Transition of Care - Patient Engagement After Inpatient Discharge (TRCPE)

CMS Weight **1**

Why it Matters
Comprehensive care coordination and effective transition from an inpatient stay can reduce readmissions, unintentional medication changes and patient misunderstandings.

Definition
Percentage of patients 18 years or older with an acute or non-acute inpatient discharge in the measurement year (Jan1 – Dec 31) with patient engagement documented

Timeframe of Compliance
Patient engagement must happen after the day of discharge or 30 days after (engagement on the day of discharge does not close the measure)

Patient Engagement Can Occur During Any of the Following:
- Outpatient visits (office or home)
- Telephone visit
- Virtual visit between patient and provider
- Telehealth visit (audio and video)
- Transitional care management

Gap Closure Methods

CPT II Codes	Structure Data	Documentation Submission
None	No	Health history and physical Home health records Progress notes

Tips and Best Practices for TRCPE
- If patient is unable to communicate, communication with a caregiver and provider meets the criteria

Transition of Care - Patient Engagement After Inpatient Discharge Measure Exclusions

Required Exclusions

Exclusion	Timeframe for Exclusion
• Patients in hospice or using hospice services • Patients who died	Any time during the measurement year

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