



HEDIS[®] Measure – Transition of Care

Transition of Care is a new 2018 Healthcare Effectiveness Data and Information Set (HEDIS) measure introduced by the National Committee Quality Assurance (NCQA) and pertains to Blue Cross Community MMAI (Medicare-Medicaid Plan)SM and Blue Cross Medicare AdvantageSM (HMO and PPO) members. The HEDIS measure collects data on the care coordination given by the member's Primary Care Provider (PCP) or ongoing care provider as documented in the member's outpatient record.

The Transition of Care guidelines address the change that occurs when a member, 18 years of age or older, is discharged from an acute care setting or non-acute setting to an outpatient self-care setting. The intent of the measure is to improve care coordination during the care transitions for an at-risk population including older adults and other individuals with complex health care needs.

If a member is transferred from an acute to a non-acute setting, the discharge will be reviewed if the member is discharged to a self-care setting.

Only one outpatient medical record can be used for all four indicators below.

- Notification of inpatient admission
- Receipt of discharge information
- Patient engagement after inpatient discharge
- Medication reconciliation post-discharge

REQUIRED DOCUMENTATION

1. Notification of Inpatient Admission

Documentation must include evidence of receipt of notification of inpatient admission on the day of admission or the following day

Admission refers to the date of inpatient admission or date of admission for an observation stay that turns into an inpatient admission.

Documentation must include evidence of receipt of notification of inpatient admission with a date/time stamp. Any of the following examples meet criteria:

- Communication *between inpatient providers or staff and the member's PCP or ongoing care provider* (e.g. phone call, email, fax)
- Communication between *emergency department and the member's PCP or ongoing care provider prior to admission* (e.g. phone call, email, fax)
- Communication about admission to the member's PCP or ongoing care provider *through a health information exchange; an automated admission discharge and transfer (ADT) alert system*
- Communication about admission to the member's PCP or ongoing care provider *from the member's health plan*
- Indication that the member's *PCP or ongoing care provider admitted the member to the hospital*
- Indication that a *specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider*
- Indication that the *PCP or ongoing care provider placed orders for tests and treatments during the member's inpatient stay*
- Indication that the *admission was elective and the member's PCP or ongoing care provider was notified or had performed a preadmission exam*

NOT ACCEPTABLE

Notification of Inpatient Admission:

- Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission does not count
- Documentation of notification that does not include a time frame or date/time stamp or is not in the specified timeframe does not count.

2. **Receipt of Discharge Information**

Documentation must include evidence of receipt of discharge information on the day of discharge or the following day.

Documentation must include evidence of receipt of discharge information on the day of discharge or the following day. Discharge information may be included in a discharge summary or summary of care record or be located in structured fields in an Electronic Medical Record (EHR). **At a minimum, the discharge information should include all of the following:**

- The practitioner responsible for the member's care during the inpatient stay
- Procedures or treatment provided
- Diagnoses at discharge
- Current medication list (including allergies)
- Testing results, or documentation of pending tests or no tests pending
- Instructions for patient care

Discharge information may be included in a discharge summary or summary of care record or be located in structured fields in an EHR.

3. **Patient Engagement After Inpatient Discharge**

Documentation must include evidence of patient engagement within 31 days after discharge.

Either of the following meets criteria:

- An outpatient visit, including office visits and home visits
- A synchronous telehealth visit where real-time interaction occurred between the member and provider via telephone or videoconferencing

4. **Medication Reconciliation Post-Discharge**

Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed.

Any of the following meet criteria:

- Documentation of the current medications with a notation that the provider reconciled the current and discharge medications
- Documentation of the current medications with a notation that references the discharge medications
- Documentation of the member's current medications with a notation that the discharge medications were reviewed
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review

- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record.
- Notation that no medications were prescribed or ordered upon discharge

ACCEPTABLE

Only documentation in the outpatient chart meets the intent, but an outpatient visit is not required.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a health care provider. Physicians and other health care providers are to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment.

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