Appendix 1: Centers for Medicare and Medicaid Services Outpatient-19 (OP-19) Quality Measure: Transition Record with Specified Elements Received by Discharged Patients(1)

**Description:** This measure is used to assess the percentage of patients, regardless of age, discharged from an emergency department (ED), or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements.

**Numerator:** Patients or their caregiver(s) who received a transition record at the time of ED discharge including, at a minimum, all of the following elements:
- Major procedures and tests performed during ED visit, AND
- Principal diagnosis at discharge OR chief complain, AND
- Patient instructions, AND
- Plan for follow-up care (OR statement that none required), including primary care 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.

**Denominator:** All patients, regardless of age, discharged from emergency department (ED).

**Denominator Exclusions:**
- Patients who expired.
- Patients who left against medical advice (AMA) or discontinued care.
- Patients who were admitted to the same hospital as the ED location.

1. Principal diagnosis at discharge OR chief complaint.
   - Definition:
     - The principal clinical diagnosis OR the chief complaint (causing presentation to the emergency department) at discharge must be documented in the transition record.
   - Individual Element Scoring:
     - **Present**: There IS documentation that the patient and/or caregiver(s) received a transition record at the time of emergency department (ED) discharge that contained the principal clinical diagnosis/diagnoses OR chief complaint(s) causing presentation to the emergency department.
     - **Absent**: There is NO documentation that the patient and/or caregiver(s) received a transition record at the time of emergency department (ED) discharge that contained the principal clinical diagnosis/diagnoses OR chief complaint(s) causing presentation to the emergency department.

2. Major procedures and tests performed (or statement that none required) during the ED visit.
   - Definition:
     - Major procedures may include:
       1. Cardioversion
       2. Arterial Access
       3. Central Line Placement
       4. Nasopharyngoscopy
       5. Anoscopy
       6. Nasal Cauterization
       7. Nasogastric Tube Placement
       8. Paracentesis
       9. Thoracentesis
       10. Thoracostomy
       11. Regional Anesthesia
       12. Procedural Sedation
       13. Straight Catheterization
       14. Foley Catheter Placement
       15. Suprapubic Tube Placement
       16. Lumbar Puncture
       17. Shunt Tap
       18. Arthrocentesis
       19. Fracture Reduction
       20. Dislocation Reduction
       21. Splint Application
       22. Fingertip/Nail Bed Injury Repair
       23. Wound Repair
       24. Laceration Repair
       25. Suture Removal
       26. Incision And Drainage
       27. Foreign Body Removal
- Major tests may include laboratory tests, radiology tests, and other imaging studies.
  - Tests that have results pending should be included, since they were performed during the ED visit.
  - If no procedures or tests were necessary, a statement to that effect must be provided in the transition record.

  o Individual Element Scoring:
    - **Present**: There IS documentation that the patient and/or caregiver(s) received a transition record at the time of emergency department (ED) discharge that contained the major procedures and tests performed during the ED visit, or included a statement that no procedure(s)/test(s) were indicated and therefore not performed.
      - Note: Statement of “none” or “N/A” satisfies this condition and should be scored as present.
    - **Absent**: There is NO documentation that the patient and/or caregiver(s) received a transition record at the time of emergency department (ED) discharge that contained ANY of the major procedures and tests performed during the ED visit, and the transition record did NOT include a statement that no procedure(s)/test(s) were indicated and therefore not performed.

3. **Patient instructions.**
   - **Definition:**
     - This may include instructions on wound care, instructions about adverse reactions, signs/symptoms of infection, instructions covering life-threatening emergencies, etc., or other instructions specific to the ED visit. (Not all-inclusive.)
   - **Individual Element Scoring:**
     - **Present**: There IS documentation that the patient and/or caregiver(s) received a transition record at the time of emergency department (ED) discharge that contained patient instructions.
       - Note: If there is a statement indicating CareNotes were included with the transition record at the time of discharge, then this criterion should be scored as present.
     - **Absent**: There is NO documentation that the patient and/or caregiver(s) received a transition record at the time of emergency department (ED) discharge that contained ANY patient instructions.

4. **Plan for follow-up care (OR statement that none required), including primary care physician, other health care professional, or site designated for follow-up care.**
   - **Definition:**
     - This may include a follow-up visit with a primary care physician or other provider; referral to another level of care or site; any post-discharge therapy (oxygen therapy, physical or occupational therapy) that might be needed; and/or durable medical equipment required.
       - If no follow-up care is necessary, a statement to that effect must be provided in the transition record.
   - **Individual Element Scoring:**
     - **Present**: There IS documentation that the patient and/or caregiver(s) received a transition record at the time of emergency department (ED) discharge that contained instructions for follow-up care.
     - **Absent**: There is NO documentation that the patient and/or caregiver(s) received a transition record at the time of emergency department (ED) discharge that contained
instructions for follow-up care, and the transition record did NOT include a statement indicating follow-up care was not required.

5. 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).
   o Definition:
     1. The post-discharge medication list in the transition record must contain any new medications prescribed as well as changes to current or “home” medications.
     2. The list of current or “home” medications should contain any over-the-counter (OTC) or herbal medications that are taken.
     3. Discontinued medications should be listed along with drug interactions and allergies.
     4. Instructions for the new medications must be documented.
        i. Instructions defined as route of administration and frequency of the medication.
           o All patients who received medication prescriptions at ED discharge will be considered as implicitly satisfying this specific criterion since medication prescriptions always include the recommended medication dosage, route of administration and frequency of use.
           o OTC medications also always include a recommended medication dosage, route of administration, and frequency of use when purchased.
     5. The quantity prescribed/dispensed must be documented or the intended duration must be listed.
        i. All patients who received medication prescriptions at ED discharge will be considered as implicitly satisfying this specific criterion since medication prescriptions always include quantity prescribed/dispensed or the intended duration.
        ii. OTC medications are considered pro re nata (p.r.n.) or as needed unless otherwise stated, and can be assumed to be taken by patients until no longer necessary without an explicit stop date.
     6. If a discharge or reconciled medication list (medication reconciliation form) is used, all of the above requirements must be fulfilled with that list.
   o Individual Element Scoring:
     ▪ **Present**: There IS documentation that the patient and/or caregiver(s) received a transition record at the time of emergency department (ED) discharge that contained a list of new medications and changes to continued medications that the patient should take after ED discharge.
     ▪ **Absent**: There is NO documentation that the patient and/or caregiver(s) received a transition record at the time of emergency department (ED) discharge that contained a list of new medications and changes to continued medications that the patient should take after ED discharge, or unable to determine from medical record documentation.

**Overall OP-19 Compliance Scoring**
- **Yes**: All of the above OP-19 data elements scored as present.
- **No**: At least one of the above OP-19 data elements scored as absent.