Transitions of Care (TRC)

CLINICAL RATIONALE

- The Centers for Medicare & Medicaid Services (CMS) defines transition of care as the movement of a patient from one setting of care to another. Settings of care may include hospitals, ambulatory primary care practices, ambulatory specialty care practices, long-term care facilities, home health and rehabilitation facilities.[1]
- Hospital discharge is a complex process representing a time of significant vulnerability for patients. Transitions increase the risk of adverse events due to the potential for miscommunication as responsibility is given to new parties. Safe and effective transfer of responsibility for a patient's medical care relies on effective provider communication with patient comprehension of discharge instructions.[2]
- The TRC measure is a hospital-level measure of performance that ensures processes are in place to identify individuals at risk for poor transitions. It helps ensure that appropriate measures are taken by care team members at any location on the continuum to ensure optimum patient health outcomes. This measure assesses the percentage of discharges for Medicare members 18 and older and reports the rate of patient engagement after inpatient discharge. It requires documentation of patient engagement (e.g., office visits, visits to the home, telehealth) within 30 days after discharge.[3]

MEASURE AT A GLANCE

Applicable specialties
Internal Medicine

Measure steward
National Committee for Quality Assurance (NCQA)

Measure identifiers
HEDIS® TRC*

Measure description
Patient(s) 18 years of age or older who had patient engagement within 30 days after discharge.

* HEDIS® TRC: Transitions of Care: Engagement within 30 days after Discharge (TRC).

1. Agency for Healthcare Research and Quality (AHRQ). Chartbook on care coordination: transitions of care.
2. Coleman EA, Berenson R. Lost in transition: challenges and opportunities for improving the quality of transitional care. Ann Intern Med. 2004;141:533-536.
3. Coleman EA. Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs. J Am Geriatr Soc.2003;51:549-555.

Humana.