Transition of Care (TRC)

5-Star Best Practices

What It Measures: The percentage of discharges for adult patients who had all four actions completed: Notification of Inpatient Admission, Receipt of Discharge Information, Patient Engagement After Inpatient Discharge, and Medication Reconciliation Post-Discharge.

Who Is Eligible: Inpatient or SNF discharge on or between January 1 and December 1 of the measurement year. This excludes patients in hospice or using hospice services during the measurement year. Every patient discharge is eligible.

Reporting Requirements: Every time patients are discharged (acute and non-acute), the following documentation is patient discharge is eligible:

Notification of Inpatient Admission:

> Within the day of or the following 2 days after inpatient admission (3 total days)

> Notification of inpatient admission includes:

- Notification via phone call, email, or fax
- Electronic health information exchange (HIE)
- ADT Feed (electronic data feed)
- Shared Electronic Medical Record (EMR)

> The information may be submitted via medical record system accessible to PCP or communication from the Health Plan.

> *Best Practice:* Proof of timely, automated receipt of notice of inpatient submission in PCP EMR and signed off.

Receipt of Discharge Information:

> Within the day of or the following 2 days after discharge (3 total days)

- Discharge information is a discharge summary containing all of the following:
  - Name of the practitioner responsible for the patient's care during the inpatient stay
  - Instructions for patient care post discharge
  - Procedures or treatment provided
  - Diagnoses at discharge
  - Medication list at discharge
  - **Testing results, pending tests, or "no tests pending"**

> This information may be submitted via medical record system accessible to the PCP

> *Best Practice:* Proof of timely receipt of discharge summary is in PCP EMR and signed off

Patient Engagement After Inpatient Discharge:

> Must happen within 30 days after discharge (but not on the date of discharge)

> Patient engagement is defined as office visits, home visits, telehealth, or transitional care management services

> The encounter may be performed by any member of the Primary Care Provider team (MA, LVN, etc.) and can be with the member's caregiver if the member is unable to communicate with the provider

> *Best Practice:*

- Follow-up visit within 7 days of discharge with the PCP
- During the post discharge visit, review discharge instruction and reconcile inpatient and outpatient medications

Medication Reconciliation Post-Discharge (MRP) (this measure is unchanged):

> On the date of discharge through 30 days after discharge (31 total days)

> Medication reconciliation is defined as medication reconciliation between A and B:

A. The last medication list in the outpatient record prior to the inpatient admission

B. The discharge medication list

> The medication list may include medication name only

> This encounter may be submitted through **1111F**

> This may be conducted by an MA or LVN if co-signed by the provider in person or via telehealth

> The intent of the measure is to ensure the patient is taking the correct medication

> *Best Practice:*

- Medication list includes medication names, dosages and frequency, over-the-counter medications and herbal or supplemental therapies
- Review medications reconciled with the patient

For more information on Medication Reconcilation Post-Discharge and Patient Engagement After Inpatient Discharge eligible code categories, please contact **NetworkQuality@scanhealthplan.com**.

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Medical Group Guidelines

How to Close the Gap in Care:

Ensure the medical record include a signed and dated progress note to include:

- Statement: "Hospital (or skilled nursing facility) discharge medications were reconciled with the current outpatient medications".
- A current medication list in the outpatient record dated the same DOS as the medication reconciliation post discharge or a current medication list within the signed and dated progress note.
- Confirmation receipt of discharge information and notification of inpatient admission with evidence it was received within 2 days of discharge (Documentation of a "received" date is not required when using a shared EMR system).
- Mode of patient engagement within 30 days of inpatient discharge including the reconcililation of in patient and outpatient medications.

What It Is: Primary care teams document and report the notification of a patient's inpatient admission, receipt of discharge information, patient engagement after inpatient discharge, and reconciliation of discharge medications with the most recent medication lists in outpatient medical records.

How it is Measured:

- *Denominator:* Inpatient or SNF discharge during the measurement year. Excludes patients in hospice or using hospice services during the measurement year. Every patient discharge is eligible.
- *Numerator:* Dated progress notes on all four actions in the medical record as indicated under "Reporting Requirements" on the reverse of this tip sheet.

What You (the Medical Group) Can Do:

- Set up a care transition team to:
  - Ensure timely communication between inpatient and outpatient teams including notification of admission and discharge.
  - Schedule appointments for patients preferably within 7 days, but up to 30 days of inpatient or SNF discharge.
  - Have an RN or pharmacist do the medication reconciliation and send it to the PCP or ongoing care provider.
- Automate notification of patient admission from the hospital to the medical group (278N) with subsequent automatic, electronic transmission of that information to the patient's PCP.
- MRP encounters may be submitted through **1111F**, 99483, 99495, and 99496.
- Rapidly receiving discharge summaries and immediately making them available for physicians to access.
- Transmitting timely notification of admission and discharge to the medical group. Medical groups should make these notifications accessible to the PCP.
- *Educate care teams about the measure.* Share the guidelines and best practices provided here.