HEDIS® Tip Sheet

Transitions of Care (TRC)

CarePartners of Connecticut's HEDIS Tip Sheets offer insights into specific HEDIS measures. These practices and tips can optimize HEDIS scores and identify opportunities to improve patient care.

The Transition of Care measure assesses the percentage of discharges for members 18 years of age and older who had each of the following. (Four rates are reported):

1. **Notification of Inpatient Admission**
2. **Receipt of Discharge Information**
3. **Patient Engagement After Inpatient Discharge**
4. **Medication Reconciliation Post-Discharge**

Below you'll find details on what documentation to provide for each.

Provider Best Practices

- **Integrate** (upload/scan) all documentation related to notification of admission and inpatient discharge to the appropriate outpatient medical record as soon as it is received.
- **Contact** your patient by phone within 7 days of notification of discharge to schedule a follow-up visit.
- **Perform** a medication reconciliation of current and discharge medications within 30 days of discharge.
- **Use** terms such as *follow-up hospitalization, admission, discharge,* and *inpatient stay* to document awareness of patient's hospitalization.
- **Document** a current medication list within each visit note.
- **Ensure** that all documentation is dated. Include an integration date for all external documents incorporated into the outpatient medical record.

Required Documentation

Notification of Inpatient Admission

Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received, integrated in the appropriate medical record, and accessible to the PCP or ongoing care provider (OCP). Notification and integration must occur on the day of admission through 2 days after admission (3 total days).

Examples:

- Communication between inpatient providers, ED providers, or specialists and the member's PCP/OCP via phone, email or fax
- Communication about admission to PCP/OCP through a health information exchange or communication through a shared EMR system*
- Indication that the PCP/OCP admitted the member to the hospital or placed orders for tests and treatments any time during the member's stay
- Documentation of a preoperative or preadmission exam/communication about a planned admission. This timeframe is not limited to day of admission through 2 days after admission.
- Emergency Department progress note indicating patient disposition: *Patient Admitted*

Receipt of Discharge Information

Include evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 days total) in the outpatient medical record with evidence of the date when the documentation was received by PCP/OCP and integrated into the appropriate medical record.

Information must include **all** of the following:

- Practitioner responsible for 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 for patient care post-discharge

Examples: Discharge summary or summary of care record filed in the outpatient medical record*

Patient Engagement After Inpatient Discharge

Documentation of patient engagement provided within 30 days after discharge in the outpatient medical record. Patient engagement cannot occur on date of discharge.

Examples: An outpatient visit including office, home, telehealth, phone, or email communication from the **day after** discharge through 29 days (30 days total). If the member is unable to communicate with the provider, interaction between the member's caregiver and provider meets criteria.

Medication Reconciliation

Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after discharge (31 total days). Please include a reference to hospital admission in the follow-up visit note after discharge.

Include a **date, current medication list** and **documentation of one** of the following:

- Reconciliation of current and discharge medications
- Reference to discharge medications (i.e., no changes to medications post-discharge, same medications post-discharge, discontinue all discharge medications, discharge medications were reviewed)
- A notation that the discharge medications were reviewed or that the current medication list and discharge medication list were reviewed on the same date of service
- Evidence that the member was seen for post-discharge follow up including an indication that the provider was aware of the hospitalization or discharge
- Documentation in the discharge summary that discharge medications were reconciled with the most recent medication list. The discharge summary must be filed in the outpatient medical record on the day of discharge through 30 days after discharge.
- No medications were prescribed or ordered upon discharge

Examples: An outpatient visit including office, home, telehealth, phone, or email communication from the **day of discharge** through 30 days (31 days total) with a current medication list and evidence that the provider was aware of the inpatient stay, or a discharge summary filed in the outpatient medical record.

Exclusions

Members in hospice or using hospice services are excluded.

**Must clearly show PCP/OCP access to the EMR or the date the information was accessible to them.*