Transitions of Care (TRC)

CareOregon Advantage

Who: Members 18 years and older who had a hospital stay in the measurement year. (Measurement year: the 12-month timeframe between January 1st - December 31st in which the service was rendered).

Why: Comprehension of and compliance with discharge instructions can reduce emergency department visits and rehospitalizations, improve post-discharge health outcomes, and decrease health care expenditures.

What: The average of the rates of discharges for members 18 years of age and older who had each of the following.

Four rates are reported:

- ***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).

How:

- ***Notification of Inpatient Admission:*** Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received. All forms of notification MUST include admission date.

  Any [*ONE*] 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 about admission between emergency department and the member's PCP or ongoing care provider (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, or discharge and transfer (ADT) alert system.
  - Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system. When using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after the admission (3 total days) meets criteria.
  - 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 any time during the member's inpatient stay.
  - Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The time frame that the

planned inpatient admission must be communicated is not limited to the day of admission through 2 days after the admission (3 total days); documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria. The planned admission documentation or preadmission exam must clearly pertain to the denominator event.

Note – Notification of admission by member or the member's family does not meet criteria.

- ***Receipt of Discharge Information:*** Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) with evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR.

  At a minimum, the discharge information must include [ALL] the following:
  - The practitioner responsible for the member's care during the inpatient stay.
  - 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
- ***Patient Engagement After Inpatient Discharge:*** Documentation of patient engagement provided within 30 days of discharge. Do not include patient engagement that occurs on the date of discharge.

  Any [ONE] of the following meet criteria:
  - An outpatient visit, including office visits and home visits.
  - A telephone visit.
  - A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication.
  - An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider).

Note – If the member is unable to communicate with the provider, interaction between the member's caregiver and provider meet criteria.

Any one of the following codes submitted within 30 days of discharge meet the measure:

CPT: 98000, 99495, 99496

- ***Medication Reconciliation Post-Discharge:*** Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days).

  Any [ONE] 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 medication with a notation that references the discharge medications (e.g. no changes in medications since discharge, same medications at discharge, discontinue all 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. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge.
- Documentation in the Discharge Summary that the discharge medications were reconciled with the most recent medication list in the outpatient record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- Notation that no medications were prescribed or ordered upon discharge.

Any one of the following codes submitted within 30 days of discharge meet the measure:

CPT Codes: 99483, 99495, 99496, 99605, 99606
CPT-II Codes: 1111F

Exclusions:

- Members in hospice.
- Members that do not have continuous enrollment from the date of discharge through 30 days after discharge (31 total days).
- Members who die anytime during the measurement year.

Cut Points: Cut points demonstrate the rates that need to be reached to achieve the specific star rating.

1 Star: Less than 44%
2 Star: 44% to less than 56%
3 Star: 56% to less than 69%
4 Star: 69% to less than 79%
5 Star: Greater than or equal to 79%

Data Info:
Performance Measure Set: Medicare Stars Measure
Quality Measurement Type: Outcome
Data Type: Claims, chart documentation
CMS National Average: 63%

Tips for Success:

- Receipt of discharge information: note that Hospital/Skilled Nursing Facilities/Other Acute Inpatient are all considered inpatient discharging facilities. If the documentation is received via fax, the document must have a fax timestamp on the uploaded document in the EMR.

- Patient engagement: patient engagement with the PCP, RN, MA or other staff meets criteria. If the engagement is not claim eligible, CareOregon chart review can close the measure gap.

- Notification of Inpatient Admission/Receipt of Discharge Information: monitor ADT systems for patient admissions (hospital) and inpatient discharges (hospital/SNF, etc.)

and communicate with the inpatient provider for timely receipt of documentation if the stay was outside your health system and/or not accessible via CareEverywhere.

- Engage with community partners (State or County case managers if applicable, CareOregon etc) if the patient is at risk of missing post-discharge followup care.
- Medication reconciliation:
  - Ensure members have valid prescriptions, their medication lists are up to date, and that all medications have an appropriate number of medication refills available.
  - Utilize health maintenance alerts to identify members that will need follow up visits or other clinical outreach.
  - Address short supplies of new medications written at hospital discharge and coordinate care with specialists as appropriate.
  - Address any recommendations made by the CareOregon pharmacist as part of our medication reconciliation. This document will be faxed to you within 7-10 days of the member's discharge.