BlueCross BlueShield of Illinois

HEDIS® Measure

Transitions of Care

Transitions of Care (TRC) is included in the Blue Cross and Blue Shield of Illinois (BCBSIL) Quality Improvement (QI) program for Blue Cross Community MMAI (Medicare-Medicaid Plan)SM members.

The **MMAI Healthcare Effectiveness Data and Information Set (HEDIS) TRC guideline** is for Medicare members, 18 years of age and older, who are admitted to an acute care or nonacute inpatient setting and are subsequently discharged to their place of residence (e.g., their home or skilled nursing facility).

Only documentation in the member's outpatient record meets criteria for this measure, and only one outpatient medical record can be used for all indicators reported. The documentation should be from the member's primary care physician (PCP) or ongoing care provider.

The measure consists of the following:

1. **Notification of Inpatient Admission**
   Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days).
2. **Receipt of Discharge Information**
   Documentation of receipt of discharge information on the day of discharge through two days after the discharge date (three days total).
3. **Patient Engagement After Inpatient Discharge:**
   Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
4. **Medication Reconciliation Post-Discharge:**
   Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Notification of Inpatient Admission

There must be documentation in the member's outpatient medical record that the PCP or ongoing care provider was notified of an inpatient admission on the day of admission or within two days after the admission (three total days).

Documentation in the medical record would include any of the following:

- A phone call, email or fax from or between the inpatient providers or staff and the member's PCP or ongoing care provider.
- A phone call, email or fax from or between the emergency department and the member's PCP or ongoing care provider.
- Notification about an admission to the member's PCP or ongoing care provider through:
  - a health information exchange
  - a discharge and transfer (ADT) alert system
  - an automated admission
  - a shared electronic medical record system
- Notification about an admission to the member's PCP or ongoing care provider from the member's health plan.
- A note or documentation that the member's PCP or ongoing care provider admitted the member to the hospital.
- A note or documentation that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider.
- A note or documentation that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay
- Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system. When using a shared EMR, documentation of a "received date" is not required to meet criteria.
  - Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission or within two days after the admission (three total days) meets criteria.

Entries showing that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned inpatient admission is not limited to the day of admission or the following day.

To meet criteria for a Planned Admission there must be documentation in the outpatient record showing:

- The PCP or ongoing care provider performed a preadmission exam **OR**
- The PCP or ongoing care provider received notification of a planned admission prior to the admit date

The planned admission documentation or preadmission exam must clearly pertain to the denominator event.

Receipt of Discharge Information

There must be documentation in the member's outpatient medical record that the PCP or ongoing care provider was notified or received discharge information on the day of discharge or within two days after the discharge (three total days). The discharge would be from an acute care or nonacute inpatient setting and a subsequent discharge to the member's place of residence (e.g., their home or skilled nursing facility).

- Documentation in the outpatient record must include evidence of receipt of discharge information on the day of discharge or within two days after the discharge (there total days) with evidence of the date when the documentation was received.
- Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR.

At a minimum, the following discharge information must be documented in the medical record:

- Practitioner responsible for the member's care in 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.

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 or within two days after the discharge (three total days).
- When using a shared EMR system, documentation of a "received date" in the EMR is not required to meet criteria. The discharge information must be filed in the EMR and accessible to the PCP or ongoing care provider on the day of discharge through two days after the discharge (three total days) meets criteria.

Medication Reconciliation Post-Discharge

Documentation in the outpatient medical record must include evidence that medication reconciliation occurred between the discharge medications and the medications the member was prior to admission. The medication reconciliation may be conducted by a prescribing practitioner, clinical pharmacist or a registered nurse. The member does not have to be present to perform the medication reconciliation.

The medication reconciliation may occur on the date of discharge through 30 days after discharge (31 total days) and must be notated in the member's outpatient medical record as evidenced by:

- Notation of the member's current medications with an entry that the provider reconciled the current and discharge medications.
- Notation of the current medications with an entry that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Notation in the member's outpatient record of the current medications and an entry that the discharge medications were reviewed.
- Notation of a current medication list, a discharge medication list and an entry that states both lists were reviewed on the same date of service.
- Notation of the current medications with evidence that the member was seen for post-discharge hospital follow-up and an entry stating that medication reconciliation or review was conducted.
  - Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge.
- Notation 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 or within 30 days after discharge (31 total days).
- Notation that no medications were prescribed or ordered upon discharge.

Patient Engagement After Inpatient Discharge

Patient engagement must be completed and documented in the member's outpatient medical record within 30 days after the date of discharge. Patient engagement on the date of discharge does not meet criteria.

- Patient engagement post-discharge will meet criteria if conducted through any of the following:
  - 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 (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider)

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