Transitions of Care (TRC)

By working together, we can improve health outcomes for your patients, our members. The Healthcare Effectiveness Data and Information Set (HEDIS®) helps us measure many aspects of performance. This tip sheet provides key details of the HEDIS measure for Transitions of Care (TRC).

What Is the Measure?

The measure assesses the percentage of discharges (acute and/or non-acute) between January 1 and December 1 for members age 18 or older who had **each** of four reported indicators 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.

Exclusions

- Members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Members who died any time 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 two days after admission (three days total) with a date when the documentation was received.

Examples include:

- 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 or 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 the member's PCP or ongoing care provider admitted the member to the hospital, or placed orders for test and treatments during the member's inpatient stay
- Indication a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider
- Indication the admission was elective and the member's PCP or ongoing care provider was notified or had performed a preadmission exam

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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 evidence of a date when the documentation was received.

Discharge information may be included in a discharge summary or summary of care record, or located in structured fields in an electronic health record. 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 (including medication allergies)
- Test results, or documentation of pending test, or no test pending
- Instructions to the PCP or ongoing care provider for 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 two days after the discharge (three days total).

Patient Engagement After Inpatient Discharge

Documentation of patient engagement (e.g., office visit, visit to the home or telehealth visit) provided within 30 days after discharge.

Note*:* Do not include patient engagement that occurs on the same date of discharge. 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 visits where real-time interaction occurred between the member and provider using audio and video communication
- An e-visit or virtual check-in

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

Evidence of patient engagement should also be captured through claims data:

Outpatient or Telehealth visit codes:

CPT: 98966-98968, 98970-98972, 98980-98981, 99202-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99421-99423, 99429, 99441-99443, 99455-99458, 99483

HCPCS: G0071, G0402, G0438-G0439, G0463, G2010, G2012, G2250-G2252, T1015

Transitional care management service codes:

CPT: 99495-99496

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Medication Reconciliation Post Discharge

Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse, documented in the medical record on the date of discharge through 30 days after discharge (31 total days).

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 referencing 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 the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review; evidence the member was seen for post-discharge hospital follow-up requires documentation indicating the provider was aware of the member's hospitalization or discharge.
- Documentation in the discharge summary must show reconciliation of the discharge medications with the most recent medication list in the outpatient medical record. There must be evidence 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

Evidence of medication reconciliation should also be captured through claims data:

Medication Reconciliation Codes:

CPT: 99483, 99495-99496

CPTII: 1111F