healthfirst
Health Insurance for New Yorkers

Transitions of Care (TRC)
Best Practices Guide

By partnering with you, 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 guide provides key details of the HEDIS measure and best practices for Transitions of Care (TRC).

TRC has four sub-measures which the Centers for Medicare & Medicaid Services (CMS) will average into one composite measure for the Medicare Stars* program.

The measure assesses the percentage of discharges for members 18 years of age and older who had each of the following:

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

1. Notification of Inpatient Admission

How to be measure compliant:
Documentation in the **outpatient medical record** must include evidence that notification of inpatient admission was received within three days (day of admission through two days after).

Best Practices:		
Investigate and implement a process to receive auto alerts when a member is admitted to or discharged from an inpatient facility or ER (e.g., Healthix, Regional Health Information Organization).	☐	Date:
Implement methods to notify other providers (PCPs, behavior health specialists, other medical specialists, and health home providers) and members' health plan. Be sure to include reason for admission and risk assessment.	☐	Date:

healthfirst
Health Insurance for New Yorkers

Transitions of Care (TRC)
Best Practices Guide

2. Receipt of Discharge Information

How to be measure compliant:
Documentation in the **outpatient medical record** must include evidence of receipt of discharge information within three days (day of discharge through two days after). The discharge information must include all the following:

- The provider responsible for the member's care during the inpatient stay
- Procedures or treatment provided
- Diagnosis at discharge
- Current medication list
- Testing results, or documentation of pending tests/no pending tests
- Instructions for patient care post-discharge

Best Practices:		
Communicate between inpatient providers and the member's PCP through phone call, email, fax, HIE ADT alert, or a shared EMR.	☐	Date:
Discharge information may include, but is not limited to, a discharge summary or summary of inpatient care record; documentation of test/procedure results; or documentation of pending tests/scheduled follow-up. Information must be maintained in the member's medical record within three days of discharge from an inpatient hospitalization.	☐	Date:
When using a shared EMR system, documentation of a "received date" is not required. Evidence that the information is filed and accessible in the EMR meets the criteria.	☐	Date:
Work with other involved providers to obtain or create a shareable care plan. Reinforce and revise as necessary.	☐	Date:
Create a process (e.g., Care Team huddles) to communicate member's discharge progress and plan of action.	☐	Date:

healthfirst
Health Insurance for New Yorkers

Transitions of Care (TRC)
Best Practices Guide

3. Patient Engagement After Inpatient Discharge

How to be measure compliant:
Documentation of patient engagement (e.g., office visits, visits to the home, telehealth visit) provided within 30 days after discharge.

Best Practices:		
Schedule a follow-up appointment with PCP and member before discharge.	☐	Date:
Schedule follow-up appointments as appropriate. Call to remind the member about upcoming appointments, and to bring a medication list, discharge summary, any relevant discharge information, insurance information, and a list of questions for the provider.	☐	Date:
Address member/caretaker barriers to attending the follow-up appointment (e.g., transportation, financial issues, language, etc.).	☐	Date:
Recommended code to use for quality credit: **Patient Engagement** Patient Engagement After Inpatient Discharge 99201-99397		

healthfirst
Health Insurance for New Yorkers

Transitions of Care (TRC)
Best Practices Guide

4. Medication Reconciliation Post-Discharge

How to be measure compliant:
Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). Must be completed by a prescribing provider (MD, DO, NP, PA, clinical pharmacist).

Best Practices:		
Create a standard process for reconciling members' medications upon admission intake and discharge.	☐	Date:
Review the reconciled medication list with member/caregiver. Offer a simple and easy-to-follow medication list tool. Refer member—or caregiver, if member is unable to understand or manage their medications—to home health services for medication management support.	☐	Date:
Provide the medication list to the PCP/behavioral health provider and member/caregiver during the discharge appointment. Include a care summary, care plan, and any relevant tests.	☐	Date:
Document in notes that the discharge medication list has been reconciled and reviewed. Ensure that the discharge summary with listed medications is uploaded to providers' EMR.	☐	Date:
Recommended code to use for quality credit: **Medication Reconciliation Post-Discharge (CPT-CAT-II)** Discharge medications reconciled with the current medication list in outpatient medical record (COA) (GER) 1111F		

*Every year, Medicare evaluates plans based on a 5-star rating system.

Coverage is provided by Healthfirst Health Plan, Inc., Healthfirst PHSP, Inc., and/or Healthfirst Insurance Company, Inc. (together, "Healthfirst").

© 2021 HF Management Services, LLC
1480-21