HEDIS® MY 2021

Medical Record Review Training Guide

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9/13/2021

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What is HEDIS®?

What is HEDIS®?

HEDIS® MY 2021 includes 91 measures across six (6) domains:

Effectiveness of Care	Utilization and Risk Adjusted Utilization
Access/Availability of Care	Health Plan Descriptive Information
Experience of Care	Measures Reported Using Electronic Clinical Data Systems

AgeWell New York is required to report HEDIS® rates to the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS) and the Department. Medical record reviews are allowed for a subset of measures known as **Hybrid Measures**.

Your Role in the HEDIS® Medical Record Review (MRR) Process

As a HEDIS® medical record reviewer, your role is to help AgeWell New York increase the plan's HEDIS® rates through medical record reviews. This consists of finding the appropriate information needed for a specific HEDIS® measure within a members' medical record.

Proper Identification – What to Look for in the Medical Record

The medical record is the collective accumulation of notes kept by all practitioners who treat a member. It constitutes the official record of patient visits and treatments. It includes all test results (e.g., lab reports, pathology reports, and radiology). The complete medical record may be located in more than one place (e.g., part in the primary care provider's office, part in the specialists' offices). Electronic medical records are also considered official medical records.

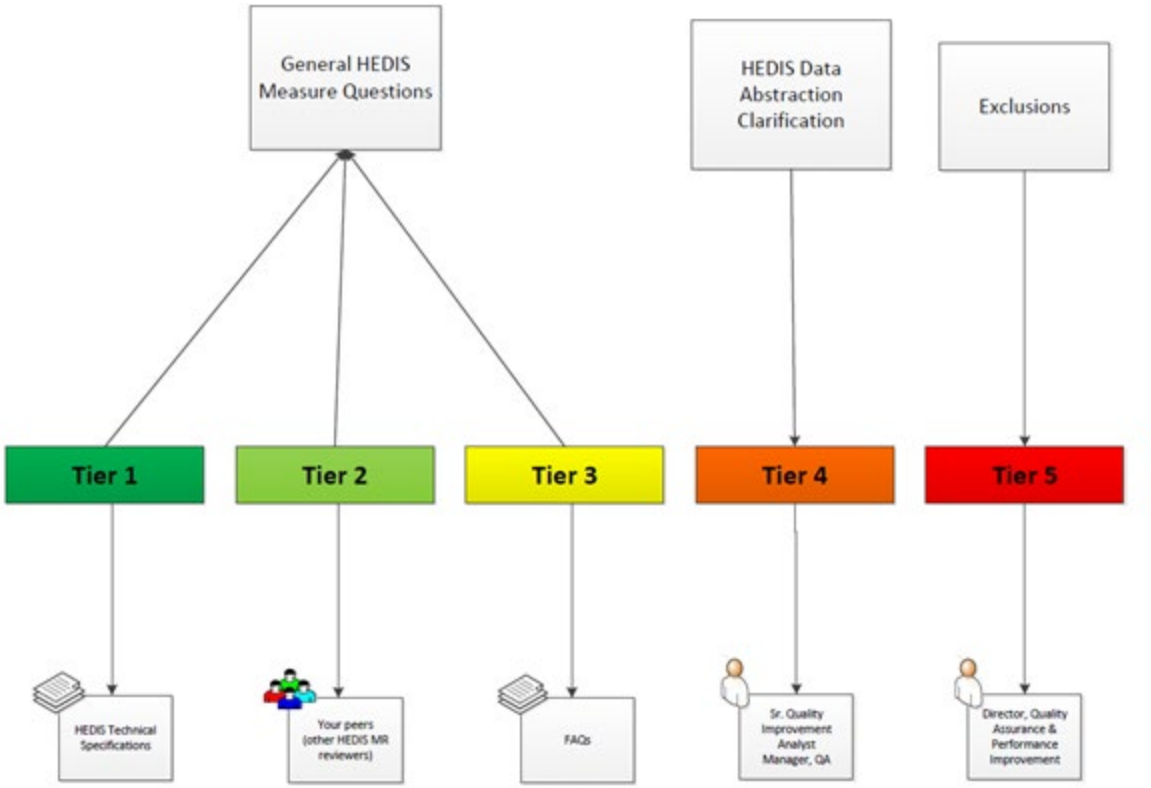
Examples of documentation that may be used for HEDIS® MRR are as follows:

- Office progress notes
- Problem lists
- Encounter forms and diagnostic reports
- SOAP notes
- Facility discharge summaries
- Immunization registries and lab reports

Medical record reviewers/abstractors should use **two (2) demographic identifiers** to validate that the correct medical record is being used. The record should have **at minimum** the **member's name and DOB** on **each page**.

Topic	Description
The Medical Record	A service should only be counted if the medical record contains the date of the service and evidence that the service occurred. Evidence must demonstrate a measure required test or service was performed rather than just ordered. Documentation of a procedure code alone does not comply.
Date Specficity	Dates must be specific enough to determine that an event occurred during the timeframe established in the measure. There are instances when documentation of the year alone is adequate; that said, terms such as "recent", "most recent" or "at a prior visit" ***are not acceptable***. Documented history of an event (e.g., a disease). Undated documentation may be used if it is specific enough to determine that event occurred during the timeframe specified in the measure.
Most Recent Test Requirements (7 day rule)	For measures that require the use of results from the most recent test, search the medical record for documentation that shows a test was performed not just ordered. Look for a numeric value, an interpretation of a numeric value (e.g., within normal limits, average, high), or documentation that a test was performed but results could not be calulcated. Undated lab results in the medical record ***cannot*** be used. Only the "collection date" can be used for laboratory services. Order date and documented date *are not* eligible for HEDIS reporting.

Where to get help



Tier 1: The ***HEDIS® MY 2021, Technical Specifications Volume 2*** and this training manual should **always** be referenced **first** when you need help.

Tier 2: Your peers (other medical record reviewers)

Tier 3: FAQs – NCQA FAQs or Advent Advisory Group FAQs

Tier 4: Medical Records Review Project Manager(s)

	Primary	Secondary
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Tier 5: Exclusions must be reviewed by the Director of Quality Assurance & Performance Improvement

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HEDIS®

MY 2021 Hybrid Measures

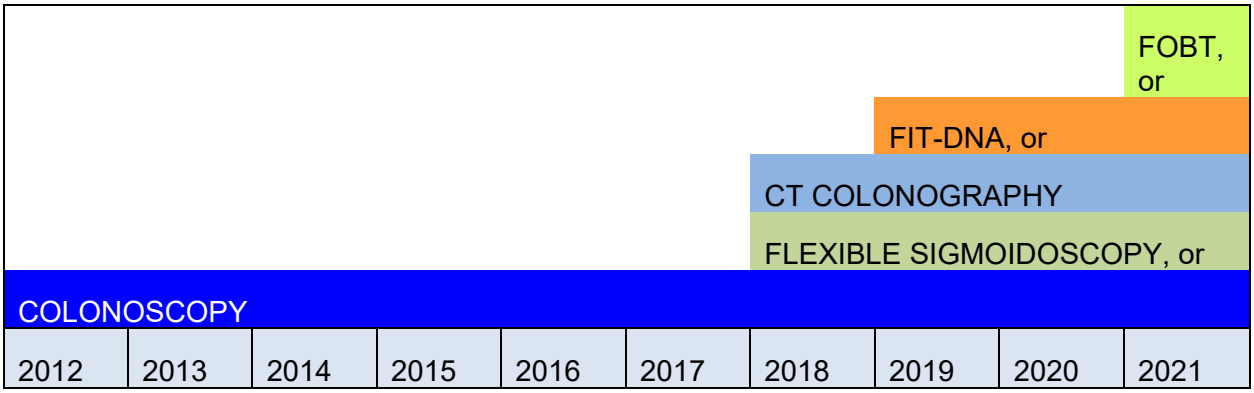
Colorectal Cancer Screening (COL)

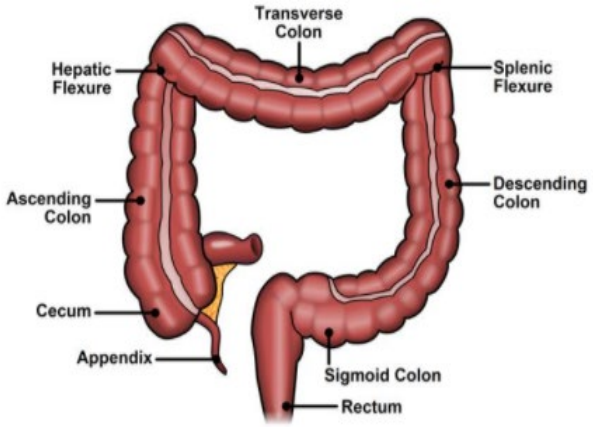
Measure description: The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Denominator inclusion: age 51–75 years as of December 31, 2021

Numerator compliance: One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following:

- FOBT during 2021
- Flexible sigmoidoscopy during 2017-2021
- Colonoscopy during 2012-2021
- CT 2017-2021
- FIT-DNA during 2019-2021



Test	Numerator Criteria Description
gFOBT	Uses a chemical to detect heme in stool. Three (3) cards are needed to be compliant.
FIT (or iFOBT)	Uses antibodies to detect the human hemoglobin protein in the stool. May accept <3 cards for compliance.
FIT-DNA	This is similar to FIT but tests additional biomarkers in 3 genes for colorectal cancer. (e.g., Cologuard)
Flexible Sigmoidoscopy	A thin, flexible tube (sigmoidoscope) is inserted into the rectum to evaluate the lower part of the large intestine. If unclear on the type of test given, check the pathology report to see if there is advancement into the splenic flexure; this is a flexible sigmoidoscopy.
Colonoscopy	A thin flexible tube is used to examine the entire colon via the rectum. If unclear on the type of test, if the pathology report shows advancement into the sigmoid colon, this is a colonoscopy.
CT Colonography	This is also known as virtual colonoscopy, uses low dose radiation CT scanning to obtain an interior view of the colon (the large intestine)
Pathology Report Unknown Type or Incomplete	

Tip: For FOBT test cards, **the less we know the better**. Please reference the below table for guidance.

FOBT Test Type	# of Cards	Compliance
gFOBT	0	No
Unknown	Unknown	Yes
Unknown	3+	Yes
Unknown	1 or 2	No
Unknown	0	No

Exclusions

***** Remember to send all possible exclusions to the Director of QA for review. Keep a copy of all documentation. All exclusions are subject to audit.*****

Optional contraindications/exclusions: This measure allows for excluding a member from the denominator if a dated note is found showing that the following occurred:

Date	Exclusion Condition
As far back in history → 12/31/2021	**Colorectal cancer**. Malignant neoplasm of the colon and other specified sites of the colon and large intestine all the way up to the appendix.
As far back in history → 12/31/2021	Total colectomy (resection)
NA	**Valid Data Error:** Wrong age/gender, evidence of hospice in 2021
NA	Health plan employee or dependent

Note: *Medical record data cannot be used for exclusions for members in SNP, LTI, frailty, advanced illness, dementia medications.*

Care for Older Adults (COA)

Measure description: The percentage of adults 66 years and older who had each of the following in 2021:

- Advance care planning.
- Medication review.
- Functional status assessment.
- Pain assessment.

Denominator inclusion: Males and females aged 66 and older

Numerator compliance: This is a multi-numerator measure. Please review the below table for the clinical information needed to meet numerator compliance.

Test	Numerator Criteria Description
Advance Care Planning	Evidence of advance care planning must include one (1) of the following: • The **presence of an Advance Care Plan in the medical record** on or before December 31, 2021. • Documentation of an advance care planning **discussion** with the provider ***and*** the date when it was discussed. **Must be in 2021.** • **Notation** that the member previously executed an advance care plan. Must be on or before December 31, 2021. ***Examples of an Advance Care Plan include:*** • **Advance directive.** Directive about treatment preferences or the designation of a surrogate who can make medical decisions for a patient who is unable to make them (e.g., living will, health care power of attorney, health care proxy). • **Actionable medical orders.** Written instructions regarding initiating, continuing, withholding, or withdrawing specific forms of life-sustaining treatment (e.g., Physician Orders for Life Sustaining Treatment [POLST/MOLST], Five Wishes). • **Living will.** Legal document denoting preferences for life-sustaining treatment and end-of-life care. • **Surrogate decision maker.** A written document designating someone other than the member to make medical treatment choices.

Test	Numerator Criteria Description
Advance Care Planning (continued)	***Examples of an advance care planning discussion*** • **Notation in the medical record** of a discussion with a provider or initiation of a discussion by a provider in 2021. – Documentation that a member declined to discuss advance care planning is considered evidence that the provider initiated a discussion and meets criteria. – Documentation that a provider asked the member if an advance care plan was in place and the member indicated a plan was not in place is not considered a discussion or initiation of a discussion. • **Oral statements.** Conversations with relatives or friends about life-sustaining treatment and end-of-life care, documented in the medical record. Patient designation of an individual who can make decisions on behalf of the patient. Evidence of oral statements must be noted in the medical record in 2021. ***Note:*** *services rendered during a telephone visit, e-visit or virtual check-in* ***meet criteria.***

Test	Numerator Criteria Description
Medication Review	A review of all a member's medications, including prescription medications, OTC medications and herbal or supplemental therapies conducted by a prescribing practitioner or clinical pharmacist during 2021 ***and*** the presence of a medication list in the medical record, as documented through either administrative data or medical record review. A medication list ***signed and dated*** during 2021 by a prescribing practitioner or clinical pharmacist. **The practitioner's signature is considered evidence that the medications were reviewed.** Documentation must come from the same medical record and must include one (1) of the following: • A medication list in the medical record, ***and*** evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed. • Notation that the member is not taking any medication and the date when it was noted. • A review of side effects for a single medication at the time of prescription alone is not sufficient. **Do not include medication lists or medication reviews performed in an acute inpatient setting.** ***Note:*** *medication review does not require the member to be present.*

Test	Numerator Criteria Description
Functional Status	Documentation in the medical record must include evidence of a complete functional status assessment ***and*** the date when it was performed. Notations for a complete functional status assessment must include one (1) of the following: Notation that **Activities of Daily Living (ADL)** were assessed or that ***at least five (5)*** of the following were assessed: 1. bathing 2. dressing 3. eating 4. transferring [e.g., getting in and out of chairs] 5. using toilet 6. walking Notation that **Instrumental Activities of Daily Living (IADL)** were assessed or ***at least four (4)*** of the following were assessed: 1. shopping for groceries 2. driving or using public transportation 3. using the telephone 4. cooking or meal preparation 5. housework 6. home repair 7. laundry 8. taking medications 9. handling finances

Test	Numerator Criteria Description
Functional Status (continued)	Result of assessment using a standardized functional status assessment tool, not limited to: • SF-36®. • Assessment of Living Skills and Resources (ALSAR). • Barthel ADL Index Physical Self-Maintenance (ADLS) Scale. • Bayer ADL (B-ADL) Scale. • Barthel Index. • Edmonton Frail Scale. • Extended ADL (EADL) Scale. • Groningen Frailty Index. • Independent Living Scale (ILS). • Katz Index of Independence in ADL. • Kenny Self-Care Evaluation. • Klein-Bell ADL Scale. • Kohlman Evaluation of Living Skills (KELS). • Lawton & Brody's IADL scales. • Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales. **Components may take place during separate visits in 2021.** A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) ***does not meet compliance*** for this measure. ***Note:*** *services rendered during a telephone visit, e-visit or virtual check-in* ***meet criteria****.*

Test	Numerator Criteria Description
Pain Assessment	Documentation in the medical record must include evidence of a pain assessment ***and*** the date when it was performed. Notations for a pain assessment must include one (1) of the following: • Documentation that the patient was assessed for pain (which may include positive or negative findings for pain). • Result of assessment using a standardized pain assessment tool, not limited to: • Numeric rating scales (verbal or written). • Face, Legs, Activity, Cry Consolability (FLACC) scale. • Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory). • Pain Thermometer. • Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale). • Visual analogue scale. • Brief Pain Inventory. • Chronic Pain Grade. • PROMIS Pain Intensity Scale. • Pain Assessment in Advanced Dementia (PAINAD) Scale. **Do not include pain assessments performed in an acute inpatient setting.** The following notations of pain in the medical record are ***not*** acceptable: • Notation alone of a pain management plan. • Notation alone of a pain treatment plan. • Notation alone of screening for chest pain or documentation alone of chest pain. ***Note:*** *services rendered during a telephone visit, e-visit or virtual check-in* ***meet criteria****.*

Controlling High Blood Pressure (CBP)

Measure description: The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) ***and*** whose BP was adequately controlled (<140/90 mm Hg) in 2021.

Denominator Inclusion: Members who had at least two (2) visits on different dates of service with a diagnosis of hypertension on or between January 1, 2020, and June 30, 2021.

Numerator compliance: The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled (<140/90 mm Hg) during 2021. To determine if a member's BP is adequately controlled, the representative BP must be identified.

Step 1:

Identify the most recent BP reading note in 2021.

- This may be the members' PCP (the PCP who most recently provided care to the member).
- If the member did not visit a PCP for the time-period or does not have a PCP, identify the practitioner who most recently provided care to the member.
- If a practitioner other than the member's PCP manages the hypertension e.g., cardiologist), the medical record of that provider may be used.

Step 2:

Identify the lowest systolic and lowest diastolic BP reading from the **most recent** BP notation in the medical record during 2021. If multiple readings were recorded for a single date, ***use the lowest systolic and lowest diastolic BP on that date*** as the representative BP.

- The BP reading must occur ***on or after*** the date when the second diagnosis of hypertension (identified using the event/diagnosis criteria) occurred.
- The systolic and diastolic results do not need to be from the same reading.

  Note: Member-reported blood pressure readings from a digital device are acceptable.

BP readings taken on the same day of the following procedures are okay to use, such as (but not limited to):

- Vaccinations.
- Injections (e.g., allergy, vitamin B-12, insulin, steroid, toradol, Depo-Provera, testosterone, lidocaine).
- TB test.
- IUD insertion.
- Eye exam with dilating agents.
- Wart or mole removal.

Do *not* include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, ***with the exception*** of fasting blood tests.
    - Therapeutic procedures that require a medication regimen, a change in diet or a change in medication include but are not limited to the following:
        - A colonoscopy requires a change in diet (NPO on the day of procedure) and a medication change (a medication is taken to prep the colon).
        - Dialysis, infusions and chemotherapy (including oral chemotherapy) are all therapeutic procedures that require a medication regimen.
        - A nebulizer treatment with albuterol is considered a therapeutic procedure that requires a medication regimen (the albuterol).
- Taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

Exclusions

***** Remember to send all possible exclusions to the Director of QA for review. Keep a copy of all documentation. All exclusions are subject to audit. *****

Date	Exclusion Condition
Anytime during MY 2021	Members receiving palliative care.

Note: *When identifying the most recent BP reading, all eligible BP readings in the appropriate medical record should be considered, regardless of practitioner type and setting* ***(excluding acute inpatient and ED visit settings).***

Comprehensive Diabetes Care (CDC)

Measure Description: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing. *
- HbA1c poor control (>9.0%). *
- HbA1c control (<8.0%). *
- Eye exam (retinal) performed.
- Medical attention for nephropathy. **
- BP control (<140/90 mm Hg).

Denominator: Members 18–75 years of age with diabetes (type 1 and type 2).

Numerator: This is a multi-numerator measure that looks for the following clinical information within the medical record: HbA1c test, Eye exam, blood pressure and medical attention for nephropathy.

Indicator	Numerator Description
HbA1c control	The most recent HbA1c level (performed during 2021) is <8.0% as identified by laboratory data or medical record review. Notation of any of the following HbA1c tests performed with the A1c level and test date: • A1c • HbA1c • HgA1c • HB1c • Hemoglobin A1c • Glycohemoglobin A1c • Glycohemoglobin • Glycated hemoglobin • Glycosylated hemoglobin Ranges and thresholds ***do not*** meet criteria for this indicator.

Indicator	Numerator Description
Eye Exam	Screening or monitoring for diabetic retinal disease through one of the following: • A **retinal or dilated eye exam** by an eye care professional (optometrist or ophthalmologist) in 2021. • A ***negative* retinal or dilated exam** (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in 2020- 2021. • **Bilateral eye enucleation** any time during the member's history through December 31, 2021. Documentation in the medical record must include one (1) of the following: • A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic **exam was completed by an eye care professional (optometrist or ophthalmologist)**, the date when the procedure was performed and the results. • A **chart or photograph** indicating the date when the fundus photography was performed and one of the following: • Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. • Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a **retinal specialist**. • Evidence results were read by a system that provides an **artificial intelligence (AI) interpretation.** • Evidence that the member had **bilateral eye enucleation** or acquired absence of both eyes. Look as far back as possible in the member's history through December 31, 2021. • Documentation of a **negative retinal or dilated exam** by an eye care professional (optometrist or ophthalmologist) **in 2020**, where results indicate retinopathy was not present (e.g., documentation of normal findings). • Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" ***does not meet criteria***.

Indicator	Numerator Description
Medical Attention for Nephropathy	Any of the following done during 2021 meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy. • A **urine test for albumin or protein**. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet the criteria: – 24-hour urine for albumin or protein. – Timed urine for albumin or protein. – Spot urine (e.g., urine dipstick or test strip) for albumin or protein. – Urine for albumin/creatinine ratio. – 24-hour urine for total protein. – Random urine for protein/creatinine ratio. • Documentation of a visit to a nephrologist. • Documentation of a renal transplant. • Documentation of a nephrectomy. • Documentation **of medical attention** for any of the following (no restriction on provider type): – Diabetic nephropathy. – ESRD. – Chronic renal failure (CRF). – Chronic kidney disease (CKD). – Renal insufficiency. – Proteinuria. – Albuminuria. – Renal dysfunction. – Acute renal failure (ARF). – Dialysis, hemodialysis or peritoneal dialysis. • Evidence of **ACE inhibitor/ARB therapy**. Documentation in the medical record must include evidence that the member received ACE inhibitor/ ARB therapy during 2021. Any of the following meet criteria: – Documentation that a prescription for an ACE inhibitor/ARB was written during 2021. – Documentation that a prescription for an ACE inhibitor/ARB was filled during 2021. • Documentation that the member took an ACE inhibitor/ARB during 2021.

Indicator	Numerator Description
Blood pressure control	The ***most recent*** **BP level taken in 2021**. Please refer to CBP guidance on pages (15-16). The member is numerator compliant if the BP is <140/90 mm Hg (139/89 mm Hg). The member is ***not compliant*** if the BP is ≥140/90 mm Hg, or if there is no BP reading in 2021 or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are **multiple BPs on the same date of service**, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

ACE/ARB Inhibitors

Description	Prescription	
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril • Enalapril • Fosinopril • Lisinopril	• Moexipril • Perindopril • Quinapril • Ramipril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Candesartan • Eprosartan • Irbesartan	• Losartan • Olmesartan • Telmisartan • Valsartan
Antihypertensive combinations	• Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-perindopril • Amlodipine-telmisartan • Amlodipine-valsartan • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide	• Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Nebivolol-valsartan • Sacubitril-valsartan Trandolapril-verapamil

Exclusions

***** Remember to send all possible exclusions to the Director of QA for review. Keep a copy of all documentation. All exclusions are subject to audit. *****

Date	Exclusion
2020 or 2021	Members who did not have a diagnosis of diabetes, in any setting ***and*** who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting.
Anytime during MY 2021	Members receiving palliative care.
N/A	Dispensed dementia medications: Donepezil, Galantamine, Rivastigmine Memantine, Donepezil-memantine

Transitions in Care (TRC)

Measure description: The percentage of discharges for members 18 years of age and older who had each of the following. Four (4) rates are reported:

1. ***Notification of Inpatient Admission*.** Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
2. ***Receipt of Discharge Information***. Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
3. ***Patient Engagement After Inpatient Discharge*.** Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
4. ***Medication Reconciliation Post-Discharge***. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Denominator Inclusion: Men and women 18 or older with inpatient admission and discharge events.

Note: *If a different discharge date is found in the medical record, and the organization chooses to use that date, you must assess all indicators using the updated discharge date, including those that were previously compliant based on administrative data.*

Numerator Compliance: This is a multi-numerator measure that looks for the following in the ***outpatient*** medical record:

Indicator	Numerator Event Description
Notification of Inpatient Admission	The **outpatient medical record** should show evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days). Documentation in the **outpatient medical record** 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 or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax). • Communication about admission between emergency department and the member's PCP or ongoing care provider (e.g., phone call, email, fax). • Communication about admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission, or discharge and transfer (ADT) alert system.

Indicator	Numerator Event Description
Notification of Inpatient Admission (continued)	• Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) 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 2 days after the admission (3 total days) meets criteria.*** • 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. • Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The time frame that the planned inpatient admission must be communicated is not limited to the day of admission through 2 days after the admission (3 total days); documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria. The planned admission documentation or preadmission exam must clearly pertain to the denominator event. **Note:** 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.***

Indicator	Numerator Event Description
Receipt of Discharge Information	Documentation in the ***outpatient medical record*** must include evidence of receipt of discharge information ***on the day of discharge through 2 days after the discharge*** (3 total days) with evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR. At a minimum, the discharge information must include all of the following: 1. The practitioner responsible for the member's care during the inpatient stay. 2. Procedures or treatment provided. 3. Diagnoses at discharge. 4. Current medication list. 5. Testing results, or documentation of pending tests or no tests pending. 6. Instructions for patient care post-discharge. **Note:** If the PCP or ongoing care provider is the discharging provider, the discharge information must be documented in the medical record on the day of discharge through 2 days after the discharge (3 total days). When using a shared EMR system, documentation of a "received date" in the EMR 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 discharge through 2 days after the discharge (3 total days) **meets criteria**.

Indicator	Numerator Event Description
Patient Engagement After Inpatient Discharge	Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any of the following meet criteria: 1. An outpatient visit, including office visits and home visits. 2. A telephone visit. 3. A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication. 4. An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider). **Note:** If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider **meets criteria**.
Medication Reconciliation Post-Discharge	Documentation in the ***outpatient medical record*** must include evidence of medication reconciliation and the date when it was performed. Any of the following meet criteria: 1. Documentation of the ***current*** medications with a notation that the provider reconciled the current and discharge medications. 2. 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). 3. Documentation of the member's ***current*** medications with a notation that the discharge medications were reviewed. 4. Documentation of a **current** medication list, a discharge medication list and notation that both lists were reviewed on the same date of service. 5. Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge. **Note:** Member does not need to be present for a medication reconciliation post-discharge.

Exclusions

***** Remember to send all possible exclusions to the Director of QA for review. Keep a copy of all documentation. All exclusions are subject to audit. *****

Note: *Any member that is found to be in hospice or using hospice services in 2021 while conducting the medical record review should be excluded.*

Medical Record Review Reminders

Uploading Members' Records into CareSeed Harvest

Before uploading the member's record, please do the following:

1. Confirm the record belongs to the member you're reviewing by:
   - Confirming the member's name ***and*** DOB on the record match what is listed in CareSeed Harvest

2. Rename the file using the standard naming convention as shown below
   - Member last name, Member first name_ALTERNATIVE MEMBER ID#_Measure Code_DOS (MMDDYYYY).PDF
     EXAMPLE: Doe, John_3002166500_CBP_12152020.PDF

3. After uploading the document into CareSeed Harvest, annotate the uploaded medical record.

4. All medical records ≥10 pages must be annotated (see below example).

Note: Do not highlight the original medical record prior to uploading into CareSeed Harvest.

The **annotation tool** within CareSeed Harvest must be used to identify evidence found within the medical record.

- Review **ALL** records in the Medical Records Chase Records Folder – **double and triple check**. It's quite possible something may have been missed

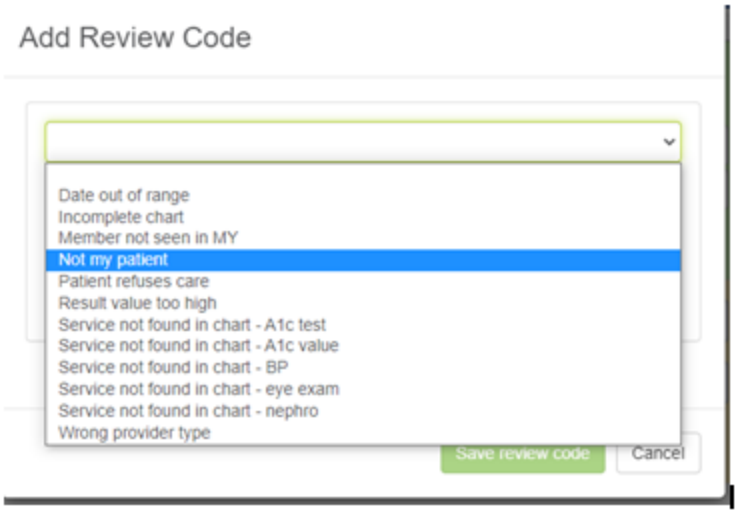
- Enter **ALL** data – do **NOT** hold anything. If for any of the measures with sub-measures where not all information can be found, you may close out the chase and send to over-read.

- If you're still missing information contact other providers, if any.

- Check CareCompass to see if there are any other providers a member may have visited in the past.

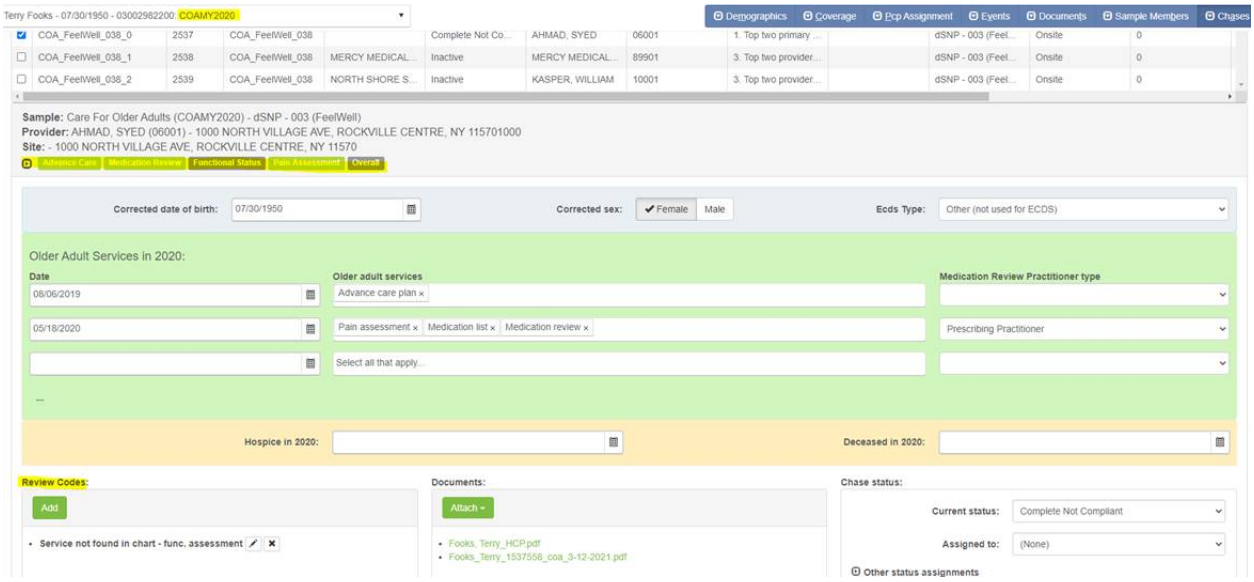
How to close out a chase and send to over-read

Closing out a chase with multiple sub-measures and something is missing you may add a relevant review code.



What to do if you're unable to find evidence:

- **<u>Do not</u>** upload the chart.
- **<u>Do not</u>** use the review codes area.
- **Leave the data entry screen blank.**
    - ➢ You will use the review codes area **<u>ONLY</u>** for the measures like CDC, COA, TRC that have sub-measures, and only if you're unable to complete any of the four (4) sub-measures. See example below.



Researching a provider in CareSeed Harvest

In CareSeed Harvest, you can research the provider to identify any attached chases. In the chase search box (see below) select “Provider”, and then begin typing the provider’s name.