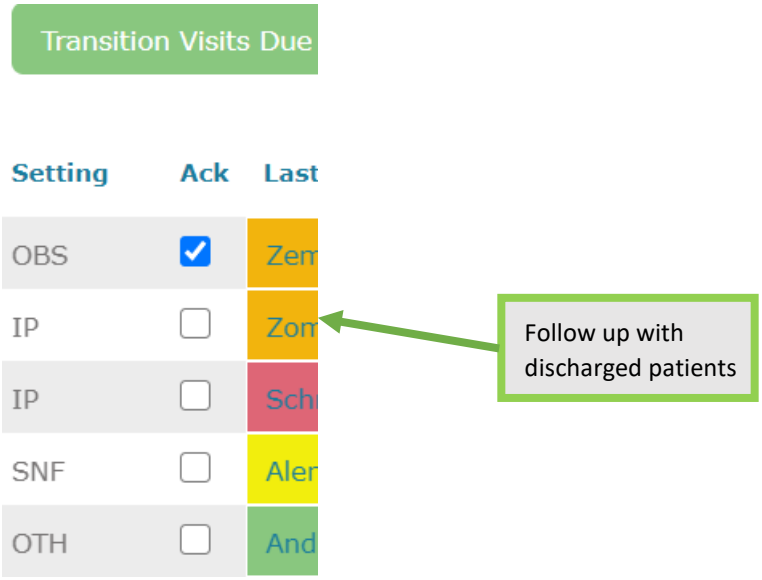
Opportunities to improve transitional care management:

- Use CareScreen® messaging to schedule the necessary follow up for patients with their PCPs
- Complete the quality measure tasks within time frame for transition of care
- Submit applicable transitional CPT codes to improve reimbursement

CareScreen® Admit/Discharge/Transfer (ADT) pop ups and messages on **Member Selection page:**

Tips and legend for Admit/Discharge/Transfer messages
Click your green "**Transition Visits Due**" button best daily and check off "Acknowledge Discharge" for applicable patients and schedule office visit:



- Hover over Last Name to see name of facility, ADT date and diagnosis

Setting column on the left indicates:

- OBS - hospital - observation
- IP - hospital inpatient
- SNF - skilled nursing facility inpatient
- OTH - other
- ! - identifies information that has been updated in the past 24 hours

Highlighting color of Last Name correlates to admission status:

- Patient was recently discharged from a hospital or a SNF
- Patient currently in a SNF
- Patient currently in a hospital
- Patient readmitted

HEDIS Quality Measures Reporting Requirements for: "Transition of Care" / "Transitional Care" After a Hospital or Other Facility Admission	
Required Steps / Tasks by PCP Practices	**Timeframe**
Document your knowledge of the admission in your medical record • One line entry saying your practice is aware of the admission	**Day of admission (or day after)**
Record that you received the discharge summary information • One line in your EMR that you received, and you reviewed the hospital (or other facility) discharge summary information	**Day of discharge (or day after)**
Medication Reconciliation after Discharge • **Make a note in the EMR that the med reconciliation was done** • Record all medications (old & new) in the EMR	**Within 30 days of discharge**
Post discharge patient engagement (office visit) after discharge • This visit may be a TOC, follow-up, or other face-to-face visit	**Within 30 days of discharge**
Click I -buttons on Quality registry page for more information on this measure	

Transition of Care CPT Codes	
1111F	Discharge medications reconciled with the current medication list in outpatient medical record within **30 days** This code cannot be submitted in combination with 99495 or 99496
99495	Transitional Care Management Services with the following required elements: • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge • Medical decision making of at least **moderate complexity** during the service period • Face-to-face visit or Telehealth, within **14 calendar days** of discharge
99496	Transitional Care Management Services with the following required elements: • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge • Medical decision making of **high complexity** during the service period • Face-to-face visit or Telehealth, within **7 calendar days** of discharge