Transitions of Care (TRC)

Description: This measure assesses the documentation of the transition of care from an acute or non-acute inpatient setting in an outpatient medical record. It aims to capture the percentage of inpatient discharges for members 18 years of age and older that meet all four components of the measure:

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

***Only **one** outpatient medical record can be used for all four indicators
*Members in hospice are excluded from the eligible population

Notification of Inpatient Admission

Documentation in the medical record must include *evidence of receipt of notification of inpatient admission on the day of admission or the following day 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., phone call, e-mail, fax)
- Communication about admission between emergency department and the member's PCP or ongoing care provider (e.g., phone call, e-mail, fax); *see tip section regarding ER referrals*
- Communication about admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission, discharge and transfer (ADT) alert system; or a shared electronic medical record system*
- 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 care provider
- Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay
- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The time frame that the planned inpatient admission must be communicated is not limited to the day of admission or the following day; 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 denominator event

Receipt of Discharge Information

Documentation must include *evidence of receipt of discharge information on the day of discharge or the following day 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 be located in structured fields in an EMR* **At a minimum**, the discharge information must include all of the following:

- 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 to the PCP or ongoing care provider for patient care

In the event *the PCP or ongoing care provider is the discharging provider*, the required discharge information must still be present in the appropriate medical record.

***Shared EMR:** When using a shared EMR system, documentation of a "*received date*" for Notification of Inpatient Admission and Receipt of Discharge Information *is not required*. Evidence that the information was *filed and accessible* to the PCP or ongoing care provider *within the compliance period* meets criteria.

Patient Engagement After Inpatient Discharge

Documentation must include *evidence of patient engagement within 30 days after discharge*. **Either** of the following meets criteria:

- An outpatient visit, including office visits and home visits
- A synchronous telehealth visit where real-time interaction occurred between the member and provider via telephone or videoconferencing

Note: An interaction between the member's caregiver and the provider meets criteria if the member is unable to communicate with the provider.

Medication Reconciliation Post-Discharge

Documentation in the outpatient medical record must include *evidence of medication reconciliation and the date when it was performed (date of discharge through 30 days after for a total of 31 days).*

Any of the following meets 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
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days)
- Notation that no medications were prescribed or ordered upon discharge

Tips:

Documentation for all four sub-measures needs to be present and collected from one record; the record of the PCP or ongoing care provider. To help meet compliance:

- Ensure clear evidence of date of receipt of admission notification and discharge information
- Ensure method of receipt is available/operational over holidays and weekends (e.g. fax machine)
- Utilize a health information exchange, automated alert system or shared EMR (a shared EMR is considered the PCP or ongoing care provider's record)
- Follow up on any provider referrals to the ER: *a referral to the ER does not count as notification if the ED visit results in inpatient admission*. Accept notification directly from the inpatient facility (not hearsay from member, member's family or caregiver)
- Document provider awareness or acknowledgement of the inpatient stay at the time of post-discharge patient engagement and medication reconciliation
- Complete patient engagement within 30 days post discharge (but not on the day of discharge)
- Ensure presence of and reference to a current listing of medications in the record for medication reconciliation with discharge medications to be counted
- Ensure medication reconciliation is documented in the record (an outpatient visit is not required)
- Ensure medication reconciliation is completed and signed by either a prescribing practitioner, clinical pharmacist or registered nurse