REFERENCE GUIDE PURPOSE:

The purpose of this Reference Guide is to outline the process for documenting Quality HEDIS measures within the Care Coordination HEDIS sub-domain. This reference guide includes documentation for the following measures, Advance Care Planning, and Transitions of Care.

DEFINITIONS & ACRONYMNS:

- HEDIS: Health Effectiveness Data and Information Set
- MY: Measurement Year
- Measurement Year: The audit year in which quality measure data is collected from.
- DOS: Date of Service
- Date of Service: The date a rendered service was provided.
- Ongoing Care Providers: Clinicians who manage the member's ongoing care, outside of the inpatient setting
- Clinical Staff: LPN, RN
- Non-clinical staff: Non licensure holding staff including, but not limited to health information management specialist, health outreach workers, etc.
- Qualifying Event: Specified event, such as diagnosis code, event code, etc. as detailed per measure, that will count towards a member's compliance.
- Measure Cohort: All the details which create a measure, be it a specific set of diagnosis, an age range, or other parameters which are defined to calculate a measure population.
- Denominator: All members with qualifying events defined by a measure cohort to make them a part of the eligible population.
- Numerator: All the members within a specified measure denominator that have had a qualifying event such as diagnosis code, event code, or whatever is detailed in the measure that shows the member has had a qualifying event to be counted as having the service of interest.
- Numerator Compliant member: A member with a qualifying event for a measure.
- Administrative Data: Transaction data, or other administrative data used to identify the eligible population and numerator. This information includes both claims and other transaction data, as well as supplemental data.
- Supplemental Data: Data used to capture missing service data not received through administrative sources (claims or encounters) or by standard electronically generated files from the service providers.
- Hybrid Data: Medical record data used to identify eligible numerator events.
- Transaction Data: Data that is created and updated within operational systems, which collects information related to intake, service, diagnostic testing, procedures, purchasing, billing, accounts receivable and accounts payable. Can be from claims, EMR data exports, etc.

Contents

Advance Care Planning (ACP)

Measure Member Cohort: 66+ years old

Measure Lookback:

Measurement Year	
Advanced care planning discussion	**Advanced care plan on file**

Description: Members who had advance care planning during the MY or an executed advanced care planin the medical record during the MY
Intent: Consideration should be given to an individual's own choices about end-of-life care; advanced care plans should be executed and updated regularly

Virtual or telephone visits are accepted for this measure.

What does HEDIS Require and By Whom?

Credentials	Documentation Requirement
Ongoing care provider, clinical staff	Dated documentation of advanced care planning discussion
Non-clinical staff, clinical staff, ongoing care provider	Living Will, MOLST, Healthcare Proxy, Power of Attorney document uploaded into the legal health record

Examples of How to Document and Where.

Report Information	Electronic Health Record - Defined Folder o Diagnostic Tests ▪ Defined Document Naming Convention • MM DD YYYY MOLST • MM DD YYYY HCP • MM DD YYYY POA
Visit Information	Electronic Health Record - Defined Structed Data Location (Social History, etc.) ▪ End of life discussion with member

Transitions of Care (TRC)

Sub-measure(s):(4): Notification of Admission

Measure Member Cohort Age Range: 18+ years old
Measure Lookback: 72 Hours, after admission
Description: Receipt of notification of inpatient admission < 72 HR
Intent: Transition from the inpatient setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient providers; intentional and unintentional medication changes; incomplete diagnostic work-ups and inadequate patient, caregiver and provider understanding of diagnoses, medication and follow-up needs. There is pressure for hospitals, health plans, and providers to improve delivery and coordination of care and lower risk for these patients. This includes examining the admission and discharge processes to prevent rehospitalization, ED visits, and other poor health outcomes.

Virtual or telephone visits are not applicable to this sub-measure.

What does HEDIS Require and By Whom?

Credentials	Documentation Requirement
Non-clinical staff, clinical staff, ongoing care provider	Notification of admission between the hospital and ongoing care provider staff by means of email, fax, phone call, etc and documentation of this communication in the member's legal health record.

Examples of How to Document and Where.

Transitions of Care Information	Electronic Health Record - Defined Structured Data Field o Admission Notification ▪ Admission Date

Transitions of Care (TRC)

Sub-measure(s):(4): Notification of Discharge
Measure Member Cohort Age Range: 18+ years old
Measure Lookback: 72 Hours, after discharge
Description: Receipt of notification of inpatient discharge < 72 HR
Intent: Transition from the inpatient setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient providers; intentional and unintentional medication changes; incomplete diagnostic work-ups and inadequate patient, caregiver and provider understanding of diagnoses, medication and follow-up needs. There is pressure for hospitals, health plans, and providers to improve delivery and coordination of care and lower risk for these patients. This includes examining the admission and discharge processes to prevent rehospitalization, ED visits, and other poor health outcomes

Virtual or telephone visits are not applicable to this sub-measure.

What does HEDIS Require and By Whom?

Credentials	Documentation Requirement
Non-clinical staff, clinical staff, ongoing care provider	Notification of discharge between the hospital and ongoing care provider staff by means of email, fax, phone call, etc and documentation of this communication in the member's legal health record.
Non-clinical staff, clinical staff, ongoing care provider	Communication with discharge summary uploaded in the legal health record.

Examples of How to Document and Where.

Transitions of Care Information	Electronic Health Record - Defined Structured Data Field o Post-Discharge Activity ▪ Facility ▪ Discharge Diagnosis ▪ Level of Care ▪ Discharge Date ▪ Notes • Brief clinical note, summarizing discharge plan

Transitions of Care (TRC)

Sub-measure(s):(4): Medication Reconciliation Post Discharge

Measure Member Cohort Age Range: 18+ years old
Measure Lookback: 31 Total Days
Description: The percentage of discharges 01/01-12/01 of MY for members 18 + y/o where medications were reconciled < 30 days after discharge (including discharge day=31 total days)
Intent: Transition from the inpatient setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient providers; intentional and unintentional medication changes; incomplete diagnostic work-ups and inadequate patient, caregiver and provider understanding of diagnoses, medication and follow-up needs. There is pressure for hospitals, health plans, and providers to improve delivery and coordination of care and lower risk for these patients. This includes examining the admission and discharge processes to prevent rehospitalization, ED visits, and other poor health outcomes.

Virtual or telephone visits are acceptable for this measure.

WHAT DOES HEDIS REQUIRE AND BY WHOM?

Credentials	Documentation Requirement
RN, PA, NP, MD, DO, Clinical Pharmacist	- Medication reconciliation where discharge medications are reconciled with the list in the outpatient medicalrecord. - Medication list in the member's legal health record.

EXAMPLES OF HOW TO DOCUMENT AND WHERE.

Visit Information	Electronic Health Record - Defined Visit Type o Post-Discharge Activity ▪ Medication • Discontinued Medications • New Medications
Visit Information	Electronic Health Record - Visit completed by appropriate provider o Medication List ▪ Medications Reconciled - Note indicated provider is aware of recent hospitalization/discharge **Note must be signed by appropriate provider**

Transitions of Care (TRC)

Sub-measure(s):(4): Patient Engagement After Inpatient Discharge

Measure Member Cohort Age Range: 18+ years old
Measure Lookback: 30 Days after Discharge
Description: The percentage of discharges 01/01-12/01 of MY for members 18 + y/o where patient engagement < 30 Days after Discharge (e.g., office visits, visits to the home, telehealth)
Intent: Transition from the inpatient setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient providers; intentional and unintentional medication changes; incomplete diagnostic work-ups and inadequate patient, caregiver and provider understanding of diagnoses, medication and follow-up needs. There is pressure for hospitals, health plans, and providers to improve delivery and coordination of care and lower risk for these patients. This includes examining the admission and discharge processes to prevent rehospitalization, ED visits, and other poor health outcomes

Virtual or telephone visits are acceptable for this measure.

What does HEDIS Require and By Whom?

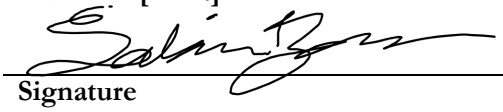
Credentials	Documentation Requirement
Clinical staff, ongoing provider	An outpatient visit, in person, or through a synchronous or asynchronous telehealth visit

Examples of How to Document and Where.

Visit Information	Electronic Health Record - Defined Visit Type o Post-Discharge Activity
Virtual Check-In	Electronic Health Record - Post Discharge Virtual Check- in

RELATED DOCUMENTS:

APPROVALS:

Sabrina N Zecher	Manager, HEDIS
CCA SUBJECT MATTER EXPERT[Print]	**Title [Print]**
	12/01/2021
Signature	**Date**