Appendix H – Care Transitions Measure Summary

Care transitions refer to the movement of patients from one health care provider or setting to another. For people living with serious and complex illnesses, transitions in setting of care are prone to errors. For example, one in five patients discharged from the hospital to home experience an adverse event within three weeks of discharge. The current rate for hospital readmissions among Medicare beneficiaries within 30 days of discharge is nearly 20%, contributing to lower patient satisfaction and rising health care costs[2].

Note: In the table below, the "Technical Description" of the Emergency Department Transfer Communication (EDTC) measure and sub-measures is taken from the Stratis Health Data Collection Guide: Emergency Department Transfer Communication Measures; the "Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Question" descriptions are taken from the HCAHPS website; and the "Description for Consumer" is taken from Hospital Compare.

Measure Abbreviation, Name	Data Entry or Origin	Technical Description/ HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
EDTC Emergency Department Transfer Communication	EDTC spreadsheet sent to state Flex Coordinator	Composite of seven sub-measures; 27 data elements. Patients who are transferred from an Emergency Department (ED) to another health care facility have… • EDTC-SUB 1: Administrative Communication (two data elements) – Physician to physician communication and health care facility to health care facility communication prior to discharge • EDTC-SUB 2: Patient Information (six data elements) – Patient identification information sent to the receiving facility within 60 minutes of discharge • EDTC-SUB 3: Vital Signs (six data elements) – Communication with the receiving facility within 60	Not reported on Hospital Compare	• Identify and implement a standardized process for documentation and transfer of information to the next setting of care • Update paper transfer forms to ensure capture of all the required data elements and documentation that the information was communicated to the next setting of care • Implement prompts and documentation in the electronic health record (EHR) to ensure elements are captured and communicated to the receiving facility, whether electronically or via a printed-paper form • Initiate discussions with organizations, both hospitals and

[2] Geoffrey Gerhardt et al., "Data Shows Reduction in Medicare Hospital Readmission Rates During 2012," *Medicare & Medicaid Research Review* 3 (2013), accessed April 1, 2015, doi: 10.5600/mmrr.003.02.b01.

Measure Abbreviation, Name	Data Entry or Origin	Technical Description/ HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
		minutes of discharge for patient's vital signs • EDTC-SUB 4: Medication Information (three data elements) – Communication with the receiving facility within 60 minutes of discharge for medication information • EDTC-SUB 5: Physician or Practitioner Generated Information (two data elements) – Communication with the receiving facility within 60 minutes of discharge for history and physical and physicians orders and plan • EDTC-SUB 6: Nurse Generated Information (six data elements) – Communication with the receiving facility within 60 minutes of discharge for key nurse documentation elements • EDTC-SUB 7: Procedures and Tests (two data elements) – Communication with the receiving facility within 60 minutes of discharge of tests done and results sent • EDTC-All: Number of patients transferred to another health care facility whose medical record documentation indicated that all of the relevant elements for each of the seven sub-measures were communicated to the receiving hospital in a timely manner		long-term care centers that frequently receive patients from the ED, regarding opportunities for improved transfer communication and care for patients • Develop standardized setting of care processes to report outstanding test or lab results to the next setting of care if not available prior to transfer

Measure Abbreviation, Name	Data Entry or Origin	Technical Description/ HCAHPS Survey Question	Description for Consumer	Best Practices/Resources
HCAHPS Composite 6	Discharge Information	During this hospital stay… • Did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital? (Q19) • Did you get information in writing about what symptoms or health problems to look out for after you left the hospital? (Q20)	Patients who reported that "Yes", they were given information about what to do during their recovery at home	• Conduct pre-discharge assessment of ability of patient and/or family to provide self-care, including: problem solving, decision making, early symptom recognition and taking action, quality of life, depression and other cognitive and functional ability factors • Develop a comprehensive shared care plan using a shared decision making approach. Consider patient values and preferences, social and medical needs • Throughout the patient stay, work with the patient and family to prepare for discharge and follow-up planning, including goals, questions and concerns • Ensure written discharge plan is easy to read and includes only essential education on health condition, using plain language and health literacy principles
HCAHPS Composite 7	Care Transition	During this hospital stay… • Staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left. (Q23) • When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. (Q24)	Patients who "Strongly Agree" they understood their care when they left the hospital	In addition to the above strategies: • Use personal health records or patient portals to ensure patients have access to necessary information, including: lab results, radiology results, prescription refills requests and ability to email doctors, nurses and staff with questions • Whenever possible, make follow-up appointments or arrangements for other services prior to discharge, always with patient and family input regarding availability and preferences