HEDIS - Transitions of Care (TRC)

NCQA has released a new hybrid HEDIS® measure, which will be included in the medical record audit for HEDIS 2018.

This measure will capture the percentage of discharges for members 18 years of age and older who had each of the following during the measurement year. Four rates are reported:

- **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.*

**Chart documentation tips**

- Include evidence of receipt of notification of inpatient admission with a date stamp in the patient chart.
  - Communication between inpatient providers or staff and the member’s PCP or ongoing care provider (e.g., phone call, e-mail, fax).
  - Communication between emergency department and the member’s PCP or ongoing care provider prior to admission (e.g., phone call, e-mail, fax).
  - 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 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 timeframe 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.

- Include evidence of receipt of discharge information on the day of discharge or the following day in the patient chart. At a minimum, the information should include:
  - The practitioner responsible for the member’s care during the inpatient stay.
  - Procedures or treatment provided.
  - Diagnoses at discharge.
  - Current medication list (including allergies).
  - Testing results, or documentation of pending tests or no tests pending.
  - Instructions for patient care.

- Documentation must include evidence of patient engagement within 30 days after discharge.
  - Engagement can either be an actual outpatient visit (including office and home visits) OR
  - A synchronous telehealth visit where real-time interaction occurred between the member and provider via telephone or video-conferencing

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

CPT Codes are available for two of the submeasures:
## Patient Engagement after Inpatient Discharge

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## Medication Reconciliation Post-Discharge

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