMINATOR:**

All patients discharged from the ED or hospital

**EXCLUSIONS:**

Patients who are discharged to acute care, long-term care or skilled nursing

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

**Community physician:** The primary care provider (PCP) or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a primary care physician, specialist or mid-level practitioner, or be an office location, facility or clinic.

**Informal caregiver:** A person, such as a family member, who provides care and support to the patient

**Medication reconciliation:** The process of:

- 1) Reviewing the patient's discharge medication regimen (name, dose, route, frequency, and purpose),
- 2) Comparing the discharge medication regimen with what the patient is currently taking (including non-prescription medications), as well as with their prior medication regimen, to identify and resolve any discrepancies, and
- 3) Providing an updated list to the patient or informal caregiver (such as family).

**Outpatient clinician:** Physician, nurse practitioner, physician assistant, nurse or certified nursing assistant at the community physician's office, which can be an office location, facility or clinic

**NOTES:**

In addition to performing medication reconciliation, the multi-disciplinary Transitions of Care Consensus Policy Statement also recommends that patients be provided with a medication list that is accessible (paper or electronic), clear and dated.<sup>3</sup> A checklist for post-hospital discharge office visits is also available and recommends that outpatient clinicians use a “teach back” mechanism to test patients’ comprehension of their medications’ purpose and instructions.<sup>2</sup>

Outpatient clinicians seeking to exceed the minimum standard set forth by this best practice may consider adopting medication reconciliation as an “always event” that is completed during every patient encounter, not only those immediately following ED or hospital utilization.

**CLASSIFICATION:**

National Quality Strategy Priorities:	Making care safer by reducing harm caused in the delivery of care Promoting effective communication and coordination of care
Actual or Planned Use:	Quality improvement with benchmarking; contracting; pay for performance
Care Setting:	Community physician office
Patient Condition:	Not applicable – all patients
Data Source:	Medical record or electronic audit trail
Level of Analysis:	Practitioner, unit, facility or community (e.g., health system or state)
Measure Type:	Process measure
Target Population:	All patients in the hospital for outpatient observation or an inpatient admission

**MEASURE HISTORY:**

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

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**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

14 June 2013

<sup>1</sup> Coleman EA, Smith JD, Raha D, Min SJ. Posthospital medication discrepancies: prevalence and contributing factors. *Arch Intern Med.* 2005; 165(16):1842–7.

<sup>2</sup> Coleman EA. The post-hospital follow-up visit: A physician checklist to reduce readmissions. Available: <http://www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist>, 11 Apr 2013.

<sup>3</sup> Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. *J Gen Intern Med.* 2009; 24(8):971-6.

**SELECTED SOURCES:**
**Safe transitions best practice measures for community physician offices**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (hospitals) and their community partners (e.g., primary care providers) and stakeholders (e.g., state agencies and payors).

Selected sources from Steps #1 (the medical literature, national campaigns and standards) and #2 (community preferences) are below.

Author, Year	Discharge Setting	Intervention or Observation	Findings	Related Best Practice Measure for Community Physician Offices
Coleman et al., 2009 <sup>1</sup>	Hospital	Provided a transitions coach to help improve patient education and self-management in the 30 days after hospital discharge	Using the Care Transitions Intervention (CTI) chronically ill hospitalized patients and their caregivers to take a more active role in their care reduced rates of hospital readmission. The coaching tenets include assessing patient comprehension and helping patients use a personal health record, understand their condition, perform medication reconciliation and undertake recommended follow-up.	5-7
Coleman, 2011 <sup>2</sup>	n/a	Offers a proposed checklist for efficient communication and collaboration between inpatient and outpatient physicians after a hospital stay	Per the author, “the post-hospital follow-up visit presents an ideal opportunity for the primary care physician to prepare the patient and family caregiver for self-care activities and to head off situations that could lead to readmission.” This issue brief provides a checklist for post-hospital follow-up with the primary care provider’s office and incorporates tenets of Coleman’s CTI model (above), such as medication reconciliation.	2,6-7
Community Preference (Rhode Island)	n/a	Incorporated community preference (and later, input and endorsement) into the development of the Safe Transitions Best Practice Measures for Hospitals	The multi-stage stakeholder consensus process allowed Healthcentric Advisors to ensure that all of the best practice measures addressed the local causes of poor transitions and were feasible within the local context.	1-3

Author, Year	Discharge Setting	Intervention or Observation	Findings	Related Best Practice Measure for Community Physician Offices
Joint Commission, 2013 <sup>3</sup>	Multiple	Developed “National Patient Safety Goals”	Along with other patient safety goals, the Joint Commission outlines expectations for medication reconciliation in the emergency department and hospital.	7
National Quality Forum, 2010 <sup>4</sup>	Multiple	Includes 34 Safe Practices for Better Healthcare that have been demonstrated to be effective in reducing the occurrence of adverse healthcare events, including poor care transitions	The Safe Practices include recommendations for medication reconciliation and for discharge systems. Discharge systems must have: a “discharge plan” prepared for each patient at the time of hospital discharge, including a scheduled follow-up appointment; standardized communication that occurs between the inpatient and outpatient clinicians; and the confirmed receipt of summary clinical information by receiving providers.	1,4,7
Physician Consortium for Performance Improvement, 2009 <sup>5</sup>	ED, hospital	Developed the “Care Transitions Performance Measurement Set (Phase I: Inpatient Discharges & Emergency Department Discharges)”	Multiple physician professional societies came together to identify and define quality measures for patients undergoing care transitions. For patients discharged from the hospital, suggested process measures included: 1) a transition record with specific minimum elements, 2) timely transmission of the transitions record, and 3) provision of medication reconciliation list to patients.	5-7
Society of Hospital Medicine, 2008 <sup>6</sup>	Hospital	A national initiative to improve the care of patients transitioning from the hospital to home	Project BOOST (Better Outcomes for Older adults through Safe Transitioning) is a Society of Hospital Medicine program that includes resources, tools and recommendations related to information flow between inpatient and outpatient providers and targeted patient intervention to improve satisfaction and reduce hospital readmission rates.	4-6

Author, Year	Discharge Setting	Intervention or Observation	Findings	Related Best Practice Measure for Community Physician Offices
Snow et al., 2009 <sup>7</sup>	Multiple	Developed consensus policy statement about care transitions	Co-authored by many physician professional societies, including the Society of Hospital Medicine; establishes principles and standards for managing transitions, including timely communication among providers and patient involvement. Suggests establishing local and national standards for continuous quality improvement and accountability.	1-3,5-7

**KEY:**

1. Clinical information sent with emergency department (ED) referrals
2. Real-time verbal information provided to ED or hospital clinicians, if needed
3. Clinical information provided to ED or hospital clinicians, if needed
4. Confirmation of receipt of discharge information sent to hospital
5. High-risk patients contacted via phone after ED or hospital discharge
6. Follow-up visits conducted after patient discharge from the hospital
7. Medication reconciliation completed after ED or hospital discharge

**REFERENCES:**

- <sup>1</sup> Coleman EA, Smith JD, Raha D, Min SJ. Posthospital medication discrepancies: prevalence and contributing factors. *Arch Intern Med.* Sep 12 2005;165(16):1842-1847.
- <sup>2</sup> Coleman EA. The post-hospital follow-up visit: A physician checklist to reduce readmissions. Available: <http://www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist>, 11 Apr 2013.
- <sup>3</sup> Joint Commission. National patient safety goal on reconciling medication information (Jt. Comm). Available at: [http://www.jointcommission.org/standards\\_information/npsgs.aspx](http://www.jointcommission.org/standards_information/npsgs.aspx). Accessed Jan 17, 2013.
- <sup>4</sup> National Quality Forum. Safe Practices. 2010. Available: [http://www.qualityforum.org/Projects/Safe\\_Practices\\_2010.aspx](http://www.qualityforum.org/Projects/Safe_Practices_2010.aspx), 11 Apr 2013.

<sup>5</sup> ABIM Foundation, American College of Physicians, Society of Hospital Medicine, The Physician Consortium for Performance Improvement (PCPI). Care transitions performance measurement set (Phase I: Inpatient discharges & emergency department discharges). Available at: <http://www.abimfoundation.org/News/ABIM-Foundation-News/2009/~media/Files/PCPI%20Care%20Transition%20measures-public-comment-021209.ashx>. Accessed Jan 17, 2013.

<sup>6</sup> Project Better Outcomes for Older adults through Safer Transitions (BOOST). Available: [www.hospitalmedicine.org/BOOST/](http://www.hospitalmedicine.org/BOOST/), 11 Apr 2013.

<sup>7</sup> Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. *J Gen Intern Med*. 2009; 24(8):971-6.

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