Transitions of Care (TRC)

Description of Measure

The percentage of discharges for patients 18 years of age or older, as of December 31 of the measurement year, who had an acute or non-acute inpatient discharge on or between January 1 and December 1 of the measurement year (MY), and had each of the following:[1]

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

Documentation

The following codes are for medication reconciliation post-discharge:

Code	Description
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least moderate complexity and a face-to-face visit within 14 days or discharge.
99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least high complexity and a face-to-face visit within 7 days of discharge.

Component	Timing	Outpatient medical record requirements
Notification of Inpatient Admission (NIA)	Receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 days total)	Documentation in the PCP or OCP EMR's with a date stamp, of when the following information was received: ■ Information from the facility, admitting provider or a specialist that the patient was admitted ■ The PCP or OCP ordering tests or treatments during the inpatient stay also meets criteria. ■ A pre-admission exam, which documents that the planned admission, not just a procedure, by the PCP or OCP also meets Criteria (this does not use the NIA date ranges)
Receipt of discharge information (RDI)	Receipt of discharge information on the day of the discharge through 2 days after the discharge (3 days total)	Documentation in the PCP or OCP medical record with a date stamp, of when the following information was received from the discharging facility the date of discharge to 2 days after: ■ Practitioner responsible for patient's care during the inpatient stay ■ Procedures or treatment provided ■ Diagnosis at discharge ■ Current medication list ■ Testing results, notation of pending tests or no tests pending ■ Instructions for patient care post discharge
Patient engagement after inpatient discharge (PED)	Patient engagement provided within 30 days after discharge	Type of visit: Outpatient, Telehealth, Telephone Visits can be performed by medical assistants, LPN's, RN's to meet criteria
Medication reconciliation post-discharge (MRPD)	Medication reconciliation completed on the date of discharge through 30 days after discharge (31 total days)	Medications to be reconciled with discharge medications to current medication list. Documentation of medications reconciled, reviewed, or statement that no medications were prescribed/ordered upon discharged, meets criteria.

Exclusions	Patients are excluded if they are in hospice ■ In hospice or using hospice services in measurement year ■ Members who have died in measurement year
Tips for Success	■ Documentation of notification must include a date when the document was received. ■ Develop a centralized team or assigned roles to communicate with patients post-discharge. ■ Implement a standard post-discharge call template to reduce patient risk and readmissions that incorporates: - Medication reconciliation - Confirms a follow-up appointment is scheduled and kept - Assesses patient comprehension of his or her diagnosis and discharge instructions - Assesses patient's or caregiver's ability to self-manage medications - Incorporates knowledge of the "red flags" of a worsening condition and what to do or who to contact - Whom to contact for questions or concerns about their care going forward - Summary of the conversation through a medical record accessible by the patient or caregiver, or sent to the patient and caregiver ■ Include non-acute (surgical) admissions in post-discharge outreach and medication reconciliation, even if post-surgical treatment is being performed through a specialist. ■ Reduce errors at time of discharge by using a computer order entry system to generate a list of medications used before and during the hospital admission. ■ Ensure the medication list that was the result of reconciliation is in the chart note or can be pulled up in reference to the reconciliation later. EMR medication lists that update upon prescribing are not sufficient to demonstrate the medications that were in place upon reconciliation.

Resources

I. National Committee for Quality Assurance, HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans