Transition of Care (TRC)

Overview

- Transitions of care is about ensuring that patients have a seamless care coordination from one setting of care to another
- Settings of care may include hospitals, ambulatory primary care practices, ambulatory specialty care practices, long term care facilities, home health and rehabilitation facilities
- TRC include 4 components
  - ❑ Notification of inpatient admission
  - ❑ Receipt of Discharge Information
  - ❑ Patient Engagement after inpatient discharge
  - ❑ Medication Reconciliation post-discharge

https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/

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WHY IS IT IMPORTANT

- It's vital that provider groups are informed and receive notifications of patient's hospitalization from admission to discharge, to ensure that there is a safe and effective transfer of responsibility, because patient's medical care relies on effective provider communication with patient comprehension of discharge instructions
- Transitions increase the risk of adverse events due to the potential for miscommunication as responsibility is given to new parties
- Hospital discharge is a complex process representing a time of significant vulnerability for patients

Understanding the Measure

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- How is someone identified for the measure:
  - Members 18 years of age and older who was admitted in the hospital and was discharged to an outpatient setting from January 1 to December 1 of current year

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

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TALKING POINTS WITH PROVIDER GROUPS

- Discuss with provider groups that TRC is about coordination of care after being discharged from the hospital during the current year between January 1 and December 1 and the importance of post hospital outpatient visit within 30 days
- Review with provider groups the 4 components of TRC for patients to be compliant
- Verify with provider groups that they are instructing their patients to notify them when admitted in the hospital and upon discharge make a follow up appointment
- Verify with provider groups that they have available appointments for patients that need post hospital discharge visit
- Remind provider groups to instruct their patients during their clinic visits, to contact them when admitted in the hospital

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PROVIDER GROUP'S KEYS TO SUCCESS

- Encourage provider groups to have available appointments for patients that need post hospital f/u visits or offer telehealth visit if in-person appointment is not available
- Remind provider groups that Admission and Discharge Notification must be in outpatient medical record that is accessible to the Primary Care Provider (PCP) or Ongoing Care Provider (OCP)
- With a shared EMR, a separate "received" date is not required. However, there must be evidence the information was filed or uploaded into the EMR and available for the PCP or OCP on the day of discharge or within 2 days after discharge
- Remind provider groups that medication reconciliation can be done via telephone by an RN

Resources

- HEDIS Quick Reference Guide (page 28)
- Adult Pocket Guide
- MRP Flyer
- CPT II Codes Flyer