Transitions of Care: Guide to Compliance

HEDIS measure Transitions of Care (TRC) assesses key points of transition for Medicare and Dual-Eligible Special Needs Plan (D-SNP) Members following their discharge from an inpatient setting.

Of the four TRC sub-measures, two are rated based on documentation, rather than claims. The following information can be used by practices as a guide for how to successfully achieve compliance with proper documentation.

Measure Intent: Coordination of care to promote patient safety between inpatient and outpatient settings. Settings include acute inpatient facilities (hospitals) and non-acute inpatient facilities (rehabilitation centers, skilled nursing facilities, and long-term care facilities).

TRC Sub-Measures	How to Achieve Compliance to Maximize TRC Rates
1. **Notification of inpatient admission** must occur on the date of admission through two days after admission. Documentation must include evidence of the date it was transmitted to and received by the outpatient practice (PCP, or Ongoing Care Provider**). Compliance is achieved through medical record documentation only. There are no codes to apply for this sub-measure.	• Identify and copy patient's PCP in all hospital documentation • Copy PCP in documentation of planned admissions such as pre-op clearance exams or consultations • Outpatient practices must document evidence that notification of inpatient admission was received in the outpatient record within the required 48 hour timeframe (a fax cover sheet or legible date/time stamp is evidence)* • Documented ADT or RHIO/HIE notifications of admission are acceptable • Consider configuring EHR systems with a dated outbound communications section (printable)

TRC Sub-Measures	How to Achieve Compliance to Maximize TRC Rates
2. **Receipt of discharge information** must occur on the date of discharge through two days after discharge. Documentation must include evidence of the date it was transmitted to and received by the outpatient practice (PCP or Ongoing Care Provider**). Compliance is achieved through medical record documentation only. There are no codes to apply for this sub-measure.	Discharge information must include all the following: • Practitioner responsible for Member's care during the inpatient stay at that facility • 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 RHIO/HIE discharge information is compliant if each element is noted.
3. **Medication reconciliation post-discharge** sub-measure can be closed with a CPTII claim or documentation that medications were reconciled on the day of discharge or within 30 days after discharge.	Use CPTII code 1111F: Discharge medications reconciled with the current medication list in the outpatient medical record.
4. **Patient engagement post-discharge** sub-measure can be closed with a CPT claim or a visit notation to indicate knowledge of Member's inpatient hospitalization, within 30 days after discharge.	Use CPT code 99496: Transitional Care Management. Direct contact with patient or caregiver within two days of discharge or face-to-face visit within seven days. Use CPT code 99495: Transitional Care Management. Direct contact with patient or caregiver within two days of discharge or face-to-face visit within fourteen days.

*When using a shared EHR system, documentation of a "received date" in the EHR is not required to meet criteria. Evidence that the information was filed in the EHR and is accessible to the PCP or Ongoing Care Provider within the required timeframe is compliant for sub-measures one and two.

**The Ongoing Care Provider renders inpatient care for the stay and follows in an outpatient setting post-discharge (surgeon, interventionalist, specialist).