



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0649

Corresponding Measures:

De.2. Measure Title: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Co.1.1. Measure Steward: PCPI

De.3. Brief Description of Measure: Percentage of discharges from an emergency department (ED) to ambulatory care or home health care, in which the patient, regardless of age, or their caregiver(s), received a transition record at the time of ED discharge including, at a minimum, all of the specified elements

1b.1. Developer Rationale: Providing detailed discharge information enhances patients' preparation to self-manage post-discharge care and comply with treatment plans. Additionally, studies have shown that many hospital readmissions can be prevented by patient education, pre-discharge assessment, and domiciliary aftercare (1). One study found that patients participating in a hospital program providing detailed, personalized instructions at discharge, including a review of medication routines and assistance with arranging follow-up appointments, had 30% fewer subsequent emergency visits and hospital readmissions than patients who received usual care at discharge (2).

By requiring the completion and prompt transmission of a detailed "transition record" for discharged patients, this measure is promoting a significant enhancement to the customary use of the discharge summary. Numerous studies have documented the prevalence of communication gaps and discontinuities in care for patients after discharge, and the significant effect of these lapses on hospital readmissions and other indicators of the quality of transitional care (3-5). Current information and communication technology can facilitate the routine completion and transmission of a transition record within 24 hours of discharge, which could greatly reduce communication gaps and help improve patient outcomes.

1. Benbassat J, Taragin M. Hospital readmissions as a measure of quality of healthcare. Archives Internal Medicine. 2000;160:1074-81.
2. Jack BW, Chetty VK, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization. Ann Intern Med 2009; 150:178-187.
3. Sabogal F, Coots-Miyazaki M, Lett JE. Effective care transitions interventions: Improving patient safety and healthcare quality. CAHQ Journal 2007 (Quarter 2).
4. Moore C, Wisnevesky J, Williams S, McGinn T. 2003. Medical errors related to discontinuity of care from an inpatient to an outpatient setting. Journal of General Internal Medicine 18:646-651.
5. Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. Ann Intern Med 2005;143(2):121-128.

S.4. Numerator Statement: Discharges in which the patient or their caregiver(s) 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

S.6. Denominator Statement: All discharges for patients, regardless of age, from an emergency department (ED) to ambulatory care (home/self care) or home health care

S.8. Denominator Exclusions: Exclusions:

Patients who died

Patients who left against medical advice (AMA) or discontinued care

Exceptions:

Patients who declined receipt of transition record

Patients for whom providing the information contained in the transition record would be prohibited by state or federal law

De.1. Measure Type: Process

S.17. Data Source: Electronic Health Data, Paper Medical Records

S.20. Level of Analysis: Facility, Integrated Delivery System

IF Endorsement Maintenance – Original Endorsement Date: May 05, 2010 **Most Recent Endorsement Date:** Aug 10, 2012

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Not applicable

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. ***Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.***

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[0649_Evidence_Measure_Submission_Form.doc](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Please update any changes in the evidence attachment in red. Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. If there is no new evidence, no updating of the evidence information is needed.

No

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

IF a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

IF a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and provide rationale for composite in question 1c.3 on the composite tab.

Providing detailed discharge information enhances patients' preparation to self-manage post-discharge care and comply with treatment plans. Additionally, studies have shown that many hospital readmissions can be prevented by patient education, pre-discharge assessment, and domiciliary aftercare (1). One study found that patients participating in a hospital program providing detailed, personalized instructions at discharge, including a review of medication routines and assistance with arranging follow-up appointments, had 30% fewer subsequent emergency visits and hospital readmissions than patients who received usual care at discharge (2).

By requiring the completion and prompt transmission of a detailed “transition record” for discharged patients, this measure is promoting a significant enhancement to the customary use of the discharge summary. Numerous studies have documented the prevalence of communication gaps and discontinuities in care for patients after discharge, and the significant effect of these lapses on hospital readmissions and other indicators of the quality of transitional care (3-5). Current information and communication technology can facilitate the routine completion and transmission of a transition record within 24 hours of discharge, which could greatly reduce communication gaps and help improve patient outcomes.

1. Benbassat J, Taragin M. Hospital readmissions as a measure of quality of healthcare. *Archives Internal Medicine*. 2000;160:1074-81.
2. Jack BW, Chetty VK, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization. *Ann Intern Med* 2009; 150:178-187.
3. Sabogal F, Coots-Miyazaki M, Lett JE. Effective care transitions interventions: Improving patient safety and healthcare quality. *CAHQ Journal* 2007 (Quarter 2).
4. Moore C, Wisnevesky J, Williams S, McGinn T. 2003. Medical errors related to discontinuity of care from an inpatient to an outpatient setting. *Journal of General Internal Medicine* 18:646–651.
5. Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. *Ann Intern Med* 2005;143(2):121-128.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.*

Performance scores for this measure are not yet available

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

The delayed or insufficient transfer of discharge information between hospital-based providers and primary care physicians remains common.

- Communication between hospital-based physicians and primary care physicians as part of the discharge process occurs between 3%-20% of the time.
- Discharge summaries were only available between 12%-34% of first postdischarge visit and between 51%-77% within 4 weeks after discharge.
- Discharge summaries often lacked important information including:
 - Diagnostic test results which were missing from 33%-63% of discharge summaries
 - Course of treatment missing from 7%-22%
 - Discharge medications missing from 2%-40%
 - Test results pending at discharge within 65% of discharge summaries
 - Follow-up plans missing from 2%-43%

A retrospective study on discharge summaries found that 21% of discharged patients did not have a discharge summary completed within a week after discharge. The absence of a discharge summary was associated with a 79% increase in the rate of readmission within 7 days and a 37% increased rate of readmission within 28 days (2).

Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831-841. doi:10.1001/jama.297.8.831

2. Li JYZ, Yong TY, Hakendorf P, Ben-Tovim D, Thompson CH. Timeliness in discharge summary dissemination is associated with patients' clinical outcomes. *Journal of Evaluation in Clinical Practice*. 2013;19:76–79. doi:10.1111/j.1365-2753.2011.01772.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity,

gender, age, insurance status, socioeconomic status, and/or disability. (*This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

We are not aware of any publications or evidence outlining disparities in this area.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

N/A

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Non-Condition Specific(check all the areas that apply):

Care Coordination, Safety, Safety : Medication

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

The measure specifications are included in this submission. Additional measure details may be found at:
<http://www.thepcpi.org/pcpi/media/documents/Care-Transitions-updated-measures-112016.pdf>

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment:

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

Yes

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

For measure 0649, the unit of measurement was changed from patients to discharges to clarify that the intent of this measure is to assess each individual discharge as a patient may have more than one discharge within a measurement period.

S.4. Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.*

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Discharges in which the patient or their caregiver(s) 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

S.5. Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Time Period for Data Collection: At each emergency department discharge during measurement period

Numerator Element Definitions:

- Transition record (for ED discharges): a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with, provided to and accepted by the patient in written, printed, or electronic format. Electronic format may be provided only if acceptable to patient.
- Summary of any major tests and procedures performed during the emergency department encounter must be included in the transition record, but it is not the intention of the measure that a complete order set is provided to all patients. The types of procedures and tests included should be defined by each emergency department prior to measure implementation and may include fracture management, wound repair, incision and drainage (I & D), foreign body removal, joint reduction, joint aspiration, chest tube placement, emergency endotracheal intubation, central line placement, or lumbar punctures. Tests may include lab tests, scans, or x-rays that were performed. Major tests that have results pending should be included, since they were performed during the encounter and will require follow up after the patient leaves the ED.
- Primary physician or other health care professional designated for follow-up care: may be primary care physician (PCP), medical specialist, or other physician or health care professional. If no physician, other health care professional, or site designated or available, patient may be provided with information on alternatives for obtaining follow-up care needed, which may include a list of community health services/other resources.

For Administrative:

Numerator Elements to be identified through medical record abstraction:

See Sample Data Collection Tool attached in Appendix A.1.

This measure may also be implemented in EHRs:

The Care Transitions measures do not lend themselves to a "traditional specification" for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure. Given the fact that every facility may use a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (ie, emergency department episode). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.

Producing the Transition Record with Specified Elements:

Emergency departments that have implemented an EHR should establish a standardized template within their system that providers will use to generate the Transition Record. A standardized template will ensure that all data elements specified in the performance measure are included each time a Transition Record is prepared. Sample Transition Records were developed and are included in the

#0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care), Last Updated: Jul 20, 2017

Care Transitions Specifications. Each facility has the autonomy to customize the format of the Transition Record, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution.

Systematic External Reporting of the Transition Record:

In order to report, at the facility level, which of the patients discharged from the emergency department have received a Transition Record, a discrete data field and code indicating the patient received a Transition Record at discharge may be needed in the EHR.

Transmitting the Transition Record with Specified Elements:

This performance measure does not require that the Transition Record be transmitted to the next provider(s) of care. However, if the Transition Record is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model (<https://ecqi.healthit.gov/qdm>). In addition, the use of recognized interoperability standards for the transmission of the Transition Record information will ensure that the information can be received into the destination EHR.

S.6. Denominator Statement *(Brief, narrative description of the target population being measured)*

All discharges for patients, regardless of age, from an emergency department (ED) to ambulatory care (home/self care) or home health care

S.7. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Time Period for Data Collection: At each emergency department discharge during the measurement period

For Administrative:

Identify patients discharged from emergency department using the following:

UB-04 (Form Locator 42 - Revenue Code):

- 0450 (Emergency Room)

AND

UB-04 (Form Locator 17 - Discharge Status):

- 01 (Discharged to home or self care (routine discharge))
- 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care)
- 21 (Discharged/transferred to court/law enforcement)

(Note: Only the above codes from UB-04 Form Locator 17 - Discharge Status should be included in the eligible population.)

This measure may also be implemented in EHRs:

Eligible discharges for the denominator should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

Exclusions:

Patients who died

Patients who left against medical advice (AMA) or discontinued care

Exceptions:

Patients who declined receipt of transition record

Patients for whom providing the information contained in the transition record would be prohibited by state or federal law

S.9. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as*

#0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care), Last Updated: Jul 20, 2017

definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

Time Period for Data Collection: At each emergency department discharge during measurement period

The PCPI distinguishes between measure exceptions and measure exclusions.

Measure exclusions:

Exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (ie, the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision. For measure Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care), exclusions include patients who died, and patients who left against medical advice (AMA) or discontinued care.

Measure exceptions:

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of exception reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care), exceptions may include patients who declined receipt of transition record, and patients for whom providing the information contained in the transition record would be prohibited by state or federal law. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Additional details by data source are as follows:

For Administrative:

UB-04 (Form Locator 17 - Discharge Status):

- 07 (Left against medical advice or discontinued care)*
- 20 (Expired)
- 40 (Expired at home)
- 41 (Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice))
- 42 (Expired - place unknown)

This measure may also be implemented in EHRs:

Discharges meeting denominator exclusions criteria should be identified through the Admission, Discharge, Transfer (ADT) system, or from another electronic system where this information is stored.

Exception Definition: Documentation is required for patients who are excepted from the measure:

- Patients who declined receipt of transition record.
- Patients for whom providing the information contained in the transition record would be prohibited by state or federal law.

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)*

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator. (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.
3. Find the patients who qualify for denominator exclusions and subtract from the denominator.
4. From the patients within the denominator (after denominator exclusions have been subtracted from the denominator), find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.
5. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: patients who declined receipt of transition record, and patients for whom providing the information contained in the transition record would be prohibited by state or federal law]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage of patients with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Not applicable. The measure is not based on a sample.

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

Not applicable. The measure is not based on a survey.

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Electronic Health Data, Paper Medical Records

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data is collected.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

See attached data collection tool.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available in attached appendix at A.1

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility, Integrated Delivery System

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Emergency Department and Services

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

Not applicable. Measure is not a composite

2. Validity – See attached Measure Testing Submission Form

0649_Transition_Record_with_Specified_Elements_Received_by_Discharged_Patients_-ED-_revised.doc

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes SDS factors is no longer prohibited during the SDS Trial Period (2015-2016). Please update sections 1.8, 2a2, 2b2, 2b4, and 2b6 in the Testing attachment and S.14 and S.15 in the online submission form in accordance with the requirements for the SDS Trial Period. NOTE: These sections must be updated even if SDS factors are not included in the risk-adjustment strategy. If yes, and your testing attachment does not have the additional questions for the SDS Trial please add these questions to your testing attachment:

What were the patient-level sociodemographic (SDS) variables that were available and analyzed in the data or sample used? For example, patient-reported data (e.g., income, education, language), proxy variables when SDS data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate).

Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or sociodemographic factors) used in the statistical risk model or for stratification by risk (e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of $p < 0.10$; correlation of x or higher; patient factors should be present at the start of care)

What were the statistical results of the analyses used to select risk factors?

Describe the analyses and interpretation resulting in the decision to select SDS factors (e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects)

No - This measure is not risk-adjusted

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for maintenance of endorsement.

No data elements are in defined fields in electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

This measure does not lend itself to a "traditional specification" for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (i.e., inpatient stay). However, we have provided guidance on how a facility should query the electronic health record for the information required for this measure, within the numerator details.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PRO data (patients, service recipients, respondents) and those whose performance is being measured.

The unit of measurement was changed from patients to discharges to clarify that the intent of this measure is to assess each individual discharge as a patient may have more than one discharge within a measurement period. This measure was found to be reliable and feasible for implementation.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

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4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
Public Reporting	
Use Unknown	

4a.1. For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

The PCPI strongly encourages the use of its measures in quality improvement and accountability initiatives and promotes their use in public reporting programs. Measures developed by the PCPI, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. As a measure developer, we work with measure implementers as opportunities arise to encourage and facilitate the integration of PCPI measures in their programs.

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

The PCPI has shared the measure with CMS and other potential implementers to gauge interest in its use within public reporting and accountability programs.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results

could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

While the PCPI creates measures with an ultimate goal of improving the quality of care, measurement is a mechanism to drive improvement but does not equate with improvement. Measurement can help identify opportunities for improvement with actual improvement requiring making changes to health care processes and structure. In order to promote improvement, quality measurement systems need to provide feedback to front-line clinical staff in as close to real time as possible and at the point of care whenever possible. (1)

1. Conway PH, Mostashari F, Clancy C. The future of quality measurement for improvement and accountability. JAMA. 2013 Jun 5;309(21):2215-6.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

We are not aware of any unintended consequences related to this measurement.

4c.2. Please explain any unexpected benefits from implementation of this measure.

We are not aware of any unexpected benefits related to this measurement.

4d1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

Not available

4d1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

Not available

4d2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

Not available

4d2.2. Summarize the feedback obtained from those being measured.

Not available

4d2.3. Summarize the feedback obtained from other users

Not available

4d.3. Describe how the feedback described in 4d.2 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Not available

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

0291 : EMERGENCY TRANSFER COMMUNICATION MEASURE

0293 : Medication Information

0297 : Procedures and Tests

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

No

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

While our measure focuses on the receipt of a transition record by patients who are discharged from an ED, measure 0291 focuses on the timely transfer of information to the receiving facility for patients who are transferred from the ED and 0293 and 0297 focus specifically on the communication of medication information and procedure/test information, respectively, for patients who are transferred from the ED to another facility. We feel that the measures are complementary in addressing the quality of care transitions.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Not applicable. There are no existing NQF-endorsed measures that address both the same target population and measure focus.

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment **Attachment:** [NQF0649_EDTransitionRecord_DataCollectionFlowsheet-636159393324696000.pdf](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): PCPI

Co.2 Point of Contact: PCPI, Measures, pcpimeasures@ama-assn.org, 312-464-5709-

Co.3 Measure Developer if different from Measure Steward: PCPI

Co.4 Point of Contact: Elvia, Chavarria, elvia.chavarria@ama-assn.org, 312-464-5709-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study must be equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

Co-chairs:

Robert M. Palmer, MD, MPH (Co-Chair) (Geriatrics/Gerontology)

Mark V. Williams, MD, FACP (Co-Chair) (Hospital medicine)

Work Group members:

Dennis M. Beck, MD, FACEP (Emergency medicine)

Judith S. Black, MD, MHA (Blue Cross and Blue Shield Association)

Caroline Blaum, MD (Geriatrics)

Clair M. Callan, MD, MBA, CPE (American College of Physician Executives)

Jayne Hart Chambers, MBA (Federation of American Hospitals)

Steven Chen, MD, MBA (Surgical oncology)

Kenneth D. Coburn, MD, MPH (Health Quality Partners)

Mirean Fisher Coleman, MSW, LICSW, CT (National Association of Social Workers)

Sydney Dy, MD, MSc (Hospice and palliative medicine)

Scott Endsley, MD, MSc (Health Services Advisory Group)

David A. Etzioni, MD, MSHS (Colon and rectal surgery)

Beth Feldpush, MPH (American Hospital Association)

Rita Munley Gallagher, PhD, RN (American Nurses Association)

G. Scott Gazelle, MD, MPH, PhD (Radiology)

Robert W. Gilmore, MD (Clinical surgery)

Eric S. Holmboe, MD, FACP (Internal medicine)

Mary Ann Kliethermes, B.S., Pharm.D. (American Society of Health System Pharmacists)

James E. Lett, II, MD (American Medical Directors Association)

Janet R. Maurer, MD, MBA, FCCP (Pulmonology)

Andie Melendez, RN, MSN, HTPC (Academy of Medical-Surgical Nurses)

Donise Mosebach, RN, MS, CEN (The Joint Commission)

Michael O'Dell, MD, MSHA, FAAFP (Family medicine)

Eric D. Peterson, MD, MPH, FAHA, FACC (American Heart Association/Cardiology)

Mark Redding MD. FAAP (Pediatrics)

Michael Ries, MD, MBA, FCCM (Critical care medicine)

Hilary C. Siebens, MD (Physical medicine and rehabilitation)

Janet (Jesse) Sullivan, MD (National Transitions of Care Coalition)

Randal J. Thomas, MD, MS, FACC, FAHA, FACP, FAACVPR (Cardiology)

Christopher Tompkins, PhD (Brandeis University)
Robert Wears, MD, FACEP (Emergency medicine)

ABIM Foundation
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American College of Physicians
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Kendra Hanley, MS
Karen Kmetik, PhD
Joanne G. Schwartzberg, MD
Patricia Sokol, RN, JD
Chyna Wilcoxson

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2009

Ad.3 Month and Year of most recent revision: 04, 2016

Ad.4 What is your frequency for review/update of this measure? Supporting guidelines, specifications and coding for this measure are reviewed annually

Ad.5 When is the next scheduled review/update for this measure? 12, 2017

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#0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care), Last Updated: Jul 20, 2017

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Ad.8 Additional Information/Comments: