TRANSITIONS OF CARE

Measurement Specifications for Star Ratings Program

Measurement Description

Percent of all discharges for which each of the four measure components (Notification of Inpatient Admission, Receipt of Discharge Information, Patient Engagement after Inpatient Discharge, and Medication Reconciliation Post-Discharge) occurred.

Measurement Source

HEDIS 2020-2021

Denominator

Acute or nonacute inpatient discharges on or between January 1 and December 31 of the measurement year. Applies to discharges of patients 18 years and older. If patient has more than one discharge during measurement period, include all discharges.

- Use admit date from first admission and discharge date from last discharge if discharge is followed by readmission/direct transfer on date of discharge through 30 days after discharge (31 days total).
- If last discharge occurs after December 1 of measurement year, exclude initial and readmission/direct transfer discharge.
- Include only nonacute inpatient discharge, if admission/discharge date for an acute inpatient stay occur between admission/discharge dates for nonacute inpatient stay.

Numerator

Eligible discharges for which ALL the following components occurred:

1. Notification of Inpatient Admission
   - Documentation in the outpatient medical record of receipt of notification of inpatient admission on the day of admission or within the following 2 calendar days (3 days total).
   - Notification may include ADT (admission or discharge and transfer) notification, EHR, email, phone, or fax.
2. Receipt of Discharge Information
   - Documentation in the outpatient medical record of receipt of discharge information on the day of discharge or within the following 2 calendar days (3 days total).
   - Discharge information includes treating provider, procedures or treatment, diagnoses at discharge, current medication list, testing results, and instructions for patient care post-discharge.
3. Patient Engagement after Inpatient Discharge
   - Evidence of patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.
   - Patient engagement may include outpatient (in office or home), telehealth, or telephone visits.
4. Medication Reconciliation Post-Discharge
   - Medication reconciliation is performed by a prescribing practitioner, clinical pharmacist, or registered nurse on the date of discharge through 30 days after discharge (31 days total).
   - Refer to *Notes* section for more information.

Evidence of the date each component occurred must be present.

Exclusion Criteria	
Hospice	Patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Notes

- Any of the following meet criteria for documentation of Medication Reconciliation Post-Discharge:
  a. Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.
  b. 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).
  c. Documentation of the member's current medications with a notation that the discharge medications were reviewed.
  d. Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
  e. 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.
  f. 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).
  g. Notation that no medications were prescribed or ordered upon discharge.
- Medication List: A list of the patient's 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.
- Medication Reconciliation: A review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. A patient does not need to be present during the review.

Supplemental Data

For Medication Reconciliation Post-Discharge:

Encounter: 99483, 99495, 99496

Intervention: 1111F

Best Practice

- Ensure documentation of the following includes date of service: notification of inpatient admission, receipt of discharge information, patient engagement after inpatient discharge, and medication reconciliation post-discharge in the medical record.
- Update workflows as needed for multidisciplinary communication and shared accountability.
- Standardize plans, procedures, forms, and training.
- Make education materials and follow-up care timely and easily accessible for patients

Star Ratings Performance Thresholds

Year	1 STAR	2 STARS	3 STARS	4 STARS	5 STARS
2022	TBD	TBD	TBD	TBD	TBD