Resources for Hospital Discharge Planners

Selected Guidelines and Performance Measures for Venous Thromboembolism (VTE) Treatment and Care Coordination

Evidence-Based Guidelines

The American College of Chest Physicians (ACCP) Selected Guideline Recommendations for VTE*[1]

- In patients with deep vein thrombosis (DVT) of the leg or pulmonary embolism (PE) and no cancer, as long-term (first 3 months) anticoagulant therapy, dabigatran, rivaroxaban, apixaban, or edoxaban over vitamin K antagonist therapy (eg, warfarin) is suggested
- In patients with a first or second unprovoked VTE and who have a low or moderate bleeding risk, extended anticoagulant therapy (no scheduled stop date) over 3 months of therapy is suggested
- In patients with low-risk PE and whose home circumstances are adequate, treatment at home or early discharge over standard discharge (eg, after the first 5 days of treatment) is suggested

Selected Excerpts From Various Performance Measures

The Joint Commission Measures[2]

National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism†	The number of patients discharged to home, home care, or home hospice on warfarin with written discharge instructions that address topics including monitoring, compliance, dietary restrictions, and potential adverse drug reactions/interactions.

Selected HEDIS® Measures (2020)

Transitions of Care[3]	The percentage of inpatient discharges for Medicare members 18 years and older who had notification of inpatient admission, receipt of discharge information, patient engagement after inpatient discharge, and medication reconciliation postdischarge during the measurement year.
Follow-up After Emergency Department (ED) Visit for People With Multiple High-Risk Chronic Conditions[4]	The percentage of ED visits for Medicare members 18 years and older with multiple high-risk chronic conditions and follow-up care within 7 days of the ED visit.

Care coordination measures make up a significant proportion of 2020 Merit-based Incentive Payment System (MIPS)‡ improvement activities, and are represented in MIPS advancing care information measures and quality measures.[5,6]

DVT = deep vein thrombosis; HEDIS = Healthcare Effectiveness Data and Information Set; PE = pulmonary embolism.

*Adapted from 2016 ACCP guidelines. See guidelines for full recommendations: Kearon C et al. *CHEST*. 2016;149(2):315-352.

†The National Quality Forum (NQF) has endorsed this and other performance measures for managing VTE in the hospital setting.

‡MIPS is part of the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program (QPP).

www.CarePathHealthyEngagements.com

Selected Excerpts From Various Performance Measures (cont)

National Voluntary Consensus Standards for Care Coordination[7]

The NQF has endorsed these and other performance measures for effective inpatient discharges to home/self-care or any other site of care.

Measure	Assessment
Reconciled medication list received by discharged patients (medications include prescription, over-the-counter, and herbal products)	Patients or their caregiver(s) who received a reconciled medication list at discharge including, at a minimum, medications in the following categories: **Medications to be taken by the patient** • Continued medications prescribed before inpatient stay that the patient should continue taking after discharge, including any change in dosage or directions • New medications started during inpatient stay that are to be continued after discharge, and new medications that the patient should begin taking after discharge • Information provided for all medications should include prescribed dosages, instructions, and intended duration **Medications not to be taken by the patient** • Medications taken by the patient before the inpatient stay that should be discontinued after discharge • Medications that were administered during inpatient stay that caused an allergic reaction or adverse event and were therefore discontinued The medical record must indicate that the physician is aware of medications not to be taken by patient, and will either keep or change the inpatient facility discharge medications.
Transition record with specified elements received by discharged patients	Patients 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. Record to include all of the following elements: **Inpatient care** • Reason for inpatient admission • Major procedures and tests performed, and summary of results • Principal diagnosis at discharge **Postdischarge/patient self-management** • Current medication list • Studies pending at discharge (eg, laboratory, radiology) • Patient instructions **Advance care plan** • Advance directives or surrogate decision-maker documented, or documented reason for not providing advance care plan **Contact information/plan for follow-up care** • 24-hour/7-day contact information, including physicians for emergencies related to inpatient stay and contact information for obtaining results of studies pending at discharge • Plan for follow-up care and primary physician, other healthcare professional, or site designated for follow-up care
Timely transition of record	Patients for whom a transition record was transmitted to the facility, primary physician, or other healthcare professional designated for follow-up care within 24 hours of discharge

Cliff Enright, *Starburst*. Artwork from The Creative Center at University Settlement.

References: 1. Kearon C, Akl EA, Ornelas J, et al. Antithrombotic therapy for VTE disease. CHEST guideline and expert panel report. *CHEST*. 2016;149(2):315-352. **2.** Centers for Medicare & Medicaid Services. Pioneers in Quality™ Expert to Expert Series: VTE-1 & VTE-2. eCQI Resource Center website. https://ecqi.healthit.gov/system/files/PIQ_EtoE_VTE-1_VTE-2.pdf. Accessed July 8, 2020. **3.** Transitions of Care (TRC). HEDIS Measures and Technical Resources. https://www.ncqa.org/hedis/measures/transitions-of-care/. Accessed August 28, 2020. **4.** Follow-up after emergency department visit for people with high-risk multiple chronic conditions (FMC). HEDIS Measures and Technical Resources. https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-people-with-high-risk-multiple-chronic-conditions/. Accessed August 28, 2020. **5.** Centers for Medicare & Medicaid Services. Quality Payment Program. https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program. Accessed July 8, 2020. **6.** Centers for Medicare & Medicaid Services. Comprehensive Medicaid Integrity Plan (CMIP). https://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/CMIP. Accessed July 8, 2020. **7.** Patient-Centered Measures = Patient-Centered Results. http://www.qualityforum.org/Measuring_Performance/ABCs/Patient-Centered_Measures_=_Patient-Centered_Results.aspx. Accessed July 8, 2020.

September 2020 em-02004v2