Transitions of Care (TRC)

Effectiveness of Care HEDIS® Measure

Measurement definition

The percentage of discharges for patients 18 years of age or older, who had an acute or non-acute inpatient discharge on or between January 1 and December 1 of the measurement year and met each of the following components:

1. Notification of inpatient admission within 2 days
2. Receipt of discharge information within 2 days
3. Patient engagement after inpatient discharge within 30 days
4. Medication reconciliation post-discharge within 30 days

Exclusions

Patients are excluded if they:

- Received hospice care during the measurement year.
- Are deceased during measurement year.

Information that patient medical records should include

Documentation of all four components must be in any outpatient record as well as accessible by the primary or ongoing care provider.

Component	Criteria	Outpatient medical record requirements
1. Notification of inpatient admission	Receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 days total).	Must document the **date of receipt** and include at least one of the following criteria: - Communication from inpatient provider, hospital staff or emergency department regarding admission (phone call, email, or fax). Referral to an emergency department does not meet criteria. - Documentation that the patient's PCP or ongoing care provider admitted the patient, or a specialist admitted the patient and notified the patient's PCP. - Communication through a health information exchange; an admission, discharge, and transfer alert system (ADT); or a shared electronic medical record. - Documentation indicating the patient's PCP or ongoing care provider placed orders for tests and treatments during the member's inpatient stay. - Documentation of a preadmission exam or a planned admission prior to the admit date. The exam must pertain to the specific admission event.

Component	Criteria	Outpatient medical record requirements
2. Receipt of discharge information	Receipt of discharge information on the day of the discharge through 2 days after the discharge (3 days total).	Must include **the date of receipt** and ALL the following criteria: - The practitioner responsible for the patient's care during the inpatient stay - Procedures or treatment provided - Diagnoses at discharge - Current medication list - Testing results, documentation of pending tests, or documentation of no tests pending - Instructions for patient care post discharge
3. Patient engagement after inpatient discharge	Patient engagement provided within 30 days after discharge. - May not occur on the date of discharge.	Must include the date of service and clinical notes for any of the following: - An outpatient visit, including office visits and home visits. - A telephone visit. - A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication. - An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not in real-time, occurred between the member and provider). *NOTE: If the patient is unable to communicate with the practitioner, interaction between the patient's caregiver and the provider meets criteria*.
4. Medication reconciliation post-discharge	Medication reconciliation completed on the date of discharge through 30 days after discharge (31 total days). NOTES: - Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse. Other staff members (MA or LPN) may document the medication reconciliation, but it must be signed off	Must include all three items described below: 1. Date the medication reconciliation was performed 2. Current medication list (at date of reconciliation) 3. Chart documentation of any one of the following: o Notation that the provider reconciled the current and discharge medications. o Notation that references the discharge medications (e.g., no changes in meds post discharge, same meds at discharge, discontinue all discharge meds, discharge meds reviewed). o Notation that the discharge medications were reviewed. o A discharge medication list with notation that both it and the current medications were reviewed on the same date of service.

Component	Criteria	Outpatient medical record requirements
	by the prescribing practitioner. - Medication reconciliation must be documented in the outpatient medical record, but an outpatient face-to-face visit isn't required.	o Evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. (Evidence includes notation of follow-up for "hospitalization", "admission", "discharge", or "inpatient stay".) ▪ *NOTE: Documentation of "post-op/surgery follow-up" alone is not considered sufficient chart evidence of a hospitalization.* o Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. Discharge summary must be dated and filed in the outpatient record within 30 days after discharge. o Notation that no medications were prescribed or ordered upon discharge.

Tips for success

- Keep open appointments so patients who are discharged from the hospital can be seen within seven days of their discharge.
- When scheduling the post-discharge visit, ask patients to bring in all their prescription medications and over-the-counter medications and supplements so that the medication reconciliation can be performed.
- Obtain and review patients' discharge summary.
- Obtain any test results that were not available when patients were discharged and track tests that are still pending.
- Connect with your area's automated electronic admission, discharge and transfer (ADT) system to receive admission, discharge and transfer notifications for your patients.
- If patients have not scheduled their discharge follow-up appointment, reach out and schedule an appointment within seven days of discharge or sooner as needed.
- Consider implementing:
    - A post-discharge process to track, monitor and follow up with patients.
    - A transitional care management program for recently discharged patients.
- You can reduce errors at time of discharge by using the computer order entry system to generate a list of medications used before and during the hospital admission.
- Safe and effective transfer of responsibility for a patient's medical care relies on effective provider communication with **patient comprehension of his or her discharge instructions.**

- Documentation of notification must include a date when the document was received.
- This measure is based on discharges. If a patient has more than one discharge, they may appear in the measure more than once.
- **Examples of documentation that are not acceptable:**
    - Documentation that the member or the member's family notified the member's primary or ongoing care provider of the admission of discharge.
    - Documentation of notification that doesn't include a date when the documentation was received.

Tips for talking with patients

- Discuss the discharge summary with patients and ask if they understand the instructions and filled the new prescriptions.
- Complete a thorough medication reconciliation and ask patients and/or caregivers to describe their new medication regimen back to you.
    - Document and date the medication reconciliation in the patients' outpatient medical record.
    - Submit a claim with CPT® II code 1111F as soon as the reconciliation is complete. It is not necessary to wait for all components of TCM or care planning services to be met.
    - Provide the patient with a current list of medications.
- Develop an action plan for chronic conditions. The plan should include what symptoms would trigger the patient to:
    - Start as needed (PRN) medications.
    - Call their doctor during after office hours.
    - Go to the emergency room.
- Have patients and caregivers repeat the care plan back to you to demonstrate understanding.
- Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future.
- Ask patients if they completed or scheduled prescribed outpatient workups or other services. This could include physical therapy, home health care visits and obtaining durable medical equipment.

Tips for coding

Visits with a practitioner can be with or without a telehealth modifier

CPT II code	Description	Component
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.	4. Medication Reconciliation
CPT code	**Description**	
98966 – 8, 98970 – 2, 98980 – 1, 99202 – 5, 99211 – 5, 99241 – 5, 99341 – 5, 99347 – 9, 99350, 99381 – 7, 99391 – 7, 99401 – 4, 99411 – 2, 99421 – 3, 99429, 99441 – 3, 99455 – 8, 99483	Outpatient and telehealth evaluation & management services	3. Patient engagement
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.	4. Medication Reconciliation
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least moderate complexity and a face-to-face (in-person or telehealth) visit within **14 days** or discharge.	3. Patient engagement 4. Medication Reconciliation
99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least high complexity and a face-to-face (in-person or telehealth) visit within **7 days** of discharge.	3. Patient engagement 4. Medication Reconciliation

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