Transitions of Care (TRC)

This measure centers on care transitions from acute (or non-acute) inpatient care settings and aims to capture the percentage of discharges for members 18 years and older that included each of the following:

1. **Notification of Inpatient Admission.** Documentation of receipt of notification of inpatient admission on the day ofadmission through 2 days after the admission (total of 3 days)
2. **Receipt of Discharge Information.** Documentation of receipt of discharge information on the day of dischargethrough 2 days after the discharge (total of 3 days)
3. **Patient Engagement After Inpatient Discharge.** Documentation of patient engagement (e.g., office visits, visits tothe home, telehealth) provided within 30 days after discharge
4. **Medication Reconciliation Post-Discharge.** Documentation of medication reconciliation on the date of dischargethrough 30 days after discharge (total of 31 days)

Exclusion: Members in hospice or using hospice services anytime during the measurement year

Notification of Inpatient Admission

Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission**on the day of admission through 2 days after the admission** with evidence of the date when the documentation was received.

Any of the following examples meet criteria:

- Communication between inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phonecall, email, fax)
- Communication about admission between emergency department and the member's PCP or ongoing careprovider (e.g., phone call, email, fax
    - ***Note:*** *When an ED visits results in an inpatient admission, notification that a provider sent the member to the ED does not meet criteria. Evidence that the PCP or ongoing care provider communicated with the EDabout the admission meets criteria.*
- Communication about admission to the member's PCP or ongoing care provider through a health informationexchange (HIE) or an automated admission, discharge, and transfer (ADT) alert system
- Communication about admission with the member's PCP or ongoing care provider through a shared electronicmedical record (EMR) system
    - ***Note:*** *When using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information was filed in the EMR and accessible to the PCP or ongoing care provider on theday of admission through 2 days after the admission meets criteria.*
- Communication about admission to the member's PCP or ongoing care provider from the member's health plan
- Indication that the member's PCP or ongoing care provider admitted the member to the hospital
- Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing careprovider

- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission
    - ***Note:*** *The time frame that the planned inpatient admission must be communicated is not limited to the day of admission through 2 days after the admission; documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria. The planned admission documentation or preadmission exam must clearly pertain to the inpatient stay.*
- Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay

Receipt of Discharge Information

Documentation in the outpatient medical record must include evidence of receipt of discharge information **on the day of discharge through 2 days after the discharge** with evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or summary of care record, or in structured fields within an EHR.

At a minimum, the discharge information must include **all the following items:**

- The practitioner responsible for the member's care during the inpatient stay
- Procedures or treatment provided
- Diagnoses at discharge
- Current medication list
- Testing results, or documentation of pending tests or no tests pending
- Instructions for patient care post-discharge

Note: *If the PCP or ongoing care provider is the discharging provider, the discharge information must be documented in the medical record on the day of discharge through 2 days after the discharge*.

And again, when using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information was filed in the EMR and accessible to the PCP or ongoing care provider on the day of discharge through 2 days after the discharge meets criteria.

Patient Engagement After Inpatient Discharge

Documentation in the outpatient medical record must include evidence of patient engagement within 30 days *after* discharge. ***Note:*** *Patient engagement completed on the day of discharge does not meet criteria.*

Any of the following meet criteria:

- 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 real-time, occurred between the member and provider)

Note: *If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria.*

Medication Reconciliation Post-Discharge

Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed.

Any of the following meet criteria:

- Documentation of the current medications with a notation that the provider reconciled the current and discharge medications
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications)
- Documentation of the member's current medications with a notation that the discharge medications were reviewed
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review
    - ***Note:*** *Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was* ***aware*** *of the member's hospitalization or discharge.*
    - ***Note:*** *Documentation of "post-op/surgery follow up" without reference to an inpatient admission does not imply a hospitalization and is not considered evidence that a provider was aware of a hospital stay.*
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record (more commonly seen in a shared EMR)
- Notation that no medications were prescribed or ordered upon discharge

Tips

To help meet compliance:

- Ensure clear evidence of date of receipt: print dates, fax dates, generation dates, upload and filed dates help determine when information was accessible to the provider
- Utilization of an HIE, ADT or shared EMR: documentation in any outpatient record that is accessible to the provider is eligible for use in reporting
- Follow up on provider ER referrals for official notification of admission
- Follow up on discharge notifications: retrieve or request the discharge *information*
- Ensure timely retrieval of discharge information from portals or HIE *(the day of and 2 days after discharge)*
- Be aware notification received from a member's family or caregiver is considered hearsay and does not meet criteria
- Member discharge instructions in general do not meet the discharge information requirements
- Have a current medication visible in the medical record either as a stand-alone list or embedded within a progress note
- Medication reconciliation:
    - completed on the day of discharge does meets criteria *(vs engagement)*
    - can be performed without the member present - *an outpatient visit is not required*
    - completed by a medical assistant or LPN does not meet criteria *unless* signed off by one the allowable providers (prescribing provider, clinical pharmacist, or registered nurse)