

Measure #58. Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges)

CARE COORDINATION MEASURE MAPPING TABLE

	MEASUREMENT PERSPECTIVE		
	<i>Patient/Family</i>	<i>Health Care Professional(s)</i>	<i>System Representative(s)</i>
CARE COORDINATION ACTIVITIES			
Establish accountability or negotiate responsibility			□
Communicate			
<i>Interpersonal communication</i>			
<i>Information transfer</i>			□
Facilitate transitions			
<i>Across settings</i>			□
<i>As coordination needs change</i>			
Assess needs and goals			
Create a proactive plan of care			□
Monitor, follow up, and respond to change			□
Support self-management goals			
Link to community resources			
Align resources with patient and population needs			
BROAD APPROACHES POTENTIALLY RELATED TO CARE COORDINATION			
Teamwork focused on coordination			
Health care home			
Care management			
Medication management			□
Health IT-enabled coordination			

Legend:

- = ≥ 3 corresponding measure items
- = 1-2 corresponding measure items

Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges)

Purpose: To measure the percentage of patients, regardless of age, discharged from an inpatient 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.¹

Format/Data Source: This process measure requires administrative claims data and data collected from the medical record.¹

Date: Measure released in 2009.¹

Perspective: System Representative(s)

Measure Item Mapping:

This measure maps to the following domains: There are no individual measure items to map.

- **Establish accountability or negotiate responsibility**
- **Communicate**
 - Information transfer
 - *Between health care professional(s) and patient/family*
- **Facilitate Transitions**
 - Across settings
- **Create a proactive plan of care**
- **Monitor, follow up, and respond to change**
- **Medication Management**

Development and Testing: The measure was endorsed by NQF as part of their preferred practices and performance measures for measuring and reporting care coordination, released in September 2010.²

Link to Outcomes or Health System Characteristics: One study showed that compared to patients receiving usual care, patients who received detailed instructions, medication review and help scheduling follow-up care at the time of discharge had 30% fewer readmissions and visits to the emergency department.¹

Logic Model/Conceptual Framework: This measure incorporates elements from The Joint Commission's 2009 Hospital Accreditation Standards and a 2008 consensus policy statement from the American College of Physicians, the Society of General Internal Medicine, the Society of Hospital Medicine, the American Geriatrics Society, The American College of Emergency Physicians and the Society of Academic Emergency Medicine.¹

Country: United States

Past or Validated Applications*:

- **Patient Age:** Not Age Specific
- **Patient Condition:** General Population/Not Condition Specific
- **Setting:** Inpatient Facility, Primary Care Facility, Not Setting Specific

*Based on the sources listed below.

Notes:

- Detailed measure specifications are included in the Physician Consortium for Performance Improvement (PCPI) report.¹
- This measure is intended for use in conjunction with two other PCPI measures (Measure #57, Reconciled Medication List Received by Discharged Patients; and Measure #59, Timely Transmission of Transition Record – Inpatients Discharged) as part of a bundled set. Each measure in the bundled set is intended to be scored separately.¹
- Because the NQF-endorsed preferred practices and performance measures for measuring and reporting care coordination were released shortly before completion of the *Atlas*, we were not able to contact the measure developers about any on-going measure development or testing. Additional information may become available in the future.

Sources:

1. American Board of Internal Medicine Foundation, American College of Physicians, Society of Hospital Medicine, Physician Consortium for Performance Improvement. Care Transitions Performance Measurement Set (Phase I: Inpatient discharges and emergency department discharges). Chicago, IL: American Medical Association; 2009.
2. National Quality Forum. Preferred practices and performance measures for measuring and reporting care coordination: a consensus report. Washington, DC: National Quality Forum; 2010.