BlueCross BlueShield of North Carolina MEDICARE

September 2023

HEDIS Measurement Year 2023 Documentation for Transitions of Care (TRC)

Please note, this communication applies to Healthy Blue + Medicare[SM] (HMO D-SNP) offered by Blue Cross and Blue Shield of North Carolina.

HEDIS® is a widely used set of performance measures developed and maintained by the NCQA. These are used to drive improvement efforts surrounding best practices.

Measure Description

The percentage of discharges for members 18 years of age and older who had each of the following:

- Notification of inpatient admission (can only be captured through medical record review)
- Receipt of discharge information (can only be captured through medical record review)
- Patient engagement
- Medication reconciliation post-discharge

What We Are Looking for in Care Provider Records:

- **Notification of inpatient admission** — documentation in the outpatient medical record must include evidence of receipt for notification of inpatient admission on the day of admission through two days after the admission (three total days) with evidence of the date when the documentation was received. Any of the following examples meet criteria:
  - Communication about admission between inpatient care providers or ER and the member's PCP or ongoing care provider (for example, phone call, e-mail, fax, information exchange, automated alert system, shared electronic medical record, or from the member's health plan)
  - Indication that the 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 preadmission exam or planned inpatient admission must be

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https://www.bluecrossnc.com/providers/networks-programs/blue-medicare-providers/healthy-blue-medicare

Blue Cross and Blue Shield of North Carolina Senior Health, DBA Blue Cross and Blue Shield of North Carolina, is an HMO D-SNP plan with a Medicare contract and a NC State Medicaid Agency Contract (SMAC). Enrollment in Blue Cross and Blue Shield of North Carolina Senior Health depends upon contract renewal.

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communicated is not limited to the day of admission through two days after the admission (three total days)

- **Receipt of discharge information** — documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through two days after the discharge (three 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 in the structured fields in an electronic health record. At a minimum, the discharge information must include the following:
  - The practitioner responsible for the member's care during the inpatient stay
  - Procedures or treatments 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** — documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any 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 care 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 care provider)
- **Medication reconciliation** — documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse. Any of the following meet criteria:
  - Documentation of the current medications with a notation that the care provider reconciled the current and discharge medications
  - Documentation of the current medications with a notation that references the discharge medications (for example, no changes in medications since discharge, same medication 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 follow-up requires documentation that indicates the care 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 medical record.

There must be evidence 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
- **Exclusions:**
    - Evidence of hospice or palliative services in 2023
    - Evidence patient expired in 2023

Helpful Hints:

- Documentation of a procedure/surgery that is typically performed inpatient (such as, aortic bypass) does not indicate that the care provider is aware of the hospitalization. Documentation of post-op/surgery follow-up alone does not indicate the care provider was aware of the hospitalization or discharge. **Make sure documentation references *the hospitalization, admission*, or *inpatient stay*.**
- If performing a pre-admission exam, document that it is a pre-admission exam.
- If performing a pre-surgical, pre-operative, or surgical clearance exam, the date of the admission must be documented.
- Implement process to receive automated alerts when a member is admitted or discharged from an inpatient facility.
- Review discharge medications with the member.
- Schedule post-hospital discharge following appointments and have the office call the member to remind them.
- Document a received date for discharge summaries and notification of inpatient admissions.
- Use the appropriate billing codes for *Medication Reconciliation and Patient Engagement*.