# Inpatient Quality Reporting Program

## Support Contractor

# Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program: Keys to Implementing and Abstracting the Tobacco Measure Data Set Questions & Answers

**Moderator:**
Reneé Parks, BSN, RN
Project Lead IPFQR Program, HSAG

**Speaker(s):**
Bruce Christiansen, PhD
Clinical Psychologist and Senior Scientist, University of Wisconsin Center for Tobacco Research & Intervention

Reneé Parks, BSN, RN
Project Lead IPFQR Program, HSAG

**February 19, 2015**
**2 p.m. ET**

**Question 1:** What are the TOB measures required for the IPFQR Program?

**Answer 1:** The required TOB measures are TOB-1, 2, and 2a. Please see the information contained in the tables at the following link: www.qualityreportingcenter.com/wp-content/uploads/2015/02/IPF-Measures-Final.pdf.

**Question 2:** Is there a list of FDA-approved tobacco cessation medications (similar to list for HBIPS antipsychotics)?

**Answer 2:** Yes, these medications are in Appendix C on Table 9.1 of the HIQR Specifications Manual located on *QualityNet* at: www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228773989482.

**Question 3:** Will you be able to accept a data file for the FY 2017 year?

**Answer 3:** Hospitals or their designated vendors will be entering numerators and denominators via the *QualityNet Secure Portal* for the IPFQR program. Data are to be collected starting January 1 through December 31, 2015 for submission July 1 through August 15, 2016, for FY 2017.

**Question 4:** Should the FY 2017 Aggregate Population counts include ICD-9 totals? Won't we be on ICD-10 by this time? Will you accept ICD-10 codes?

**Answer 4:** Discharges beginning January 2015 will still use ICD-9 codes. Transition to ICD-10 occurs October 1, 2015 and CMS will accept ICD-10 codes at that time.

**Question 5:** I have a question regarding sampling. Would TOB and SUB each mirror global measures (ED and IMM)? Should we expect similar sample size of about 102 cases plus a few more in sample size, based on the overall discharges?

**Answer 5:** Sampling for the IPFQR program will be done separately from HIQR. The same sampling tables will be used but the initial patient population will be IPF patients only. Please refer to the sampling tables in this document: www.qualityreportingcenter.com/wp-content/uploads/2015/02/IPF-Measures-Final.pdf.

**Question 6** Since education and clarifications on abstraction elements and values are only coming to us now, shouldn't consideration be given to changing [the] implementation date to at least February or March discharges? Or, at time of any audits, could there be no penalties for incorrect abstractions?

**Answer 6:** Education was provided previously. Please refer to archived webinars via this link: www.qualityreportingcenter.com/events/archive/ipf/.

Submission of the data for these measures is not due until 2016. Most facilities allow up to 30 days to close their medical records, so education in February is still timely. Please see the data submission dates and other information for the IPF Program at this link: www.qualityreportingcenter.com/resources/tools/ipf/.

**Question 7:** Cigars and pipes were listed on the slide entitled Primary Data Element: Tobacco Use Status (slide 48), but not on the following slide. Can you please clarify?

**Answer 7:** Cigars and pipe smoking is considered smoking for the purposes of this measure. If the patient smokes cigars and/or pipes daily, then select allowable value 1 for the data element *Tobacco Use Status*.

The list of inclusions in a later slide provides alternate examples of tobacco use.

**Question 8:** If the physician wrote “patient smokes < 5 a day,” would that fall under the less than four option or the heaviest usage category?

**Answer 8:** The documentation of a patient smoking less than five cigarettes a day indicates four or less, which falls under allowable value “2.”

**Question 9:** For the practical counseling, is the nurse the only discipline that can document it, or can an MHT document?

**Answer 9:** No, any healthcare provider can provide and document the initial counseling.

**Question 10:** The TOB-1 notes for abstraction for cognitive impairment only lists comatose, obtunded, confused, memory loss as examples of cognitive impairment. What about acute psychosis or thought disorder? Would that count as cognitive impairment if documented that it was present each of the first three days of admission?

**Answer 10:** Yes, psychosis refers to an abnormal condition of the mind involving a loss of contact with reality, so documentation of the patient being psychotic would be acceptable ONLY if the patient was psychotic at all times during the first three days of the hospitalization. If there is documentation that the patient’s mental status was normal at any time during the first three days of the hospitalization, then the abstractor cannot select value “6” for the *Tobacco Use Status* data element.

**Question 11:** What does “screened” mean? We ask every patient if they smoke or not. Would that be considered “screened?”

**Answer 11:** Yes, however, if the patient uses tobacco, then the tobacco use screen must also identify the type of tobacco product used, the volume used, and the timeframe of use.

**Question 12:** Are we expected to report the type(s) of tobacco patients use?

**Answer 12:** Yes, a tobacco use screen must identify the type of tobacco product used, the volume used, and the timeframe of use, if the patient uses tobacco.

**Question 13:** For TOB-2 and -2a, does the patient have to be offered and/or receive BOTH counseling and medication to be in the numerator?

**Answer 13:** For TOB-2 patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit AND receive or refuse FDA-approved cessation medications during the first three days after admission are in the numerator. For TOB-2a, patients who received counseling AND medication, if indicated, are in the numerator.

**Question 14:** If cognitive impairment is documented on day 1 and day 3 and it is clear in the medical record that the patient has long standing dementia, is it okay to select “YES” for cognitive impairment?

**Answer 14:** No, patients with long-standing dementia can have periods of lucidity during which they can be assessed for tobacco use.

**Question 15:** Will there be training on submission of non-measure data?

**Answer 15:** Training on submission of non-measure data is planned for June 2015. To sign up for IPF listserv notifications, visit the QualityNet.org website.

**Question 16:** During our admission assessment the nurse questions the patient on tobacco use, and if the patient is a smoker at that time, the nurse gives the practical counseling and handout documenting such in the assessment. Would this count as meeting the requirements?

**Answer 16:** Yes, as long as there is documentation of interaction with the patient covering the three components of practical counseling: (1) recognizing danger situations; (2) developing coping skills; and (3) providing basic information about quitting. Please refer to the following link for examples of the three components that comprise practical counseling: www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendationS/tobacco/counsel.pdf.

**Question 17:** Are there any specific requirements for what constitutes "Other reasons for not prescribing cessation medications"? In other words, does the Physician/APN/PA maintain their discretion of why they do not want the patient to receive the medication?

**Answer 17:** There is no defined list of acceptable "other" reasons. However, the reason must be in context with the tobacco cessation treatment and MUST be documented by a physician/APN/PA/pharmacist per the data element.

**Question 18:** What are Snus and Twist?

**Answer 18:** Both are forms/brands of smokeless tobacco.

**Question 19:** Can you give some examples of cognitive impairment? Some of the mental health patients are psychotic and comprehension level is difficult to determine.

**Answer 19:** Please see the list of inclusions in the data element *Tobacco Use Status.* Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for tobacco use due to the impairment (e.g., comatose, obtunded, confused, memory loss) during the entire first three days of hospitalization. Cognitive impairment must be documented at all times during the first three days of the hospitalization in order to select value "6." If there is any documentation that the patient's mental status was normal at any time during the first three days of the hospitalization, the abstractor cannot select value "6" for the *Tobacco Use Status* data element.

**Question 20:** Our admission history assessment documents information obtained from the patient. It does not say that it is a face-to–face interaction in words, but it does indicate information obtained from the patient on admission. If the TOB screening is a part of the admission screening, is this sufficient documentation that the screening occurred face-to-face?

**Answer 20:** Yes, it is the *Tobacco Use Treatment Practical Counseling* data element that requires interaction with the patient. If the patient is screened and counseled during the admission screening, there must be documentation that the counseling covered the three required components of practical counseling. If this is evident from the admission history assessment, then it would be acceptable. Simply handing a patient a pamphlet or handout is not sufficient.

**Question 21:** I could not find the specifications on *QualityNet* or Joint Commission's website. Where are the specs posted?

**Answer 21:** To access the manual for specific detailed information for the HBIPS measures, use the following link: http://manual.jointcommission.org/bin/view/Manual/WebHome. To access the manual for specific detailed information for the SUB, TOB, and IMM measures, use the following link: www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1141662756099.

**Question 22:** There is a lot of talk in the measure of three days. Does that mean that patients who are in the hospital for less than three days will not fall into the abstraction bucket?

**Answer 22:** Yes, patients with a length of stay less than or equal to three days (or greater than 120 days) are excluded from the Tobacco (TOB-1, 2/2a) measures.

**Question 23:** Why is data being collected on "light" versus "heavy" smoking if all smokers require an intervention? The abstraction burden is greater by having to look for the number of cigarettes/time frames, etc.

**Answer 23:** All smokers should get practical counseling, but those who smoke less than or equal to four cigarettes daily or those that use smokeless tobacco, etc. (refer to allowable value "2" in the data element, Tobacco Use Status), are not required to receive cessation medication.

**Question 24:** For IPF population and sampling for IPF TOB and IPF IMM, should these patients be a different sample than IPF SUB?

**Answer 24:** The population will be the same, but the sampling and the number of cases required to submit are different. Please refer to the sampling tables in this document: www.qualityreportingcenter.com/wp-content/uploads/2015/02/IPF-Measures-Final.pdf.

**Question 25:** Why was the teenage population excluded from this measure?

**Answer 25:** For the TOB and SUB measures, there is insufficient evidence to support the measures for patients younger than 18 years of age.

**Question 26:** For the future, should CMS update the definition of TOB-1 to include hookah pipes and e-cigarettes since the use among smokers with serious mental illness has been increasing?

**Answer 26:** Electronic cigarettes are not included in the measure because they contain nicotine, not tobacco. Because not all hookah pipes contain tobacco, those devices are excluded.

**Question 27:** If the documentation says "risks and benefits of no smoking discussed," does that cover the three components for practical counseling? The details of risks and benefits discussion are not spelled out.

**Answer 27:** No, this is not descriptive enough to determine that all three components have been covered. As defined in the data element *Tobacco Use Practical Counseling*, there are three components of practical counseling that require interaction with the patient to address the following: (1) recognizing danger situations; (2) developing coping skills; and (3) providing basic information about quitting.

**Question 28:** What if the practical counseling is done on the day of admission? Will this meet the measure?

**Answer 28:** Yes, documentation on the day of admission (Day "0") is acceptable since it falls within the first three days of admission.

**Question 29:** Based off of our RN assessment, a tobacco screen is generated to our cardio pulmonary department. Does this meet the needed screening process for the measure if our respiratory department does the bedside education to the patient on tobacco cessation?

**Answer 29:** Any healthcare provider may do the assessment as long as there is documentation of interaction between the patient and the caregiver and the caregiver provides counseling about recognizing danger situations, developing coping skills, and provided basic information about quitting.

**Question 30:** Is the acute hospital inpatient population included in the tobacco measure population or is this only for psychiatric units?

**Answer 30:** No, only the psychiatric inpatient population is included in the IPF program. This program covers psychiatric hospitals and psychiatric units paid under Medicare's IPF PPS (42 CFR 412.404(b)).

**Question 31:** Should patients who refused tobacco screening be included in the denominator?

**Answer 31:** If the patient refused the tobacco screening (TOB-1), they would be excluded from TOB-2 and TOB-2a.

**Question 32:** Will any reason documented by the MD/APRN/PA be accepted, such as patient not interested in quitting at this time?

**Answer 32:** No, this would be considered "refusal." For data element *Tobacco Use Treatment Practical Counseling,* select value "2." For data element *Tobacco Use Treatment FDA-Approved Cessation Medication,* select value "2."

**Question 33:** Is a validated screening questionnaire required for the IPF tobacco measure or is any hospital tobacco screening acceptable?

**Answer 33:** A validated screening questionnaire is not required for TOB-1. The screening should include the type of tobacco product used, the volume used, and the timeframe of use.

**Question 34:** TOB-1, 2, 2a are all reported as an aggregate score only, correct? No patient-level data will be submitted for Tobacco Details, correct?

**Answer 34:** Yes, aggregate data is submitted. A numerator and denominator will be calculated for each measure and the aggregate number submitted via the *QualityNet Secure Portal*.

**Question 35:** Is there to be a sample size for data collection, or are we expected to collect data on all patients 18 years of age or older, every month, that are discharged from a psych unit?

**Answer 35:** Sampling is allowed for the TOB measures. The sampling requirements are listed in the table on page three of the document at this link: Reporting/Population/Sampling Tables - www.qualityreportingcenter.com/wp-content/uploads/2015/02/IPF-Measures-Final.pdf.

**Question 36:** What if a former smoker who identifies as a non-smoker on admission relapses and requests Nicotrol within the first three days of admission? How does that affect your data?

**Answer 36:** If the patient identifies as a non-smoker within the first three days of admission and the response selected for *Tobacco Use Status* is allowable value "3," then the case would not be included in the denominator, and no further abstraction would be required. However, if there is conflicting documentation regarding tobacco use during the first three days, it would be abstracted as if the patient was a smoker and the appropriate allowable value, based on the type/volume of product used, would be selected.

**Question 37:** The slide says "The nurse must document that the screening occurred during a face-to-face interaction." Where is this in the specifications? Is this being confused with practical counseling?

**Answer 37:** It is understood that interaction with the patient would be face-to-face. Simply handing a patient cessation material does not constitute interaction. As defined in the data element Tobacco Use Practical Counseling, there are three components of practical counseling that require interaction with the patient to address the following: (1) recognizing danger situations; (2) developing coping skills; and (3) providing basic information about quitting. There must be interaction between the patient and the caregiver. Please refer to the following link for examples of the three components that comprise practical counseling: www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendationS/tobacco/counsel.pdf.

**Question 38:** I understand that facilities are penalized when a patient refuses tobacco cessation treatment. What is the rationale? What does CMS/TJC hope to accomplish by failing measures that the facility truly has no control over?

**Answer 38:** The focus of TOB-2a is to calculate only those patients that received treatment (counseling and medication if indicated). We believe that reporting of this measure will yield information that provides meaningful distinctions in the quality of care provided across IPFs. Because tobacco use cessation treatment (counseling and medication if indicated) is considered an essential step in the care process for IPF patients, we believe that it is critical

for patients, their families, and caregivers to have accurate available information on whether IPFs integrate this into their care processes. Facilities may be able to identify opportunities to increase their rate of uptake of tobacco cessation treatment by reporting TOB-2a. There are facilities that are able to provide both counseling and medication without patient refusal. By adopting this measure, CMS wants to recognize those facilities that are able to provide complete cessation treatment.

**Question 39:** If all of the components of practical counseling are addressed in a packet, and it is documented that the nurse gave the packet and explained to the patient the material, would that count?

**Answer 39:** If the documentation showed that the nurse gave the packet but did not indicate that the contents of the packet addressed all three components of practical counseling, this would not be acceptable. It must be obvious to a third party that all components were addressed per the documentation.

**Question 40:** Patients in this population are sometimes in the hospital for months at a time. This year the tobacco measures started in January 2015. How are you going to evaluate the patients who were admitted in 2014, when the measure was not in force, but were discharged in 2015? Per the webinar, since the measure was not in place until January 1, 2015, the sample will need to be drawn from discharges in January 2015 that were admitted after January 1, 2015. However, we can't possibly pass on patients that were admitted in October but discharged in January or even later. Are you going to base this measure on when they were admitted rather than when they were discharged?

**Answer 40:** The measures will be based on the discharge date. However, this question will continue to be researched with respect to the inclusion of cases admitted prior to January 1, 2015, based on the implementation date of these measures for the IPFQR Program. Additional guidance will be provided.

This material was prepared by the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. HHSM-500-2013-13007I, FL-IQR-Ch8-03052015-02