

Care Transitions Performance Measures: Promoting Better Inpatient and Emergency Department Discharges

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American Medical Association

Physician Consortium for Performance Improvement®

CFMC Learning Forum

September 10, 2009

Care Transitions Work Group

Physician Consortium for Performance Improvement® (PCPI)

- ◆ Established in 2000, convened and staffed by the AMA
- ◆ Leading, national physician-led developer of evidence-based clinical performance measures
- ◆ Over 100 member organizations
 - Medical specialty and state medical societies; specialty boards
 - AHRQ, CMS, The Joint Commission, NCQA
- ◆ Current measures portfolio
 - 43 measurement sets
 - 260+ individual measures
- ◆ 113 NQF-endorsed™ measures

Care Transitions Work Group

◆ Joint leadership by PCPI member organizations:

- ABIM Foundation
- American College of Physicians
- Society of Hospital Medicine

◆ Work Group includes representation from:

- Amer. Hospital Association
- Amer. Medical Directors Association
- Acad. of Medical-Surgical Nurses
- Amer. Nurses Association
- Amer. Soc. of Health System Pharmacists
- Natl. Association of Social Workers
- Natl. Transitions of Care Coalition
- The Joint Commission

Care Transitions Work Group

◆ Initial focus:

- Discharges from inpatient facilities or ED, to ambulatory setting or other sites of care
- Future work: other specified transitions; other topics in care coordination

◆ Principal guideline reference:

- *Transitions of Care Consensus Policy Statement**
- Additional references:
 - Joint Commission standards & National Patient Safety Goals
 - National Quality Forum Safe Practices
 - National Priorities Partnership Goals

*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.

Care Transitions Work Group

Starting point for discussion...

- ◆ *What are the desirable outcomes for patients undergoing transitions in care?*
 1. Reduction in adverse drug events
 2. Reduction in patient harm related to medical errors of omission and commission
 3. Reduction in unnecessary healthcare encounters (eg, hospital readmissions)
 4. Reduction in redundant tests and procedures
 5. Achievement of patient goals and preferences (eg, functional status, comfort care)
 6. Improved patient understanding of and adherence to treatment plan

Care Transitions Work Group

◆ *What outcome measures are already available for care transitions ?*

Readmission measures:*

1. 30-Day All-Cause Risk Standardized Readmission Rate Following HF Hospitalization (CMS)
2. 30-Day All-Cause Risk Standardized Readmission Rate Following AMI Hospitalization (CMS)
3. 30-Day All-Cause Risk Standardized Readmission Rate Following Pneumonia Hospitalization (CMS)
4. All-Cause Readmission Index (total readmissions within 30 days) (PacifiCare)

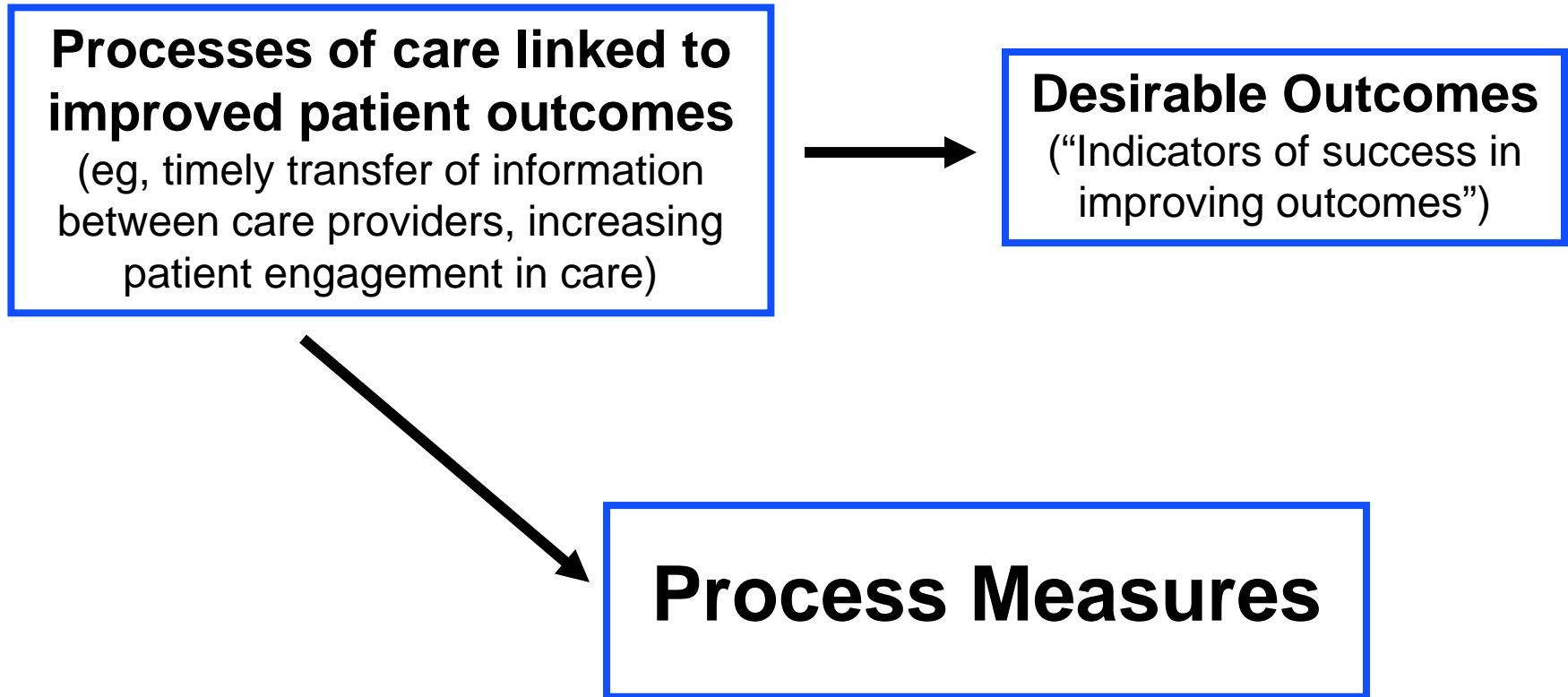
3-Item Care Transition Measure (CTM-3)*

(Coleman/Univ. of Colorado-Denver)

* all NQF-endorsed™

Care Transitions Measures

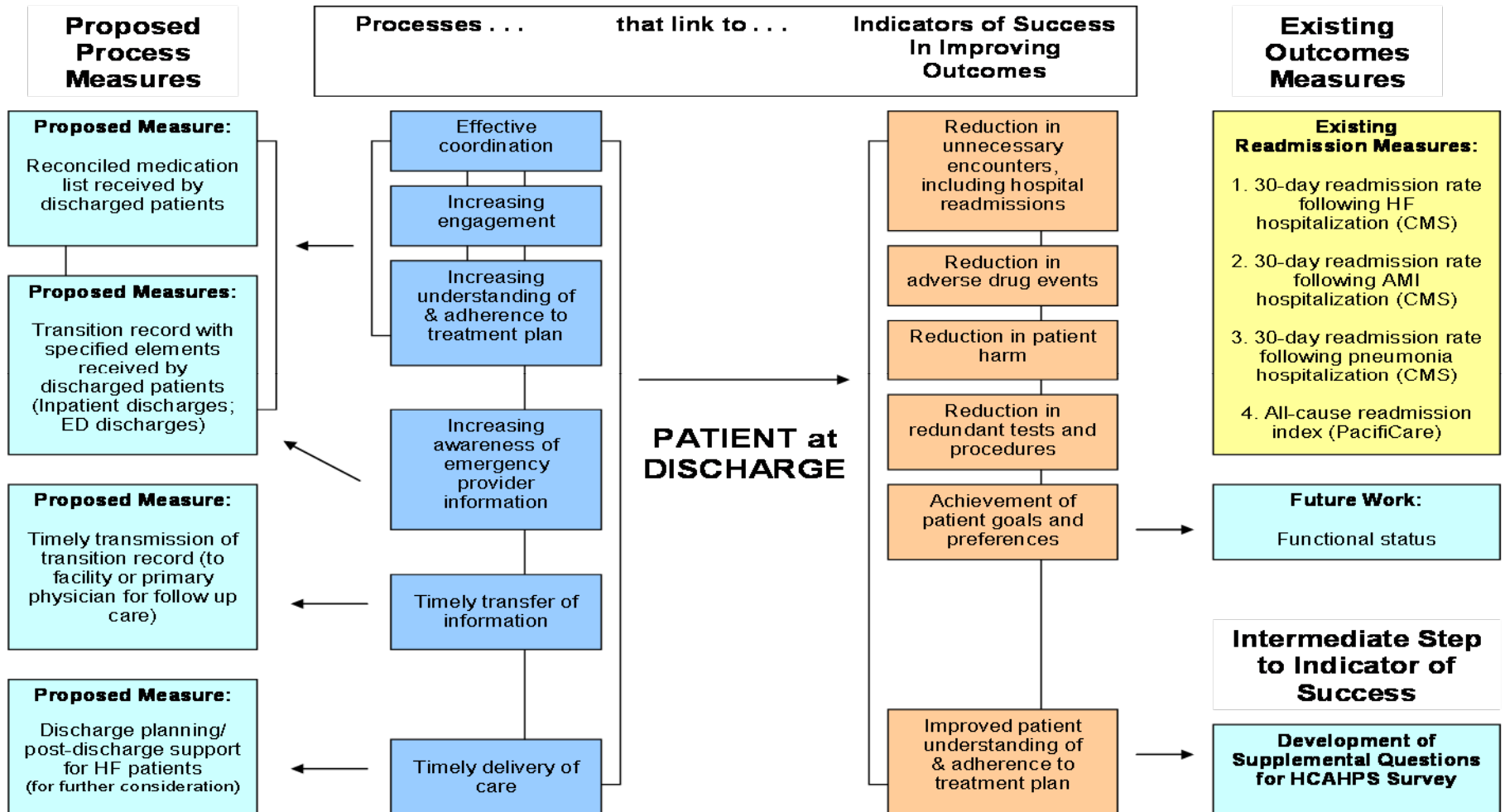
Filling measurement gaps for discharged patients...



Care Transitions Measures

Link to Outcomes:

Setting: Patients discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility or rehabilitation facility)



Care Transitions Measures

◆ Process Measures (*refer to PDF provided*)

Measures 1-3, for inpatient discharges, a “bundled” set:

1. Reconciled Medication List Received by Discharged Patients
2. Transition Record with Specified Elements Received by Discharged Patients
3. Timely Transmission of Transition Record

Measure 4, for emergency dept. discharges

4. Transition Record with Specified Elements Received by Discharged Patients

Care Transitions Measures

◆ Process Measures (continued):

5. “Timeliness” measure for Heart Failure patients referred to ACC/AHA/PCPI Heart Failure Work Group

Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented including location, date and time for a follow-up office visit, or home health visit (as specified)

Care Transitions Measures

◆ Status/ next steps:

- Approved by PCPI, June 2009
- Available at: <http://www.ama-assn.org/ama1/pub/upload/mm/370/care-transitions-ms.pdf>
- Under review for potential NQF endorsement, Care Coordination project
- Multiple testing opportunities

◆ Heart Failure measurement set available for public comments through Sept. 20:

<http://www.physicianconsortium.org/>

(click on “Public Comments” link)

Questions and Comments

Thank you; please contact me with any additional questions

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