Transitions of Care (TRC)

HEDIS® Measurement Year 2023

Measure Description: Assesses the percentage of discharges (acute and nonacute) for members 18 years of age and older who had <u>each</u> of the following during the measurement year:

- Notification of inpatient admission.
- Receipt of discharge information.
- Patient engagement after inpatient discharge
- Medication reconciliation post-discharge.

Note: *Members may be in the measure more than once if there are multiple admissions.*

Eligible Population

- Medicare members 18 years of age or older with an acute or nonacute discharge during the measurement year.
- Members in hospice are excluded from the eligible population.

Notification of Inpatient Admission

Admission refers to the date of inpatient admission or date of admission for an observation stay that turns into an inpatient admission.

Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through two days after admission with a date and timestamp. Any of the following meet criteria:

- Communication between the emergency department, inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax)
- Communication about the admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission via 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 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 test and treatments during the member's inpatient stay
- Indication that the admission was elective and the member's PCP or ongoing care provider was notified or had performed a preadmission exam

Note: The following notations **do not** count:

- Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission.
- Documentation of notification that does not include a time frame or date and timestamp

Transitions of Care (TRC)

HEDIS® Measurement Year 2023

Receipt of Discharge Information

Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through two days after discharge, with date and timestamp.

Discharge information may be included in a discharge summary or summary of care record or be in structured fields in an electronic health record.

At minimum, the discharge information must include all of the following:

- Name of practitioner responsible for the member's care during the inpatient stay.
- Procedures or treatment provided.
- Diagnoses at discharge.
- Current medication list.
- Test results, or documentation of pending test, or no test pending.
- Instructions to the PCP or ongoing care provider for patient care.

Patient Engagement Post-Discharge

Documentation of patient engagement (e.g., office visit, visit to the home or telehealth visit) provided within 30 days after discharge.
Note: *Patient Engagement that occurs on the same date of discharge does not count.*

Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any of the following will 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

Note: *Documentation in an outpatient medical record meets the intent; an outpatient visit is not required.*

Medication Reconciliation Post-Discharge

Medication reconciliation conducted by prescribing practitioner, clinical pharmacist, or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (total of 31 days).

Documentation in the outpatient medical record must include evidence of medication reconciliation and the date it was performed. Any of the following will 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 received 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

Transitions of Care (TRC)

HEDIS® Measurement Year 2023

30 days after discharge (total of 31 days).
- Notation in the medical record that no medications were prescribed or ordered upon discharge.

Note:

- Documentation in any outpatient medical record that is accessible to the PCP or ongoing care provider is eligible for use in reporting
- Only documentation in the outpatient medical record meets the intent of the measure, however the member does not need to be present

Hybrid Measure Note:

The TRC measure is hybrid. Any care not received via claims during the measurement year will result in medical record requests during the HEDIS medical record review project.

*The Health Plan has a team of member advocates, health coaches, social workers and nurses who can assist you and your patients to remove or overcome any barriers to care through benefit assistance, community resource referrals or enrollment in a THP clinical program. To refer a patient who is a THP member for assistance, call **1.877.903.7504** and let us know what we can do to help your patient receive and adhere to your recommended plan of care.*

Numerator Codes

The complete NCQA approved code set list can be referenced in the coding guide at healthplan.org/providers/patient- care-programs/quality-measures.

For questions, please contact your practice management consultant. To identify your practice management consultant please refer to healthplan.org/providers/overview/meet-practice-management-consultant.

Patient Engagement - Outpatient Visits	
CPT	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
HCPCS	G0402, G0438, G0439, G0463, T1015
Patient Engagement - Telephone Visits	
CPT	98966-98968, 99441-99443
Patient Engagement - Online Assessments	
CPT	98969-98972, 98980, 98981, 99421-99444, 99457, 99458
HCPCS	G0071, G2010, G2012, G2061-G2063, G2250-G2252
Medication Reconciliation	
CPT	99483, 99495, 99496
CPTII	1111F