

Proposed Changes to Existing Measure for HEDIS^{®1} MY 2020 Transitions of Care (TRC)

NCQA seeks comments on proposed changes to the HEDIS *Transitions of Care (TRC)* measure. This measure assesses the percentage of discharges for Medicare members 18 years of age and older and reports four rates: Notification of Inpatient Admission, Receipt of Discharge Information, Patient Engagement After Inpatient Discharge and Medication Reconciliation Post-Discharge.

NCQA proposes these updates to the TRC measure specifications to align with feedback from health plans and auditors:

- Revise the “one medical record” requirement to allow reporting “from the outpatient medical record as well as other information accessible to the PCP or ongoing care provider.”
 - This change captures other communication forms that occur regularly in the field and meet the intent of the measure (e.g., information from ADT feeds, shared EMRs).
- Update the time frame for *Notification of Inpatient Admission* and *Receipt of Discharge Information* to “on the day of admission or discharge or within the following 2 calendar days.”
 - This change clarifies how to handle documentation related to most admissions and discharges taking place over the weekend.
- Modify the “instructions for the PCP or ongoing care provider for patient care” requirement under the *Receipt of Discharge Information* indicator to “instructions for patient care post-discharge.”
 - This change clarifies the intent of the requirement and aligns it with elements found in hospital discharge summaries generated.

Supporting documents include the draft measure specification, evidence workup and performance data.

NCQA acknowledges the contributions of the Care Coordination Work Group, the Geriatric Measurement Advisory Panel and the Technical Measurement Advisory Panel.

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Transitions of Care (TRC)

SUMMARY OF CHANGES TO HEDIS MEASUREMENT YEAR 2020

- Revised the “one medical record” requirement to allow reporting from the outpatient medical record, as well as other information accessible to the PCP or ongoing care provider.
- Revised the time frame for the *Notification of Inpatient Admission* and *Receipt of Discharge Information* indicators to “on the day of admission or within the following 2 calendar days” and “on the day of discharge or within the following 2 calendar days,” respectively.
- Revised the “instructions to the PCP or ongoing care provider for patient care” requirement under the *Receipt of Discharge Information* indicator to “instructions for patient care post-discharge” and removed “Discharge instructions provided to the member to follow-up with their PCP does not meet criteria.”

Description

The percentage 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 or ~~the following day~~ within the following 2 calendar days.
- Receipt of Discharge Information.* Documentation of receipt of discharge information on the day of discharge or ~~the following day~~ within the following 2 calendar 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).

Definitions

Medication reconciliation	A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
Medication list	A list of medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.

Eligible Population

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.

Product lines	Medicare.
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Ages	18 years and older as of December 31 of the measurement year. Report two age stratifications and a total rate:
	<ul style="list-style-type: none"> • 18–64 years. • 65 years and older. • Total.
Continuous enrollment	Date of discharge through 30 days after discharge (31 total days).
Allowable gap	None.
Anchor date	None.
Benefit	Medical.
Event/diagnosis	An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. To identify acute and nonacute inpatient discharges: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. <p>The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.</p>
Readmission or direct transfer	If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). <p>Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.</p> <p>If the admission date and the discharge date for an acute inpatient stay occur between the admission and discharge dates for a nonacute inpatient stay, include only the nonacute inpatient discharge. To identify acute inpatient discharges:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. 4. Identify the discharge date for the stay.

To identify nonacute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.
4. Identify the discharge date for the stay.

Note: If a member remains in an acute or nonacute facility through December 1 of the measurement year, a discharge is not included in the measure for this member, but the organization must have a method for identifying the member's status for the remainder of the measurement year, and may not assume the member remained admitted based only on the absence of a discharge before December 1. If the organization is unable to confirm the member remained in the acute or nonacute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date.

Administrative Specification

Denominator The eligible population.

Numerators

Notification of Inpatient Admission Administrative reporting is not available for this indicator.

Receipt of Discharge Information Administrative reporting is not available for this indicator.

Patient Engagement After Inpatient Discharge Patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge. The following meet criteria for patient engagement:

- An outpatient visit (Outpatient Value Set).
- A telephone visit (Telephone Visits Value Set).
- Transitional care management services (Transitional Care Management Services Value Set).

Medication Reconciliation Post-Discharge Medication reconciliation (Medication Reconciliation Encounter Value Set; Medication Reconciliation Intervention Value Set) conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after discharge (31 total days).

Hybrid Specification

Denominator A systematic sample drawn from the eligible population.

The denominator is based on discharges, not on members. Members may appear more than once in the sample.

Organizations that use the Hybrid Method to report the *Medication Reconciliation Post Discharge* and *Transitions of Care* measures may use the same sample for both measures. Organizations may reduce the sample size based only on the prior year's audited, product line-specific rate for the lowest rate of all TRC and MRP rates.

If a separate sample from the MRP measure is used for TRC, organizations may reduce the sample based only on the prior year's audited, product line-specific rate for the lowest TRC indicator.

Identifying the medical record

~~Only one outpatient medical record can be used for all indicators reported using the Hybrid Method. The record selected may be from the member's PCP or ongoing care provider. If an organization cannot find the medical record, the member remains in the measure denominator and is considered noncompliant for the numerators.~~

To identify the appropriate medical record to review:

- Identify the member's PCP.
 - ~~If the member had more than one PCP during the time period, identify the PCP who most recently provided care to the member.~~
 - ~~If the member did not visit a PCP during the time period or does not have a PCP, identify the ongoing care provider who most recently provided care to the member.~~
 - ~~If a practitioner other than the PCP manages the member's ongoing care, the organization may use the medical record kept by that practitioner.~~

Numerators

<u>Notification of Inpatient Admission</u>	Documentation of receipt of notification of inpatient admission on the day of admission or the following day within the following 2 calendar days.
<u>Administrative</u>	Administrative reporting is not available for this indicator.
<u>Medical record</u>	Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission or the following day within the following 2 calendar days. Admission refers to the date of inpatient admission or date of admission for an observation stay that turns into an 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. Any of the following examples meet criteria: <ul style="list-style-type: none">• 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 or 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 discharge or ~~the following day~~ within the following 2 calendar 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 or ~~the following day~~ within the following 2 calendar 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.

Only documentation in the outpatient medical record that is accessible to the PCP or ongoing care provider meets the intent of the indicator.

Note: When an ED visit results in an inpatient admission, notification that a provider sent the member to the ED does not meet criteria. Evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria.

Receipt of Discharge Information Documentation of receipt of discharge information on the day of discharge or ~~the following day~~ within the following 2 calendar days.

Administrative Administrative reporting is not available for this indicator.

Medical record Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge or ~~the following day~~ within the following 2 calendar 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 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.
- Testing results, or documentation of pending tests or no tests pending.

- Instructions to the PCP or ongoing care provider for patient care post-discharge. Discharge instructions provided to the member to follow-up with their PCP does not meet criteria.

Only documentation in the outpatient medical record that is accessible to the PCP or ongoing care provider meets the intent of the indicator.

Note: If the PCP or ongoing care provider is the discharging provider, the discharge information must be documented in the medical record on the day of discharge or the following day within the following 2 calendar days.

When using a shared EMR system, documentation of a “received date” in the EMR 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 or the following day within the following 2 calendar days meets 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.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record 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 provider using audio and video communication.

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

Medication Reconciliation Post-Discharge Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (31 total days).

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record 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 (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 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.

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

Note

- *The following notations or examples of documentation do not count as numerator compliant:*
 - *Notification of Inpatient Admission and Notification of Inpatient Discharge:*
 - *Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission or discharge.*
 - *Documentation of notification that does not include a time frame or date when the documentation was received.*
 - *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.*
 - *The denominator is based on the discharge date found in administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.*
 - *If a different discharge date is found in the medical record, and the organization chooses to use that date, the organization must assess all indicators using the updated discharge date, including those that were previously compliant based on administrative data.*
 - *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (i.e., within 30 days after discharge).*
 - *Refer to Appendix 3 for the definition of PCP and ongoing care provider.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table TRC-3: Data Elements for Transitions of Care

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	<i>Each of the 2 rates</i>	<i>Each of the 4 rates</i>
Eligible population	<i>Each of the 2 rates, for each age stratification and total</i>	<i>Each of the 4 rates, for each age stratification and total</i>
Number of numerator events by administrative data in eligible population (before exclusions)		<i>Each of the 2 rates, for each age stratification and total</i>
Current year's administrative rate (before exclusions)		<i>Each of the 2 rates, for each age stratification and total</i>
Minimum required sample size (MRSS)		<i>Each of the 4 rates</i>
Oversampling rate		<i>Each of the 4 rates</i>
Number of oversample records		<i>Each of the 4 rates</i>
Number of numerator events by administrative data in MRSS		<i>Each of the 2 rates, for each age stratification and total</i>
Administrative rate on MRSS		<i>Each of the 2 rates, for each age stratification and total</i>
Number of medical records excluded because of valid data errors		<i>Each of the 4 rates</i>
Number of employee/dependent medical records excluded		<i>Each of the 4 rates</i>
Records added from the oversample list		<i>Each of the 4 rates</i>
Denominator		<i>Each of the 4 rates, for each age stratification and total</i>
Numerator events by administrative data	<i>Each of the 2 rates, for each age stratification and total</i>	<i>Each of the 2 rates, for each age stratification and total</i>
Numerator events by medical records		<i>Each of the 4 rates, for each age stratification and total</i>
Numerator events by supplemental data	<i>Each of the 2 rates, for each age stratification and total</i>	<i>Each of the 2 4 rates, for each age stratification and total</i>
Reported rate	<i>Each of the 2 rates, for each age stratification and total</i>	<i>Each of the 4 rates, for each age stratification and total</i>

Transitions of Care (TRC)

Measure Workup

Topic Overview

This measure assesses the transitions of care for Medicare members 18 years and older who had an inpatient discharge. Four rates are reported:

1. *Notification of Inpatient Admission.* Documentation of receipt of notification of inpatient admission on the day of admission or within the following 2 calendar days.
2. *Receipt of Discharge Information.* Documentation of receipt of discharge information on the day of discharge or within the following 2 calendar days.
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).

The Medicare population includes older adults and individuals with complex health needs who often receive care from multiple providers and settings, and thus experience highly fragmented care and adverse health care utilization patterns and outcomes. This population is at particular risk during transitions of care because of higher comorbidities, declining cognitive function and increased medication use (Vognar, 2015).

Transitions from the inpatient setting to home often results in poor care coordination, including communication lapses between inpatient and outpatient providers, intentional and unintentional medication changes, incomplete diagnostic workups and inadequate beneficiary, caregiver and provider understanding of diagnoses, medication and follow-up needs (Rennke et al, 2013).

Financial Importance

Poor hospital transitions are not only associated with poor health outcomes, but also increased health care utilization and cost, including duplicate medical services, medication errors and increased ED visits and readmissions (Sato et al, 2011). In 2010, Medicare beneficiaries 65 years and older accounted for 11.9 million (approximately 34%) of all hospital discharges in the United States (CDC, 2010). One study estimated that inadequate care coordination and poor care transitions resulted in \$25 billion–\$45 billion in unnecessary spending in 2011 (Health Affairs, 2012). Other studies have found that care coordination programs that do not incorporate timely transitional care elements are unlikely to result in reduced hospitalizations and associated Medicare spending (Peikes et al, 2009), and current payment structures do not provide much incentive for the collaboration necessary to implement effective care coordination post-discharge (Coleman and Berenson, 2014). With hospital stays costing the U.S. \$377.5 billion per year and Medicare members contributing to increased lengths of stay, there is more pressure for hospitals to improve their delivery of care and reduce patient harm. Part of this includes examining the discharge process, particularly for Medicare members, to prevent further variability in discharge practices that could result in rehospitalization and ED visits (Health Catalyst, 2017).

Opportunity to Improve Care

Hospital transitions require clear communication between inpatient and outpatient providers to ensure optimal health outcomes during patient handoffs (Kripalani et al, 2007; Peart, 2015; Van Walraven et al, 2002). Effective care coordination efforts must include notifying patients' primary care practitioners (PCP) of admission, PCP receipt of meaningful and timely discharge information (Kripalani et al, 2007; Kind and Smith, 2008), patient engagement through follow-up provided post-discharge and medication reconciliation post-discharge.

Supporting Evidence

Notification of inpatient admission	Significant information gaps exist regarding inpatient admissions. Multiple studies have found that PCPs are often not aware, notified or given a standard timeline for notification of their patients' hospital admissions (Commonwealth Fund, 2015; Jones et al, 2015; Moran et al, 2012; Oregon HQC, 2011; Pantilat, 2002; UT HSCSA, 2015; Ventura et al, 2010). Two studies found that direct communication between PCPs and hospital physicians rarely occurs (from 3%–23% of the time) (Kripalani et al, 2007; Bell et al, 2009). Another study found that the majority of clinicians estimated that without notifications, they would have known about less than 25% of inpatient admissions and discharges before their patient's next visit. Approximately half reported that they call the inpatient team more often when they get notifications and think that notifications improve patient safety by increasing clinician awareness of patients' clinical events and medication changes.
Receipt of discharge information	Hospital discharge processes are not standardized, present risks to patient safety and are consistently poor (Kripalani et al, 2007; Peart, 2015; Kind and Smith, 2008; Commonwealth Fund, 2015; Alpers, 2001; Goldman et al, 2001; Jack et al, 2009; RAND, 2014). Studies have found that discharge summaries are often delayed (Kripalani et al, 2007; Pantilat, 2002). One study (Peart, 2015) found that discharge summaries were unavailable at the first post-discharge visit between 66% and 88% of the time, and remained unavailable 23%–49% of the time four weeks post-discharge. Discharge summaries often lack sufficient administrative and medical information, including diagnostic test results (missing 33%–63% of the time), treatment or hospital course (missing 7%–22% of the time), discharge medications (missing 2%–40% of the time), test results pending at discharge (missing 65% of the time), patient or family counseling (missing 90%–92% of the time) and follow-up plans (missing 2%–43% of the time) (Peart, 2015; Kind and Smith, 2008). <small>Error! Bookmark not defined.</small> Another study interviewed almost 1,800 PCPs and found that discharge summaries were unavailable for 58% of patients within two weeks post-discharge (Bell et al, 2009).
Patient engagement after inpatient discharge	Numerous studies have found that timely follow-up can help ensure continuity of care and improve health outcomes (Health Affairs, 2012; Arbaje et al, 2014; Berkowitz, 2013; Bisognano and Boutwell, 2009; Braun et al, 2009; Coleman et al, 2006; Forster, 2003; Hansen et al, 2013; Harrison et al, 2011; Hernandez et al, 2010; Lin, Barnato and Degenholtz, 2011; Misky et al, 2011; Muus et al, 2010; Naylor et al, 2003; The Bridge Model, 2016), however, studies have also found poor patient engagement post-discharge and significant opportunities for improvement. For example, many patients do not know their discharge diagnosis, do not understand the purpose of their new medications and do not receive sufficient discharge instructions and necessary follow-up (Health Affairs, 2012; Lin et al, 2011; Balaban et al, 2008). A growing body of literature has demonstrated that Medicare beneficiaries do not receive follow-up to the extent it is needed (Hansen et al, 2013; Harrison et al, 2011). One study found that nearly half of all Medicare patients do not have an outpatient follow-up prior to readmission. A study of Medicare fee-for-service claims data for nearly 12 million Medicare beneficiaries discharged from a hospital found that 20% of patients were readmitted within 30 days, and 50% of nonsurgical patients were readmitted without having seen an outpatient doctor for follow-up (Bell et al, 2009). Another study, which focused on high-risk patients, found that an average of 38% of hospital patients had early follow-up after discharge (Bell et al, 2009). Additionally, the consensus that fragmented discharge services leads to a higher chance of post-discharge adverse events and early readmission due to poor management serves as an indicator demonstrating the importance of initiating discharge plans at the time of admission (Mennuni et al, 2017).

Medication reconciliation post-discharge	<p>Medication reconciliation is critical post-discharge for all individuals who use prescription medications. Prescription medication use is common among adults of all ages. On average, 82% of adults in the U.S. take at least 1 medication (prescription or nonprescription, vitamin/mineral, herbal/natural supplement); 29% take 5 or more.</p> <p>Older adults are the biggest consumers of medications: 17%–19% of people 65 and older take at least 10 medications in a given week (Slone, 2006). 62% of adults 65 and older have multiple chronic conditions; the higher number of chronic conditions they experience, the more providers are involved in their care. As the number of providers increases, the less likely patients are to understand, remember and reconcile multiple instructions (Vogeli et al, 2007). Patients with more than 1 chronic condition are likely to take more medications; therefore, ensuring proper medication reconciliation is imperative to preventing unintended complications.</p> <p>The high prevalence of prescription medications can result in potentially negative consequences for patients if not used and monitored appropriately. Approximately 1.5 million preventable adverse drug events occur in the United States each year (Johnson and Bootman, 1995). Many of these result from medication errors, drug interactions or inappropriate use of medications. About half of all adverse drug events are considered preventable (AHRQ, 2019).</p> <p>Hospital medication records are often incomplete when patients are admitted. A comparison of medication histories maintained for admitted patients with community pharmacy records revealed that hospital records omitted 25% of the medications in use. As a result, patients were discharged from the hospital without being continued on some chronic medications (Lau et al, 2000).</p> <p>Significant changes can occur to a patient's medications during hospitalization. Beers et al. found that 45% of all discharge medications were initiated during hospitalization. Provider errors and patient misunderstanding of discharge medications are also common. One observational study found that 81.4% of patients experienced a provider error or had no understanding of at least one intended medication change upon discharge. Providers were more likely to make an error on a medication that was unrelated to the primary diagnosis, which emphasizes the importance of knowing the patient's current medications upon admission and discharge so that they are properly reconciled. Patients were more likely to misunderstand medication changes that were unrelated to the primary diagnosis, which stresses the importance of proper communication to the patient prior to and following discharge.</p>
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Note: Medication Reconciliation Post-Discharge is also a standalone measure in HEDIS, which Medicare plans report separately.

Gaps in Care

Recent data from the HEDIS Health Plan measure set shows that there is room for improvement for the TRC measure given current performance rates. However, rates have improved from when the measure was introduced in 2017 to 2018—increasing from 11.7% to 16% for *Notification of Inpatient Admission*, 6.9% to 10.8% for *Receipt of Discharge Information*, 78.5% to 81.4% for *Patient Engagement After Inpatient Admission*, and 43.6% to 52.7% for *Medication Reconciliation Post-Discharge*.

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HEDIS Health Plan Performance Rates: Transitions of Care

Table 1. HEDIS TRC Measure Performance—Notification of Inpatient Admission—Medicare Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	525	449 (85.5)	16.0	20.4	0.7	2.7	7.8	21.2	49.4
2017	505	449 (88.9)	11.7	16.9	0.5	1.7	4.9	14.1	32.6

*For 2018 the average denominator across plans was 363 discharges, with a standard deviation of 103.

Table 2. HEDIS TRC Measure Performance—Receipt of Discharge Information—Medicare Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	525	449 (85.5)	10.8	17.7	0.0	0.5	2.2	11.9	35.8
2017	505	449 (88.9)	6.9	13.2	0.0	0.5	1.7	5.1	24.1

*For 2018 the average denominator across plans was 363 discharges, with a standard deviation of 103.

Table 3. HEDIS TRC Measure Performance—Patient Engagement After Inpatient Discharge—Medicare Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	525	472 (89.9)	81.4	7.4	73.7	77.8	82.2	85.9	89.5
2017	505	467 (92.5)	78.5	10.1	70.0	75.9	80.3	83.7	87.1

*For 2018 the average denominator across plans was 905 discharges, with a standard deviation of 7,747.

Table 4. HEDIS TRC Measure Performance—Medication Reconciliation Post-Discharge—Medicare Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	525	472 (89.9)	52.7	18.5	29.4	41.2	51.5	66.6	77.9
2017	505	465 (92.1)	43.6	20.6	18.7	28.2	42.3	57.4	73.4

*For 2018 the average denominator across plans was 446 discharges, with a standard deviation of 685.