



TRANSITIONS OF CARE (TRC)



PURPOSE OF THE MEASURE

- The purpose of TRC is to assess the percentage of discharges for members 18 years of age or older who had each of the following:
- Notification of Inpatient Admission- Documentation of receipt of notification of inpatient admission on the day of admission through two days after admission (3 total days).
- Receipt of Discharge Information- Documentation of receipt of discharge information on the day of discharge through two days after discharge (3 total 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 of discharge through 30 days after discharge (31 total days).
 - ✓ Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient record.
 - ✓ Medication list is defined as 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.

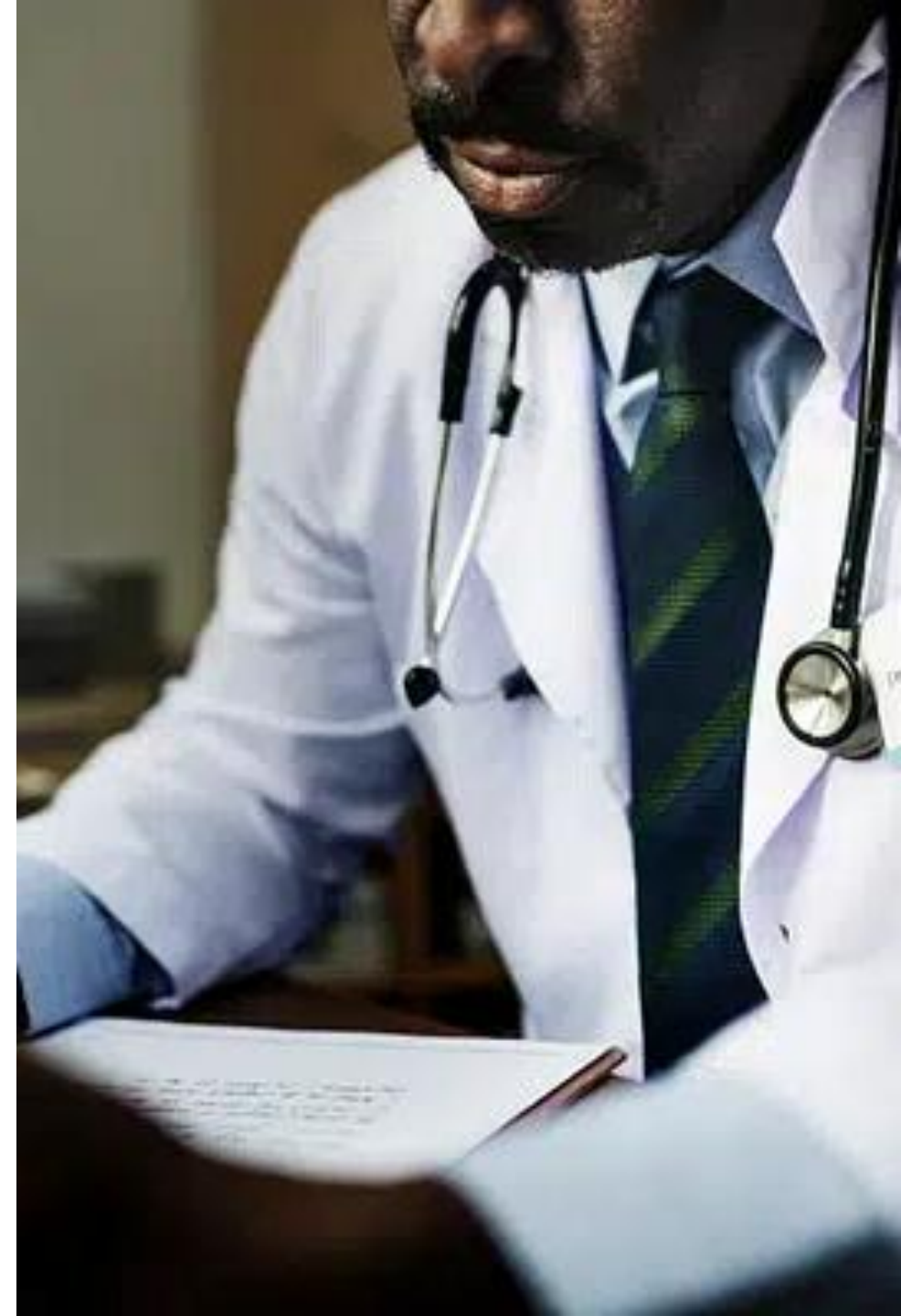
GENERAL GUIDELINES

Be sure the record is accessible to the member's PCP or ongoing care provider. Do not enter information from a record that does not appear to be accessible to a PCP or ongoing care provider.

If a specialist assumed responsibility for the member's care, they can be considered an "ongoing care provider." This can be the ongoing care provider who most recently provided care to the member.

Any provider can count as a patient's ongoing care provider if they provide care to a member in and out of the hospital.

- Example: If a member was in the hospital for COPD and saw a pulmonologist the following week, the pulmonologist could be considered the ongoing provider as they were treating them for the disease in the hospital.
- Example: If the member was in the hospital for a knee amputation and saw the surgeon after hospitalization, the surgeon can be the ongoing care provider.
- Example: If the member sees the specialist that saw them for the disease/issue for which they were hospitalized after they are released, that is considered the ongoing care provider.



NOTIFICATION OF INPATIENT ADMISSION

- Document the date that the PCP or ongoing care provider was notified of the inpatient admission prior to admission (for a planned admission) or on the day of admission through two days after admission. Admission refers to the date of inpatient admission.
- Documentation 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:
 - ✓ Communication between inpatient providers/staff and the member's PCP or ongoing care provider (e.g phone call, e-mail, fax)
 - ✓ Communication between emergency department and the member's PCP or ongoing care provider prior to admission (e.g., phone call, e-mail, fax)
 - ✓ 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.
 - 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 admission through two days after admission meets criteria.
 - When using a shared EMR, look for evidence that the medical record number (MRN) is the same in the outpatient chart and inpatient chart to prove it is a shared EMR. There must be outpatient records in the chart to prove it is a shared EMR.
 - When using a shared EMR, the discharge summary can count as evidence of notification of inpatient admission IF the discharge is within two days after admission (e.g., admission date 02/15/2026, discharge date 2/17/2026- discharge summary found in a shared EMR- this is acceptable notification of inpatient admission).

NOTIFICATION OF INPATIENT ADMISSION

- Examples of Notification of Inpatient Admission (continued):
 - ✓ 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.
 - ✓ Indication that the admission was elective and the member's PCP or on-going care provider was notified or had performed a preadmission exam.
 - This example is the only time when the communication about the admission can be prior to the admission date.
 - Do not count documentation that the member or member's family notified the member's PCP or ongoing care provider of the admission.
 - 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
-

ACCEPTABLE NOTIFICATION OF INPATIENT ADMISSION

PSE Appt H&P

Presurgical Evaluation

65 year old Male

04/29/2024

Height: 6' 0" Weight: 73.5 kg BMI: (21.97)

VITAL SIGNS: BP 135/67 | Pulse 58 | Temp 98.5 °F (36.9 °C) (Temporal Artery) | Resp 15
| Ht 1.829 m (6") | Wt 73.5 kg (162 lb) | SpO2 98% | BMI 21.97 kg/m²

ALLERGIES:

Allergies

Allergen

- Penicillins

Reactions

Hives and Swelling

HISTORY OF PRESENT ILLNESS:

is a 65 year old male pt who is seen here today for pre-surgical evaluation. He has a h/o PAD/AAA and is scheduled for Bilateral Aorto femoral bypass Graft. Currently denies fever and chills, new cough, SOB or CP.

He is scheduled for surgery w/ Dr. on **05/02/2026**

ACCEPTABLE NOTIFICATION OF INPATIENT ADMISSION

Chahine, MD	Progress Notes	Encounter Date	05/05/2026
Physician	Signed		
Specialty: Hematology and Oncology			
Cancer Center			
Date of evaluation:	05/05/2026		
Primary Care Physician:	Capers, MD		
Reason for evaluation:			
Chief Complaint			
Patient presents with			
• Colon Cancer			
Primary cancer of cecum			
Subjective: Here for follow up. Very tearful about upcoming surgery.			
Seen by Dr. Valente on	4/30/2024	scheduled for surgery on	5/14/2024, excision of colon mass; Excision of spots on liver and spleen.

This patient has remained hemodynamically stable during their ED course.

Diagnosis:

1. Acute alcoholic intoxication with complication (HCC)
2. Generalized abdominal pain
3. Rectal bleeding

Disposition:

Patient's disposition: Admit to CCU/ICU

UNACCEPTABLE NOTIFICATION OF INPATIENT ADMISSION

NOTIFICATION OF DISCHARGE INFORMATION

- Document the date that the PCP or ongoing care provider was notified of discharge or when they received discharge information on the day of discharge through two days after discharge.
 - ✓ Discharge information may be included in a discharge summary or summary of care record. At a minimum, the discharge information must include all 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 test pending
 - Instructions for patient care post-discharge
 - Instructions can include "flu with PCP in two weeks" or "take all antibiotics as prescribed." They do
 - ✓ Do not need to be instructions to the PCP. They can be instructions to the member or caregiver.
-

ACCEPTABLE
NOTIFICATION
OF
DISCHARGE
INFORMATION

Date and time of transmission: Sunday, 06/16/2026 2:36:24 PM
Number of pages including this cover sheet: 06

11:11:59

FAX

ACCEPTABLE NOTIFICATION OF DISCHARGE INFORMATION

Discharge Summary

Mehta, MD (Physician) • General Internal Medicine



DISCHARGE SUMMARY

PATIENT NAME:
MRN:

Code Status: Prior

Highest Readmission Risk Score: 50

The 30 day readmissions risk score is derived from an internally validated risk model which evaluates patient level characteristics, utilization history, medication orders and lab results up until the day of discharge. Patients with a score of 40 or above are considered highest risk for readmission. Specific patient level drivers will be listed at the bottom of the summary.

The 30 day readmissions risk score is derived from an internally validated risk model which evaluates patient level characteristics, utilization history, medication orders and lab results up until the day of discharge. Patients with a score of 40 or above are considered highest risk for readmission. Specific patient level drivers will be listed at the bottom of the summary.

Admission Information

Admission Information

ADMIT DATE: 06/16/2026

DISCHARGE DATE: 06/16/2026

MY DOCTORS AND MEDICAL TEAM:

My Main Hospital Doctor: Mehta, MD

Primary Care Provider: I Mehta, MD

My Medical Team Members: Treatment Team:

Attending Provider: Mehta, MD

Physician Assistant: I Leshner, PA-C

Attending: Mehta, MD

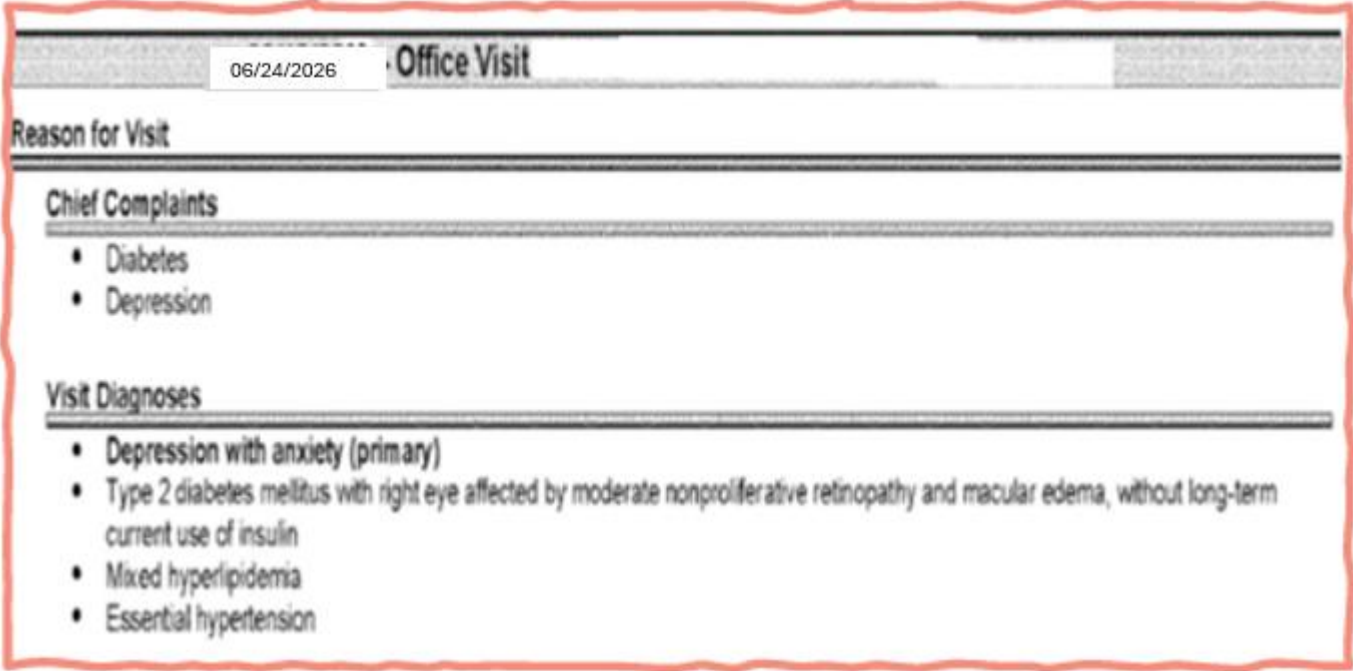
PATIENT ENGAGEMENT AFTER INPATIENT DISCHARGE

- Document the date of patient engagement after inpatient discharge within Do not include patient engagement that occurs on the date of discharge.
- Either 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 the provider via telephone or videoconferencing.
- An e-visit or virtual check-in (asynchronous telehealth not in real-time).
- If the member is unable to communicate with the provider, interaction between the member's
- caregiver and the provider meets criteria.

Patient engagement does not have to be related to the hospitalization. Any visit within 30 days of discharge is acceptable.

There are no provider specifications for patient engagement. Any applicable visit documented in the outpatient record accessible to the PCP or ongoing care provider within 30 days of discharge meets criteria regardless of the provider type and reason for the visit. It can be a visit with an PT, OT, LPN, RN, or MA alone.

ACCEPTABLE PATIENT ENGAGEMENT AFTER INPATIENT



06/24/2026	Office Visit
Reason for Visit	
Chief Complaints	
• Diabetes • Depression	
Visit Diagnoses	
• Depression with anxiety (primary) • Type 2 diabetes mellitus with right eye affected by moderate nonproliferative retinopathy and macular edema, without long-term current use of insulin • Mixed hyperlipidemia • Essential hypertension	

ACCEPTABLE PATIENT ENGAGEMENT AFTER INPATIENT DISCHARGE

06/16/2024 - Legacy Encounter in NOMS DATA CONVERSION LEGACY

Clinical Notes

Progress Notes

Version 1 of 1

MD at 06/16/2024

Service: MD

Encounter Date 06/16/2024

Author Type: MD

Status: Signed

DOB: 12/09/1983 (39 yo F) Acc No. DOS 06/16/2024

39 Y old Female, DOB: 12/09/1983
Account Number

Guarantor: PCTP

Insurance: Referring

Home: Appointment Facility

Medical: DO

Progress Note: MID

Reason for Appointment
1. Surgical post op pain

History of Present Illness
Constitutional:
She is here for a post op visit. She has a lot of social issues but is otherwise doing well.

Current Medications
Taking
Orilissa (Eloxxin Sodium) 200 MG Tablet 1 tablet Orally Twice a day

Past Medical History
Vaginal infections.
Herpes.
Diabetes.
Endometriosis.
Anxiety disorder.
Depression.
Bowel disorders.
Ulcer.
Arthritis.

Surgical History
Liver biopsy
RA TLH and LSO 3/2023

Family History
Father: unknown
Mother: unknown

Social History
Migrated Social History:
Migrated Social History: Unknown.

Gyn History
Hysterectomy RA TLH and LSO.

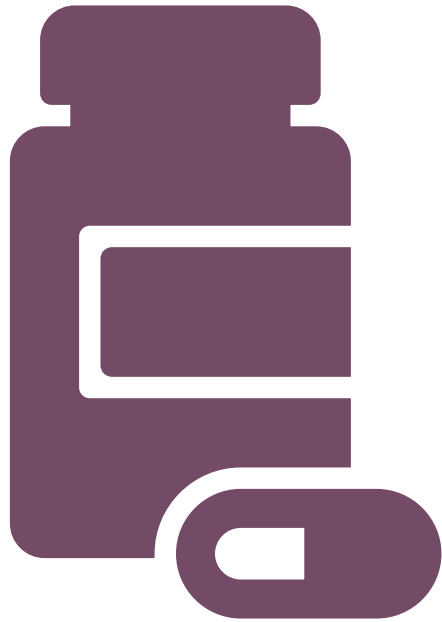
OB History
Pregnancy 0.

Allergies
Ketorolac

Printed: 1:58 PM

Page 19

MEDICATION RECONCILIATION



- Medication reconciliation must be conducted by a prescribing practitioner (e.g., physician assistant, nurse practitioner, primary care provider), clinical pharmacist or registered nurse on the date of discharge through 30 days after discharge (31 total days).

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.

NOTES

- Only documentation found in the outpatient chart meets criteria for a medication reconciliation. Do not use inpatient records.
 - A medication reconciliation can NOT be done in a nursing home or skilled nursing facility, as these are not considered outpatient facilities.
 - A medication reconciliation from an assisted living facility is acceptable.
 - A list of discharge medications or discharge summary is NOT required for the medication reconciliation to be acceptable.
 - There must be a current medication list in the outpatient record, either on the progress note where reconciliation is found or a standalone medication list.
 - The medication reconciliation must be found in an outpatient medical record; however, an outpatient visit is not required.
 - ✓ Example: Provider has noted on current medication list in the medical record that he has reviewed both the discharge medications and current medications. He did not see member that day, but the medications were reconciled
-

Admit Date 10/05/2026 Discharge Date __ 10/09/2026 __

Date/Time of Medication Reconciliation Completed: __ 10/18/2026

Name of RN (CM/PCC) Completing Review of Medication Reconciliation with E-Signature

Medication Reconciliation completed:

X Current Medications: see attached medication list

X Discharge Medications: see attached medication list

X Medication Changes: Metformin was increased to 100mg BID, cyclobenzaprine 5mg PRN started, Isosorbide Mononitrate 30mg daily started, Torsemide 20mg daily started

X Same Medications: see attached medication list

X Discontinuation of Medications: Member stopped midodrine 10mg

X No Medications prescribed/ordered at discharge: see medications list

ACCEPTABLE MEDICATION RECONCILIATION
EXAMPLES

EXCLUSIONS

- Member died during 2026
- Members who use hospice services or elect to use a hospice benefit anytime during the measurement year 2026, regardless of when services performed
 - Palliative care is not considered the same as hospice care