HEDIS® Hybrid Measure Abstraction: TRC

Prepared for: 9th Annual HEDIS® Training Webinar
December 9, 2019
HEDIS® 2020 Tech Specs Changes/Updates
Section: Effectiveness of Care - Medication Management and Care Coordination
Page: 305

Summary of changes from 2019:

- Modified value sets to make them compatible with digital measure formatting.
- Removed “with or without a telehealth modifier” language; refer to General Guideline 43.
- Added instructions for identifying acute inpatient events that occur between the admission and discharge dates of a nonacute inpatient stay.
- Clarified in the Notification of Inpatient Admission and Receipt of Discharge Information numerators that a “received date” is not required when reporting the indicators using a shared EMR system.
Summary of changes (continued):

- Added a Note to the Notification of Inpatient Admission numerator to clarify that provider notification that a patient was sent to the ED does not meet criteria if the ED visit results in inpatient admission.
- Clarified in the Receipt of Discharge Information numerator that the required discharge information must be in the appropriate medical record even when the PCP or ongoing care provider is the discharging provider.
- Clarified in the Patient Engagement After Inpatient Discharge numerator that an interaction between the member’s caregiver and the provider meets criteria if the member is unable to communicate with the provider.
- Added the Rules for Allowable Adjustments of HEDIS® section.
The intent of this measure aims to improve care coordination during care transitions, which includes older adults and those with complex health needs.

Things to look for as transition of care:
- Inpatient transfer to a SNF
- Inpatient transfer to home health
- Inpatient transfer to long-term care, home health, or rehabilitation facility
- Inpatient transfer to PCP
- Instructions given to patient during discharge

This measure was created to close the gap from an inpatient setting to outpatient follow-up care.
Measure Description:
The percentage of discharges for members 18 years of age and older who had each of the following:
(Four rates are reported)
Only one outpatient medical record can be used for all indicators that are reported using the hybrid method.

1. Notification of Inpatient Admission - documentation of receipt of notification of inpatient admission on the day of admission or the following day.
2. Receipt of Discharge Information - documentation of receipt of discharge information on the day of discharge or the following day.
3. Patient Engagement After Inpatient Discharge - documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
4. Medication Reconciliation Post-Discharge - documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).
Transitions of Care

Notification of Inpatient Admission

Documentation 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 when the documentation was received.

Any of the following examples meet the criteria:

- Communication between inpatient providers or staff and the member’s PCP or ongoing care provider (e.g., phone call, e-mail, fax).
- Communication about admission between emergency department and the member’s PCP or ongoing care provider (e.g., phone call, email, fax).
TRC Transitions of Care

Notification of Inpatient Admission (continued)

- The communication must be about the member’s inpatient stay and must occur on the day of admission or the following day.
- 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, or a shared electronic medical record 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.
Notification of Inpatient Admission (continued)

- 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/or treatments to occur anytime during the member’s inpatient stay (this can be documented up to the day before discharge).

- Documentation that the PCP or ongoing care provider performed a pre-admission exam or received communication about a planned inpatient admission. The timeframe that the planned inpatient admission must be communicated is not limited to the day of admission or the following day. Documentation that the PCP or ongoing care provider performed a pre-admission exam or received notification of a planned admission prior to the admit date also meets the criteria. The planned admission documentation or pre-admission exam must clearly pertain to the denominator event.
Test Your Knowledge

Question: NCQA Case #255071 9/23/2019

TRC Notification of Admission

If the PCP record shows Admission History and Physical (H&P) with a transcribed date and "CC to the PCP" in an integrated medical record, is this sufficient to meet the requirement for admission notification?

(Example EPIC software)
Test Your Knowledge

Answer: NCQA Case #255071 9/23/2019

The example described above meets criteria for the Notification of Inpatient Admission numerator if the information is documented on the day of admission or the following day (third bullet in the Medical Record section on bottom of page 308 in HEDIS® 2020 Volume 2).
Test Your Knowledge

Question: NCQA Case #255075 9/23/2019

TRC Notification of Admission

In the screenshot of the hospital record that shows date of admission and the “Communication" section shows message to "Marcus Welby," which happens to be the PCP. Is this sufficient? (EPIC software example)
Test Your Knowledge

Answer: NCQA case #255075 9/23/2019

The example described above may be used to meet the Notification of Inpatient Admission criteria if documented on the day of admission or the following day (third bullet in the Medical Record section at the bottom of page 308 in HEDIS® 2020 Volume 2).
Example of VALID Inpatient Admission

PCP consulted-Admit
1003 Consulted with [REDACTED] who accepted patient for admission.

MESSAGE:
------------
>> [REDACTED] MESSAGE (01/12/17 09:42 AM):
>> FYI patient called to advise you that he was admitted to Bayfront due to seizures.
Evidence of receipt of notification of inpatient admission with a date stamp.

Date stamp or fax date must be on the document. In this example it is 09/19/2019.
Example of Communication Notification (EPIC).

Summary of care document sent to (Provider name), MD (PCP).
Example of History and Physical (H&P) with fax received date.

Evidence of receipt of notification of inpatient admission with a date stamp.

Fax received 9/30/19 10:20 A.M.

H&P

Marcus Kelly, MB (Physician) • Internal Medicine

EXAMINATION AND PHYSICAL

ACUTE HEART FAILURE

ACHIEVE OUTCOMES: Manage patient with acute heart failure with diuretics, slightly decreased EF, grossly clear lungs.

HANKS, Tom

DATE OF BIRTH: 06/27/1946

MED REC NUMBER:

ADMITTING PHYSICIAN: Warren Daily, MD, Hematology

ADMISSION DATE: 9/29/2019

DATE OF DEATH: 9/29/2019

CHEF CONSULTANT: Dr. Tom, speech, and hearing.

HISTORY OF PRESENT ILLNESS: The patient is a 74-year-old black male presents to the ER feeling well, timed, clear, present for several hours prior to admission. He denied any syncopy. There was no chest pain, shortness of breath, or shortness of breath.

No nausea, vomiting, or diarrhea. He has a creatinine of 3.0. His labs show an elevation in total bilirubin, serum creatinine, and calcium. He has a history of hypertension and diabetes.

On presentation to the ER, his blood pressure is 130/60. He was given a liter of normal saline IV. He is advised for noncompliance with the usual oral sodium, please reduce the oral sodium intake.

PAST MEDICAL HISTORY:

1. Long-standing systemic hypertension.
2. Hypertension.
3. Coronary artery disease.

PAST SOCIAL HISTORY:

1. History of smoking cessation with smoking treatment in 2010.

PAST MEDICAL HISTORY:

1. Chronic anemia, age 7 years ago at University of Maryland.
2. He has had a colonoscopy and pulmonary x-ray every 2 years. He is due in the next two months for repeat.

ANXIETY:

1. Anxiety, 14/10/19, no daily.
2. Tension 30 mg 30 mg/day.
3. Alprazolam 51 mg 30 mg/day.
4. Trazodone 50 mg daily.
5. Buspirone 10 mg twice daily.
6. Estrogen in mg every other day.
7. Estrogen in mg every other day.
8. Furosemide 40 mg subcutaneous.
9. Furosemide 40 mg subcutaneous.
10. Furosemide 10 mg subcutaneous.

ALLERGIES: Common cold because of his kidney failure.

SOCIAL HISTORY: Married, 1 son, lives in Baltimore. Hobbies: reading, music.

FAMILY HISTORY: Father died at the age of 60 of myocardial infarction. Mother died at the age of 50 of myocardial infarction.


PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 36.3, pulse 100, respirations 16, blood pressure 120/80.

GENERAL: Inspiration reveals a plethoric, well-developed black male in no acute distress. He is slightly tachypneic.

BEX: Apical S1 is normal, rate and rhythm to listen. No diastolic murmur.

NECK: He is troponin 0.2 mg/ml by T. Normal

LOCAL: Clear to auscultation.

HEART: No regular without murmurs, gallop, or rub.

ABDOMEN: Soft without grossly palpable, guarding, tenderness, or rebound.

EXTREMITIES: None in lower leg edema. The distal pulses intact on 1 or 2.

NEUROLOGICAL: Cranial nerve intact. Motor intact. No focal lesions.

Fax received 9/30/19 10:20 A.M.
Example of History and Physical (H&P) with transcribed date with cc to provider.

Valid evidence of receipt of notification of inpatient admission with a date stamp.
Examples of inpatient admission alone is NOT ENOUGH; it needs to include the fax date or transcription date.
Points to Remember

- ED visits alone do not meet criteria of an admission.
- When an ED visit results in an inpatient admission, notification that a provider sent the member to the ED does not meet criteria. There must be evidence that the PCP or ongoing care provider communicated with the ED about the admission.
**Invalid Examples**

1. Inpatient admission is after 2 days of admission
2. Communication between family member and PCP/ongoing care provider about notification
3. ED visit results in an inpatient admission, notification that a provider sent the member to the ED does not meet criteria
4. Pre-operative clearance is not same as admission
5. Fax line without date

**Valid Examples**

1. Inpatient admission is valid if below evidence found on the same of admission day or +1 day of admission
2. Communication via phone call, fax between PCP, and inpatient hospital staff/providers
3. Communication between ED (about admission) and PCP about patient’s admission (e.g., via phone call, fax or letter)
4. Communication through a shared EMR system
5. Member’s PCP/o going care provider admit the patient
6. PCP/Ongoing provider order any test during emergency
7. PCP/On-going care provider perform pre-admission exam before admission
8. Admission H&P with fax line evidence with date (admission day or +1 day)
**Step 1:** Confirm Admission Date. If there is any change in the admission date, click on Change and add new DOA.

**Step 2:** Enter Date of Notification.

**Step 3:** Select dropdown for Admission Type.
Receipt of Discharge Information

Documentation of receipt of discharge information on the day of discharge or the following day.

Discharge information may be included in but not limited to a discharge summary or summary of care record or located in structured fields in an EHR. **At a minimum, the discharge information MUST include all of the following:**

- The practitioner responsible for the member’s care during the inpatient stay
- Procedures or treatment provided
- Diagnoses at discharge
- Medication list at discharge medication list
- Testing results or documentation of pending tests or no tests pending
- Instructions for patient care must be to the PCP or ongoing care provider

**You might find 3 of the bullets on a discharge summary and the other 3 bullets from a summary of care document which will meet the intent of this numerator. Note, all 6 bullets do not have to be from one document.**
Receipt of Discharge Information (continued)

**NOTE:** If the patient is re-admitted within 30 days, we would consider the first admission date and last discharge date (discharge of re-admission).

If the DOD from administrative data is greater than 30 days from the discharge date in the record, reviewer is instructed to place the record on hold and confirm with supervisor before proceeding. To consider a discharge date > 30 day variance, documentation should show an admission date within 30 days of the original date of discharge or a transfer and continued care at the new facility.

If the medical record documentation is unclear, regarding timeframes after review from Advantmed SME panel, the record will be escalated to the client using Clinical Alerts queue.
Helpful Hints

Look beyond admission H&P, documentation may be in other parts of an EMR record (e.g., fax, emails, phone messages, ADT alert systems).

Check 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, or a shared electronic medical record system.
Helpful Hints

Shared electronic medical record systems may show inpatient documents in combination with the outpatient record. Remember orders for tests OR treatments, could be more than just lab or radiology. This is any medical order given by the PCP including medication changes, diet restrictions, physical therapy orders, etc.

Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member’s inpatient stay.
Helpful Hints

**Emergency Department** - Notification must include documentation that the patient was admitted to inpatient services, not just seen in the emergency department.

**Member/Family Reported** - Admissions reported to PCP by the member or family members are not compliant for this numerator.

**Multiple Hospital Stays** - Review tool closely as the Advantmed tool may contain multiple hospital stays for a single member. Be sure you do not edit the administrative date or discharge date that is for a separate admission.
Test Your Knowledge

Question: NCQA Case #255077 9/23/2019

If the Discharge Summary is documented in the "integrated EMR" with the notation of “CC to the primary care physician” and the transcription date is documented, is it sufficient to meet the criteria for notification of discharge assuming all the other required components are present?
Test Your Knowledge

Answer: NCQA Case #255077 9/23/2019

The example described may be used to meet the criteria for the Receipt of Discharge Information numerator if documented in the medical record during the timeframe specified in the measure.
Test Your Knowledge

Question: NCQA Case #255083 9/23/2019

TRC Notification of Discharge

Is the presence of the Discharge Summary in the PCP medical record that states the transcription date and time and "CC to the primary care physician" (assuming all components are in the Discharge Summary) sufficient as documentation of notification of discharge for TRC?
The example described above may be used to meet criteria for the Receipt of Discharge Information numerator if documented in the medical record during the timeframe specified in the measure.
Discharge Notification: Example of Provider Evidence Compliant

**PHYSICIAN/ADMISSION INFORMATION:**
Admit Date: 7/2/2018
Attending Physician: David A Mintzer, MD
Primary Care Physician: Grace A Alfonsi, MD

<table>
<thead>
<tr>
<th><strong>ED to Hosp-Admission</strong></th>
<th>Last attending: Suehler, Klaus Karl, MD • Treatment team</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/19/2018 - 7/25/2018 (6 days)</td>
<td>Principal problem: Encephalopathy acute</td>
</tr>
<tr>
<td>Status: Discharged</td>
<td>Mercy Hospital</td>
</tr>
</tbody>
</table>

**Discharge Summary**
Hospital Course (Problems, Investigations, Interventions, End results including med changes):
1. Acute Blood Loss Anemia secondary to GI Bleed- Pt was admitted to the hospitalist service and started on PPI. She was transfused with 2 units of PRBC. She had just been discharged on 3/20 after she was managed for gastric ulcer and bleed. Her hgb dropped and she was feeling dizzy and continued passing black stools so she came back to the hospital. Initial plan was to transfuse her with 2 units of PRBC and discharge home if she was asymptomatic, however hgb dropped again and dc was held yesterday. She had an EGD done today which revealed a duodenal bulb erosion with ulcer which was not bleeding. She has been started on double dose omeprazole and she is to continue carafate. Hgb has remained stable post transfusion and I have added ferrous sulphate to her prescription.

PCP to follow-up on:
1. Anemia
Discharge Notification: Example of Procedures/Treatment Compliant

**BRIEF HOSPITAL COURSE**

Wallace, Mary is a 84 y.o. female who presented with somnolence, palpitations and found to be in rapid ventricular response. Somnolence related to medications, hypercarbia, and UTI.

**Encephalopathy acute - resolved**
- Multifactorial
- Likely related to UTI, central acting medications, hypercarbia
- Treated UTI, adjusted chronic medications, needs CPAP at home (referred to OP sleep study, logistics difficult given her paraplegia/care needs, but it sounds she can get in-home sleep study after OP consult at sleep clinic)
- Reinstated the medication changes (dilaudid) that the pain team put forth on previous admission which she is tolerating well and controlling her pain.
Discharge Notification: Discharge Diagnosis Compliant

**Discharge Diagnoses**
1) acute hypoxia secondary to pulmonary edema
2) acute decompensated heart failure with
3) severe MR

**Discharge Diagnoses**
- #NSTMI
- #HFrEF
- #Afib
- #DMII
- #Hypotension
- #CKD
- #Intertrigo
Discharge Notification: Current Medication List Compliant

Discharge Medications:

**DISCHARGE MEDICATIONS**

**START taking these medications**

- ferrous sulfate 226 mg tablet  
  Take 1 tablet (325 mg total) by mouth three times daily.  
  Commonly known as: FERISOL

- sucralfate 1 g tablet  
  Take 1 tablet (1 g total) by mouth four times daily. You must Crush tablets and made into a syrup.  
  Commonly known as: CARAFATE

**CHANGE how you take these medications**

- omeprazole (delayed-release) 40 mg capsule  
  Take 1 capsule (40 mg total) by mouth twice daily. Twice daily for 2 months then back to once daily.  
  What changed:  
  - when to take this  
  - additional instructions  
  Commonly known as: PROPEC

**CONTINUE taking these medications**

- cycloSPORINE 0.05 % eye drops  
  Place 1 drop into both eyes every 12 hours.  
  Commonly known as: RESTASE
Discharge Notification: Testing Results Compliant

Diagnostic Studies/Surgical Procedures:
CT Abdomen 10/29
1. Acute uncomplicated pancreatitis.
2. Distended bladder. No hydrenephrosis

CT Abdomen 10/31
1. Acute interstitial pancreatitis with worsened peripancreatic fat stranding.
2. No evidence for pancreatic parenchymal necrosis.
3. 2.0 cm acute peripancreatic collection forming along the tip of the caudate lobe of the liver.
4. New small bilateral pleural effusions with adjacent atelectasis.
## Discharge Notification: Testing Results Compliant

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Order Name</th>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/27/2018</td>
<td>Prepare Red Blood Cells (NOT TO BE GIVEN WITHOUT TRANSFUSE ORDER)</td>
<td>Preliminary</td>
<td></td>
</tr>
<tr>
<td>2217</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/26/2018</td>
<td>Prepare Red Blood Cells (NOT TO BE GIVEN WITHOUT TRANSFUSE ORDER); 2 Units</td>
<td>Preliminary</td>
<td></td>
</tr>
<tr>
<td>1810</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Discharge Notification: Follow up Instructions Compliant

Surgical input appreciated, plan for interval cholecystectomy in 6-8 weeks
Patient will require IR follow-up for the drain check and cholangiogram
Subsequently patient would follow up with surgery for cholecystectomy
Discussed with patient and daughter

Outpatient Tests Requested:
- CMP and digoxin level later this week
- IR guided cholangiogram prior to surgery
Discharge Notification: Follow up Instructions Compliant

**Issues for Follow-up by PCP:**
1. Patient and caregiver confusion over medication schedule and it’s complexity. Consider using a pill box to simplify daily med schedule, if not already used.
2. Pt has follow up with cardiology but will need a BMP 1 week after discharge, and a weigh in.
3. Medications we stopped: amlodipine and glipizide. Consider d/c statin given her age.
4. Pt home med list shows seroquel, we did not continue this in hospital but consider in future to limit polypharmacy.
Discharge Notification: Follow up Instructions NOT-Compliant

Cardiac 2 gm Sodium Low Fat Diet

**ACTIVITY AS TOLERATED**

**DISCHARGE INSTRUCTIONS**

- Metoprolol twice a day is to regulate your heart rate and preventing it from beating fast.
- Propafenone is also to regulate your heart rate. It’s taken 3 times a day.
- Eliquis is a blood thinner. It’s taken twice a day.
- Avoid falling and trauma as Eliquis increases the bleeding risk.
- If you develop bleeding, stop Eliquis and seek urgent medical help.
- IT IS PREFERRED NOT TO TAKE CELECOXIB (Celebrex) anymore, it MAY interact with Eliquis.

Order Comments:
Example of Discharge Summary with fax received date.

Evidence of the receipt of notification of discharge information with a fax date stamp.

Assume all the data is present.
Example of Discharge Summary with transcribed date.

Evidence of receipt of notification of discharge information with a transcribed date stamp and CC to the Provider.

Assume all data is present.
TRC Transitions of Care

Note: Lists PCP Name
Outside Provider Message with Date
Hospital Encounter
Fax Date
Valid Examples

1. Receipt of discharge information is valid if below evidence found on the same admission day or +1 day of admission
2. The practitioner responsible for the member’s care during the inpatient stay
   - Attending physician
   - Admitting physician with authentication in admission note
3. Procedures or treatment provided (e.g., ECG, CABG, any treatment like IV infusion, surgery)
4. Diagnoses at discharge
5. Current medication list (discharge medications)

Invalid Examples

1. Discharge instructions provided to the member to follow-up with their PCP does not meet criteria
2. Only admitting physician for practitioner responsible for the member’s care during the inpatient stay
3. Fax line without date
4. Discharge summary with ‘CC’ to other provider and ‘dictated or transcribed date’ on same day of discharge or +1 day of discharge
5. Discharge summary with ‘CC’ to other provider without ‘Dictated or transcribed date’ on same day of discharge or +1 day of discharge
### Transitions of Care

#### Discharge Notification

<table>
<thead>
<tr>
<th>Valid Examples</th>
<th>Invalid Examples</th>
</tr>
</thead>
</table>
| 6. Testing results, or documentation of pending tests or no tests pending.  
  - Any labs like HbA1c, CBC, CMC, any blood tests  
  7. Instructions to PCP or ongoing care provider for patient care.  
  - Example: Outpatient Tests requested  
  - Patient require IR follow up for drain check  
  8. Discharge summary with fax line evidence with date (admission day or +1 day) with all 6 components  
  9. Discharge summary with “CC” to PCP/ongoing care provider and “dictated or transcribed date” on same day of discharge or +1 day of discharge | 6. Only “dictated or transcribed date” on same day of discharge or +1 day of discharge |
**TRC** Transitions of Care

**Step 1:**
Enter Date of Notification

**Step 2:**
Select components whichever you find in the medical record per criteria
Patient Engagement After Inpatient Discharge

Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) provided within 30 days after discharge.

**Do not include patient engagement that occurs on the date of discharge.

Documentation must include evidence of patient engagement within 30 days after discharge. Either of the following meets the 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
Patient Engagement After Inpatient Discharge (continued)

What is telehealth?
Defined as the use of electronic information and telecommunications technologies to support and promote *long-distance* clinical healthcare, patient and professional health-related education, public health, and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

This may be found in the medical record in the form of a phone call to the patient, email communication, or video conferencing. It is often part of a case management or care coordination program.
Test Your Knowledge

Question: NCQA Case # 212651 11/9/2018

Patient Engagement After Inpatient Discharge

For the Patient Engagement After Inpatient Discharge sub-measure, who is required to perform this engagement? Does it follow the MRP sub-measure of RN, clinical pharmacist, prescribing practitioner?
There is no provider type requirement for the Patient Engagement After Inpatient Discharge indicator; any practitioner can conduct the visit or provide the transitional care services as long as the information is documented in the PCP or ongoing care provider outpatient medical record. That said, while patient engagement services performed by an RN, clinical pharmacist, or prescribing practitioner meet criteria, services are not required to be performed by those provider types.
1. Patient engagement (e.g., office visits, visits to the home, or telehealth) provided within 30 days after discharge

2. Below notes are valid:
   - Outpatient visit
   - Office visit
   - Home visits
   - Telehealth visit is valid
   - Real-time interaction occurred between the member and provider using audio and video communication

3. If the member is unable to communicate with the provider, interaction between the member’s caregiver and the provider meets criteria

1. Patient engagement (e.g., office visits, visits to the home, or telehealth) provided after 30 days after discharge
Step 1:
Enter Date for patient engagement

Step 2:
Select dropdowns engagement type whichever you find in the medical record per criteria
Medication Reconciliation Post Discharge

- This information is the same in the MRP measure training.
- We have listed it separately in the event that a client is not reporting TRC and only reporting MRP or if a client is listing separately for any reason.
Measure Description:
The percentage of discharges from January 1 – December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

Definition of Medication Reconciliation: (continued on next slide)
- A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.

This measure assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the medication list documented in the medical record or the process used to document the most recent medication listed in the medical record.
Definition of Medication Reconciliation (continued)

- Evidence of Medication Reconciliation and or Review – record does not have to specifically state “reconciled” or “reviewed” to be valid. Search for other key words or phrases.

- Please note that the definition is a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. The medication reconciliation and or review can be done by a prescribing physician, clinical pharmacist, and/or registered nurse.
Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meets 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 (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. (continued next slide)
Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. (cont.)

- 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 medical 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.
Follow the steps below:

- Pay attention to the answer tool of the Date of Discharge which will guide you to the timeframe of the hospital outpatient visit that you should be looking for within the medical record.
- Once you can determine you have an outpatient hospital follow-up visit, the next step is looking for the “medication list being reviewed or reconciled” or evidence the patient’s current medications were reviewed and reconciled in the hospital follow-up visit.

The next slide will provide helpful hints for medication review.
Helpful Hints for identification of Medication Review:

*Look for additional statements (along with medication list)*

- Continue current meds
- Medications were updated
- Increase/decrease in medication dosage (for meds which are mentioned in the current medication list)
- Discontinuation of medication(s)
- Refill medication(s)
- Medication reviewed/reconciled
- Continue current medication regimen/treatment
- No changes in medications
- No medications prescribed
- Taking or stopping medication(s)
Helpful Hints

If we have valid evidence of hospital follow up visit along with current medication list and documentation like Medication list was updated and reviewed, we can consider it as valid as per guidance in the HEDIS® 2020 Tech Specs because provider is aware of hospitalization and has reviewed the medications. Also, the below notations can be compliant for medication review:

- Medication list was updated (same as medications were updated)
- Medication list was reviewed (same as medications were reviewed)
- Medications were reconciled
- Continue current medication documented under the disease so we can consider it as listed and reviewed

- Continue current medication documented under the disease so we can consider it as listed and reviewed
- Medications were updated in EMR software
- Medications were updated in the chart with notation like “see chart or medication list”

Current medication list must be documented in the outpatient medical record.
Helpful Hints (continued)

Discharge medication review

- If provider documents the discharge medications with review in the hospital follow up visit, we can consider it as valid with evidence of medication list (CURRENT medication list must be present in either D/C summary or follow up visit).

Example of discharge medications contained within an encounter.

Echo 3/15/19 showed ejection fraction is 55-60%, MVP and moderate mitral regurgitation. Discharged on 3/17/19 on Eliquis, amiodarone and metoprolol. Reviewed and noted.

*Remember, we MUST have a CURRENT medication list also.*
Helpful Hints (continued)

Discharge medication review

- If we have discharge medications in the discharge summary and current medication list in the hospital follow up visit, we compare the discharge medications with current medication list to consider the review. We can consider valid medication review if almost all medications are matched except 2 or 3.
Helpful Hints (continued)

Discharge medication review

- If we have discharge medications in the discharge summary and current medication list in the hospital follow up visit, we compare the discharge medications with current medication list to consider the review. We can consider valid medication review if almost all medications are matched except 2 or 3).
Helpful Hints (continued)

- If in the HPI, documentation includes “patient came for transition into care” we can consider it as a discharge for valid evidence of hospital follow-up.

- If the patient is discharged from the hospital and there is evidence of a readmission, but no discharge date is found in the medical record for that readmission, then we may use the original follow up from the initial discharge “hospital follow-up” and consider medications reconciled if the visit was prior to the readmission.

See NCQA on next slide
Test Your Knowledge

NCQA Case #255070 (9/27/2019)

**Question:** If we have an obvious *outpatient visit* that is citing a hospital F/U of an admission after the discharge date from admin data (example: original DOD is 3/12/19 and record reads "hospital follow up of admission of 3/28/19" and the date of the follow up is 4/4/19) and all components are there, provider reconciled medications but we have no discharge date for the re-admission (3/28/19), can we capture this visit without a new discharge date of last readmission as it is obviously within 30 days of the original admission date?
Test Your Knowledge

NCQA Case #255070 (9/27/2019)

**NCQA's response:** In this example the date of discharge is 3/12/19. For the numerator event the member must have had medication reconciliation on the date of discharge through 30 days after discharge (31 days total). In this example medication reconciliation on 4/4 is during the required timeframe (within 30 days of the 3/12 discharge date). **If the medical record contains documentation of a different discharge date than the date identified by administrative data, the health plan can work with the auditor to correct the discharge date for the member** (any changes require auditor review and approval). **However**, if the medical record contains only an admission date (without a discharge date) the date of discharge from administrative data must be used.
Test Your Knowledge

NCQA Case #174391 (2018)

**Question:** In the medical record, we have post discharge follow up with documentation of medications reviewed or reconciled. Is this sufficient to capture medication reconciliation or do we require a current medication list in the post discharge follow-up?
Test Your Knowledge

NCQA Case #174391 (2018)

NCQA's response: A current medication list is required. Documentation of the post discharge follow-up with notation of medications reviewed or reconciled would not be sufficient without the current medication list. For HEDIS® 2018 reporting the medical record must include documentation of the current medications (e.g., a current medication list) in order to meet criteria. Documentation in the outpatient medical record must include evidence of a medication reconciliation (e.g., a review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record) and the date when it was performed.
Test Your Knowledge

NCQA Case # 229886 (2019)

Date of Discharge: 3/12/2018

Date of progress note: 3/25/2018

Test Your Knowledge

NCQA Case #229886 (2019)

NCQA's response: No, the examples described above do not count as evidence of post-discharge hospital follow-up. **Documentation that a patient had a procedure or surgery without any reference to the hospitalization is not considered evidence that the provider was aware of the hospitalization.** Keep in mind that in order to meet the criteria in the fifth bullet on page 238 (HEDIS® 2019 Volume 2), the current medication list is required in addition to evidence of medication reconciliation or review and documentation that the member was seen for post-discharge hospital follow-up.
Evidence of medication review here as evidence of:

- Hospital follow-up “f/u after being discharged”
- Physician addressed current and discontinued medications as well as refills

Physician is aware of medications in this example as he is discontinuing medications so it is fair to assume that he is aware of the patient’s medications listed in this DOS.

**Note:** Context gives the evidence of medication “review” and or “reconciliation” without using either term in this progress note.
Evidence of medication review here as evidence of:

- Hospital follow-up: Evidence of “recent hospital stay”
- Physician addressed current and discontinued medications as well as orders

Physician is aware of medications as evidence of medications

Note: Context gives the evidence of medication “review” and or “reconciliation” without using either term in this progress note.

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### Diagnoses:
- Essential (primary) hypertension(1) - No Workup
- Other nonrheumatic aortic valve disorders(13.8) - No Workup

### Medication Orders:
- **Prescribed: hydralazine 100mg 1 tablet by mouth Twice A Day as directed #80 Refills(2).**
  - Prescription sent to Walgreens Pharmacy 1234, 5678 Main St, Anytown, USA
  - Prescription valid until 01/01/2020
- **Prescribed: amiodipine 10mg 1 tablet by mouth Daily as directed #30 Refills(2).**
  - Prescription sent to Walgreens Pharmacy 1234, 5678 Main St, Anytown, USA
  - Prescription valid until 01/01/2020

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### RX refill - Generalized: Patient is here for acute complaint of needing a medication refill
- Recent hospital stay for hypokalemia and hypernatremia.
- POC appointment on 5/9 for flu of HTN with moderate progression, due to needing multiple medications.

### History of Present Illness:
The patient presents with a chief complaint of constant (but worse at times) RX refill since Thu, Apr 25, 2019. The patient describes the severity as moderate.

### Review of Systems:
The patient denies the following recent symptoms:
- Constitutional: denies change in appetite
- Cardiovascular: denies chest pain/pressure
- Neurological: denies headache

### Allergies:
- Penicillin: reaction(s): nausea, vomiting

### Current Medications:
- Lorazepam 0.5 mg tablet
- Amiodipine 10 mg tablet
- Hydralazine 100 mg tablet
- Verapamil 3.5 mg tablet
- Valsartan 120 mg tablet
- Hydrochlorothiazide 25 mg tablet

### Medical History:
- Anxiety disorder, unspecified (status Active)
- Major depressive disorder, single episode, unspecified (status Active)
- Cardiac murmur, unspecified (status Active)
- Essential (primary) hypertension (status Active)
Evidence of medication review here as evidence of:

- Hospital follow-up: Physician has acknowledged patient was in hospital by stating “at hospital was given...”

Assume that documentation and dates are within the valid timeframe

(DOS continued on next slide)
Evidence of medication review here as evidence of:

- Hospital follow-up: Evidence of “recent hospital visit” and “admitted to hospital”
- Medications listed and reconciled
Evidence of medication review here as evidence of:

- Medications listed and reviewed on same date as DOS

DOS continued on next slide
Evidence of medication review here as evidence of:

- **Hospital follow-up**: Evidence of “s/p hospital” please note the statement of hospital follow-up may be anywhere within the DOS.
Evidence of medication review here as evidence of:

- **Hospital follow-up**: Evidence of "detailed discussion of hospital admission with daughter of the patient and provider, this can be considered valid as evidence of hospital follow-up visit."

We have a medication list and the patient is taking Levaquin and Prednisone as documented in the discussion section.
Evidence of medication review here as evidence of:

- Hospital follow-up: Documentation of f/u from ER and admitted for low sodium, which is valid evidence because the patient was admitted to the hospital. We have a medication list and evidence of reconciliation in the visit, so it is valid to capture the MR from this visit.
Can we abstract MRP measure from this example?

No. Documentation that a patient had a procedure or surgery without any reference to the hospitalization is not considered evidence that the provider was aware of the hospitalization.
Helpful Hints

If member remained in acute care after December 1, 2019

- Exclude both the initial discharge and the readmission discharge if the readmission discharge occurs after December 1, 2019.
- If a member remains in an acute or non-acute facility through December 1, 2019, a discharge is not included in the measure for this member. However, the organization must have a method for identifying the member’s status for the remainder of 2019, and may not assume the member remained in the facility based only on the absence of a discharge before December 1, 2019.
Can we abstract an exclusion for the MRP measure from this example?

No, because the patient did not remain in the hospital after 12/1/2019. Please remember, the patient must remain in the hospital after 12/1/2019 to be considered an exclusion.
# Transitions of Care

## Medication Reconciliation

### Valid Examples

1. Evidence of hospital follow up note with medication list
2. Current medication list in hospital follow up note with signature of valid provider (even if medication review evidence not found additionally)

### Invalid Examples

1. Medication Reconciliation evidence without current medication list
2. Cannot consider only surgery follow up evidence as hospital follow up evidence without inpatient admission evidence
3. Alone ER follow up note without evidence of inpatient admission
4. Medication review performed by invalid provider type like: MA/LVN/LNP
Step 1:
Enter Date for Medication reconciliation

Step 2:
Select dropdowns Reviewer for providers (Prescribing Practitioner, Clinical Pharmacist or RN) whichever you find in the medical record per criteria

Step 3:
Select dropdowns Assessments whichever you find in the medical record per criteria. (Example: Hospital follow up visit with medication list)
Points to remember

The following notations or examples of documentation do not count as numerator compliant:

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
- Documentation of notification that does not include a timeframe or date stamp

The Medication Reconciliation Post-Discharge numerator assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the medication list documented in the medical record or the process used to document the most recent medication list in the medical record.
Advantmed Policy for Shared EMR

- Advantmed does not combine records received from different locations, therefore, if both, inpatient and outpatient records are found in the same medical record (more than just H&P or D/C summary), Advantmed consider this a shared EMR.
Types of secondary pursuit notes:

- Alternate Provider Identified
- Other
Step 1:
Select Yes in dropdown if you find exclusion

Step 2:
Enter DOS if patient is admitted or remained acute or non-acute facility after 12/1/2019.
Example of the Advantmed tool view
Questions?
Thank you.