

Care coordination

Transitions of Care (TRC)

Transitions of Care (TRC) Measure year 25 | Weight = 1 (with four component measures)

Overview

The Transitions of Care (TRC) measure assesses instances of admission and discharge information delivered to a patient's physician, as well as evaluating patient engagement provided within 30 days after an acute or nonacute discharge on or between Jan. 1 and Dec. 1 of the measurement year for patients 18 years of age and older.

The TRC measure organizes patient care and follow-up activities after a hospital admission and discharge. There are four components that contribute to the TRC score, and each requires engagement from the primary care physician (PCP) within a certain period of time, as listed below.

- Notification of Inpatient Admission (TRC-NIA)
- Receipt of Discharge Information (TRC-RDI)
- Patient Engagement After Inpatient Discharge (TRC-PED)
- Medication Reconciliation Post-Discharge (TRC-MRP)

For all the components, take note if the patient is readmitted or transferred directly to an inpatient care setting within 30 days of discharge. In this event, use the first admission's admit date and the discharge date of the last discharge.

Exclusions

- Patients in hospice, using hospice services or receiving palliative care anytime during the measure year
- Patients who died anytime during the measurement year
- Discharges occurring after Dec. 1 of the measurement year

Measure best practices

- Have processes in place with hospitals to facilitate sharing of admission and discharge information.
- Be aware of patients' inpatient stays and obtain timely discharge summaries.
- Review discharge summaries to ensure that the minimum required information is included.
- Have processes to accommodate scheduling appointments as close to the point of discharge as possible, ideally within seven days. If a patient cannot be seen within seven days, checking in with patients by telephone is highly encouraged.
- Ensure all notifications of admits or discharges are appropriately documented in patient charts and follow-up actions are conducted.

Notification of Inpatient Admission (TRC–NIA) MY25

Measurement period

January–December

Applicable data collection method

Medical record review only

Action needed for compliance

- PCP practice must document, in the patient's outpatient medical record, receipt of notification of inpatient admission on the day of admission or within the two following days (three days total).
- Evidence must include the date the documentation was received.

Service required

Documentation in the patient's outpatient medical record of the admission communications:

- Between inpatient providers or staff and the PCP or ongoing care provider
- Between the emergency department (ED) and the PCP
- From a health information exchange or an automated admission, discharge and transfer (ADT) alert system
- Through a shared electronic health record (EHR) for first system (received date is not required but must have been accessible to the PCP on the day of admission or within the two following days)
- From the patient's health plan

There are no procedure codes that can be submitted via claims to address TRC–NIA. Information is collected via health plan medical record review only.

- If an observation stay turns into an inpatient admission, the admit notification must be documented as being received on the admit date of the observation stay or within the two following days.
- For planned admissions, documentation of a preadmission exam or advance admission notification is acceptable and:
 - Must clearly apply to the admission event and include a time frame for the planned inpatient admission
 - Is not limited to the admit date or the two following days

There may be other indications in the outpatient medical record about the admission if:

- The PCP admitted the patient or ordered tests and treatments anytime during the patient's inpatient stay.
- A specialist admitted the patient and notified the PCP.
- There is documentation that the PCP performed a preadmission exam for—or received communication about—a planned inpatient admission.

Receipt of Discharge Information (TRC–RDI) MY25

Measurement period

January–December

Applicable data collection method

Medical record review only

Action needed for compliance

- PCP practice must document discharge receipt information on the day of discharge or within the two following days (three days total).

Service required

Documentation must include:

- Name and credentials of the physician or practitioner responsible for the patient'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 to the PCP or ongoing care provider for patient care

If using a shared EHR system, evidence that the information was filed in the EHR and accessible to the patient's PCP on the day of discharge or within the two following days meets criteria—and “received date” isn't required.

Patient Engagement After Inpatient Discharge (TRC–PED) MY25

Measurement period

January–December

Applicable data collection methods

Administrative and hybrid

Eligible population

Patients 18 years of age and older who were discharged from an inpatient facility

Service required

- Engagement must take place within 30 days of discharge.
- Engagement that takes place on the day of discharge is not measure compliant.
- Follow up with patients as soon as possible following an acute stay discharge to prevent readmission and ensure understanding of post-discharge instructions.
- Medication reconciliation can be performed on the day of discharge. If that has not happened, be sure to do so at the follow-up event.

Note: If a patient is unable to communicate, their PCP can interact with their caregiver for any reason, including setting up an appointment.

The engagement can take place via any of the following ways:

- Outpatient visits, including office or home visits
- A telephone visit
- Synchronous telehealth visit where real-time interaction occurred between the patient and their PCP with audio and video communication
- Asynchronous or e-visits/virtual check-ins that are not real time

Medication Reconciliation Post-Discharge (TRC–MRP) MY25

Measurement period

January–December

Applicable data collection methods

Administrative and hybrid

Eligible population

Patients 18 years of age and older who were discharged from an inpatient facility

Service required

- Medications must be reconciled by an approved provider on the date of discharge up to 30 days after discharge (31 days total). However, follow up with patients as soon as possible after discharge to avoid duplication or dangerous reactions.
- Medication reconciliation must be conducted by an approved provider, e.g., prescribing practitioner, clinical pharmacist or registered nurse.
- Documentation must reference both the current medication and the discharge medication in order to meet HEDIS measure criteria
- Licensed practical nurses (LPNs) and other nonlicensed staff can perform the medication reconciliation, but it must be co-signed anytime in the measurement year by an approved provider.
- When patients are directly transferred to another facility, perform reconciliation for final discharge.

Different codes will be required depending upon when the MRP is conducted. Refer to most recent coding information

Healthcare Effectiveness Data and Information Set (HEDIS®)

Code	Definition
98966, 98967, 98968, 99441, 99442, 99443, 99483	Telehealth visit (audio only)
99495, 99496	Transitional care management service
98969, 98970, 98971, 98972	Online assessments

The coding information in this document is subject to changing requirements and should not be relied on as official coding or legal advice. All coding should be considered on a case-by-case basis and supported by medical necessity and appropriate documentation in the medical record.

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