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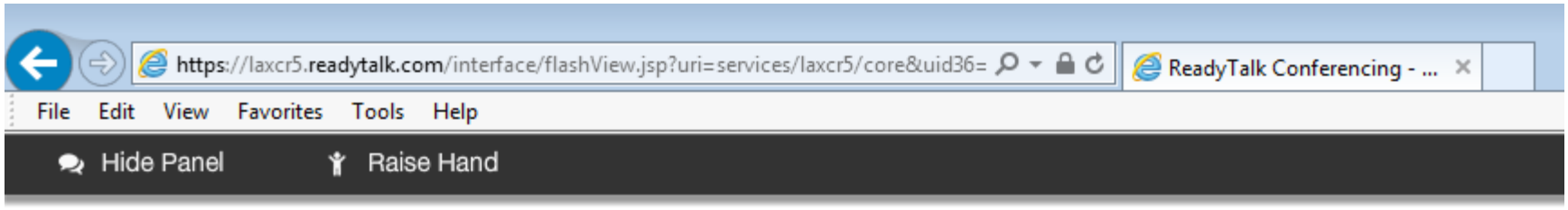

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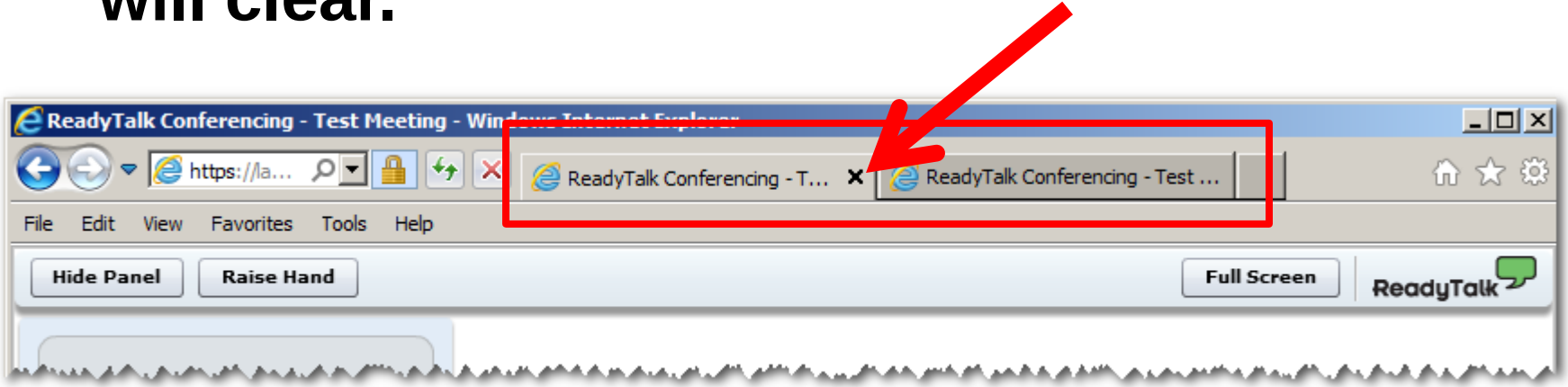

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Navigating to Success: A Review of the Abstraction Process for the Transition Record Measures

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Webinar Chat Questions

As a reminder, we do not recognize the raised hand feature in the Chat tool during webinars.

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Acronyms

AD	Advance Directive
AMA-PCPI	American Medical Association-convened Physician Consortium for Performance Improvement®
CMS	Centers for Medicare & Medicaid Services
EHR	Electronic Health Record
FAQs	Frequently Asked Questions
FR	Final Rule
FY	Fiscal Year
HIPAA	Health Insurance Portability and Accountability Act
IPF	Inpatient Psychiatric Facility
IPFQR	Inpatient Psychiatric Facility Quality Reporting
PAD	Psychiatric Advance Directive
ROI	Release of Information

Purpose

The purpose of this presentation is to review and provide clarification on how to accurately abstract elements of the transition record measures that continue to present challenges to IPFQR Program participants.

Learning Objectives

At the conclusion of this presentation, attendees will be able to:

- Abstract data accurately for the Transition Record with Specified Elements Received by Discharged Patients and the Timely Transmission of Transition Record measures
- Identify resources pertinent to data abstraction for the Transition Record with Specified Elements Received by Discharged Patients and the Timely Transmission of Transition Record measures

Overview

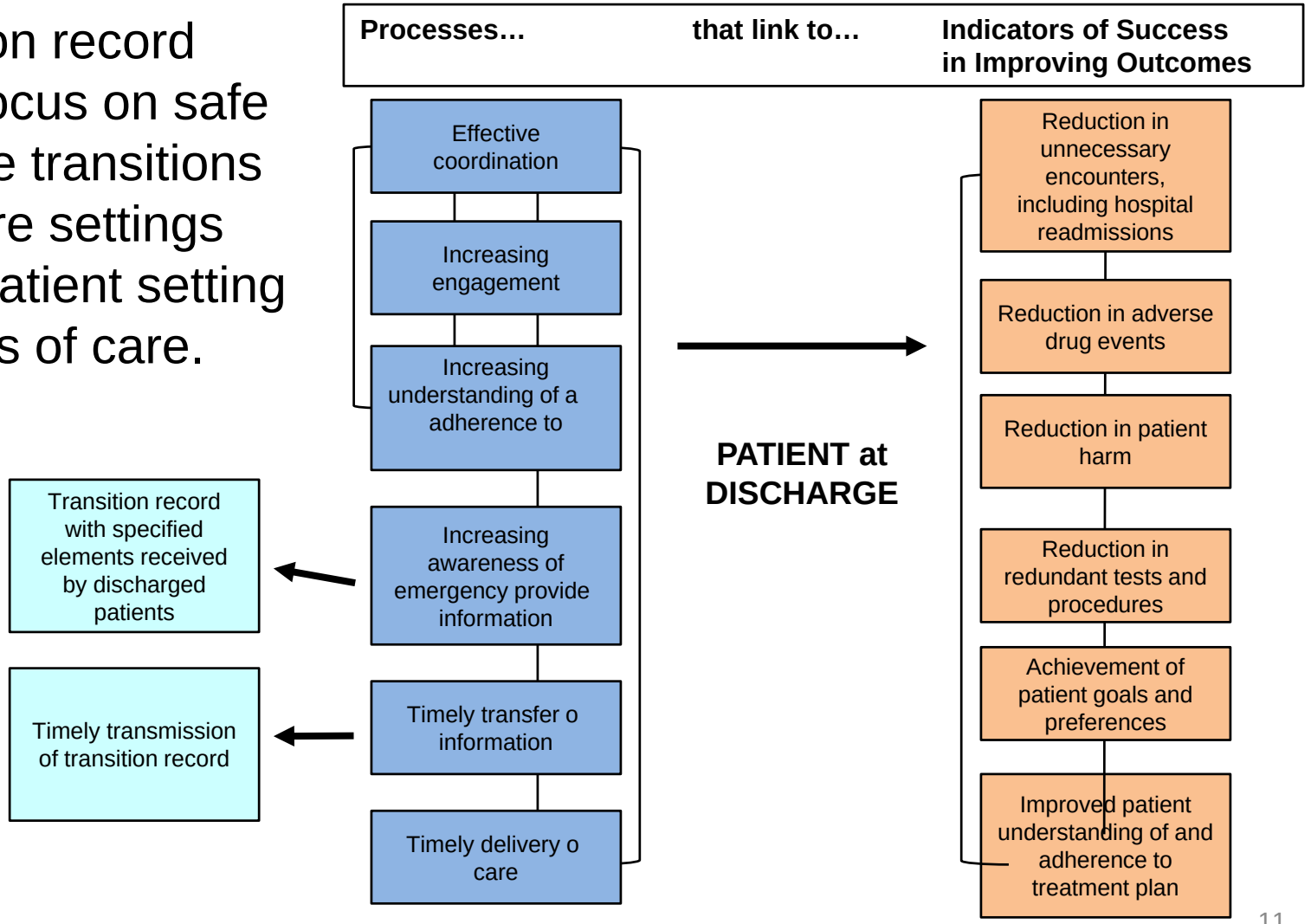
The IPFQR Program New Measure and Non-Measure Reporting – Part 2 webinar held on January 21, 2016, included a comprehensive review of all of the elements of the transition record measures.

Over the last year, we received a number of comments and recommendations about these measures. We made minor modifications in response to these recommendations that have been incorporated into the IPFQR Program Manual and the optional paper tool for the transition record measures, which were published in November 2016.

In response to requests for guidance on how to accurately abstract data for these measures, we have prepared this presentation to review the Transition Record measure resources, address the most commonly asked questions, and clarify key components of the measure abstraction process.

Linking the Transition Record Measures to Success in Improving Outcomes

The transition record measures focus on safe and effective transitions between care settings from the inpatient setting to other sites of care.



SOURCE: AMA-PCPI PUBLICATION FROM APRIL 2016

Abstracting Data for the Transition Record Measures

Know Your Resources!

CMS has provided information about the transition record measures in the following resources:

- IPFQR Program manual
  - Section 2 (pages 20-25) includes measure descriptions and definitions of terms
  - Appendix C (page 99) is the Initial Patient Population algorithm
- Data Collection Tool for Compliance with the *Transition Record with Specified Elements Received by Discharged Patients* and *Timely Transmission of Transition Record* Measures
  - Seven page, optional paper tool
  - Measure descriptions and definitions mirror those found in the IPFQR Program manual
  - Guidance for measure abstraction provided
- Frequently Asked Questions
  - Recently published, optional document
  - Question and answer pairs pertinent to the transition record measures included

Transition Record with Specified Elements Received by Discharged Patients:
Numerator and Denominator Statements

Transition Record with Specified Elements Received by Discharged Patients

The **numerator** is comprised of patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge. All 11 elements must be captured to satisfy the measure numerator.

The **denominator** includes all patients, regardless of age, discharged from the inpatient facility to home/self-care or any other site of care. The measure excludes patients who died, left against medical advice (AMA), or discontinued care. Patients who discontinued care include those who eloped or failed to return from leave, as defined in the notes below.

Sample Question and Answer Pairs in the FAQs document

Question: If one of the 11 required elements of the transition record is missing, will this case fail the entire measure?

Answer: Yes, all 11 elements must be completed and documented as discussed with the patient or caregiver to pass the measure.

Question: Does there need to be a statement that the patient was given this information in printed or electronic format?

Answer: Yes. The transition record may only be provided in an electronic format if acceptable to the patient and only after all components have been discussed with the patient.

Inpatient Care:
Reason for IPF Admission vs. Principal Diagnosis at Discharge

Definitions of the elements “Reason for IPF admission” and “Principal diagnosis at discharge” are included to aid in the abstraction process.

Are the following elements included in the transition record?	Element Satisfied? Yes	No	Definition
Reason for IPF admission			Documentation of the events the patient experienced prior to this hospitalization; the reason for hospitalization may be a short synopsis describing or listing the triggering or precipitating event. A diagnosis alone is not sufficient.
Principal diagnosis at discharge			Documentation indicating the final principal diagnosis at the time of discharge.

Question: Can the principal diagnosis at discharge in a patient record be used to meet the “Reason for IPF admission” element if no reason for admission is documented?

Answer: No. The principal diagnosis is not the reason for admission. The “Reason for IPF admission” and the “Principal diagnosis at discharge” are two separate elements of the transition record and must be documented separately.

Inpatient Care:
Reason for IPF Admission vs. Principal Diagnosis at Discharge

Question: Can a diagnosis be used as the reason for admission? For example, would a diagnosis, such as depressive disorder recurrent severe without psychotic features, meet this portion of the transition record?

Answer: No. To meet the "Reason for IPF Admission" element, the transition record must describe the events that led to the patient being admitted to the hospital. A brief description of why the patient came into the hospital is required and listing a diagnosis alone is not sufficient. Per the definition for this element in the IPFQR Program manual and the paper tool: "Documentation of the events the patient experienced prior to this hospitalization; the reason for hospitalization may be a short synopsis describing or listing the triggering or precipitating event. A diagnosis alone is not sufficient."

Inpatient Care:
Major Procedures and Tests, Including Summary of Results

Abstraction guidance is included in the definition of the “Major procedures and tests, including summary of results” element.

Are the following elements included in the transition record?	Element Satisfied? Yes	No	Definition
Major procedures and tests, including summary of results			All procedures and tests noteworthy in supporting patient diagnosis, treatment, or discharge plan, as determined by provider or facility. Examples may include complete blood count and metabolic panel, urinalysis, and/or radiological imaging. Select Yes in the Element Satisfied column if major procedures and tests are in the transition record. If documentation exists in the transition record indicating that no major procedures or tests were performed, then select Yes in the Element Satisfied column.

Post-Discharge/Patient Self-Management:
Current Medication List

Abstraction guidance is included in the definition of the “Current medication list” element.

Are the following elements included in the transition record?	Element Satisfied? Yes	No	Definition
Current Medication List			The current medication list should include prescriptions, over-the-counter medications, and herbal products in the following categories: • **Medications to be TAKEN by patient:** Medications prescribed prior to IPF stay to be continued after discharge AND new medications started during the IPF stay to be continued after discharge AND newly prescribed or recommended medications to be taken after discharge. Prescribed or recommended dosage, special instructions/considerations, and intended duration must be included for each continued and new medication listed. A generalized statement regarding intended duration, such as a blanket statement indicating that the patient should continue the medications until told to stop, would be acceptable for routine medications. • **Medications NOT to be taken by patient:** Medications (prescription, over-the-counter, and herbal products) taken by the patient before the inpatient stay that should be discontinued or withheld after discharge.

Question: If there are no discontinued medications, does there need to be documentation of “no discontinued medications?”

Answer: It is not necessary to document that there are no discontinued medications.

Post-Discharge/Patient Self-Management: Studies Pending at Discharge (or documentation that no studies are pending)

Abstraction guidance is included in the definition of the “Studies pending at discharge (or documentation that no studies are pending)” element.

Are the following elements included in the transition record?	Element Satisfied? Yes	No	Definition
Studies Pending at Discharge (or documentation that no studies are pending)			Medical tests not concluded at discharge. Examples include complete blood count and metabolic panel, urinalysis, or radiological imaging. Select Yes in the Element Satisfied column if studies pending at discharge are in the transition record. If documentation exists in the transition record, indicating that no tests are pending at discharge, then select Yes in the Element Satisfied column.

Question: If there were no studies or tests completed during the stay, does the transition record still have to say there were no studies or tests performed AND none were pending to select “Yes” to both of these elements?

Answer: Yes, both elements must be addressed in documentation. If using the optional paper tool, apply the following:

- If documentation exists in the transition record indicating that no major procedures or tests were performed, select “Yes” in the Element Satisfied column for the “Major procedures and tests, including summary of results” element.
- If documentation exists in the transition record indicating that no tests are pending at discharge, select “Yes” in the Element Satisfied column for the “Studies pending at discharge (or document that no studies are pending)” element.

Advance Care Plan:

Advance Directives or Surrogate Decision Maker Documented OR Documented Reason for not Providing Advance Care Plan

Are the following elements included in the transition record?	Element Satisfied? Yes	No	Definition
Advance Directives or surrogate decision maker documented OR documented reason for not providing advance care plan			A written, signed statement that details the patient's preferences for treatment should the patient be unable to make such decisions for him/herself, whether that incapacitation be due to medical or mental health reasons. The statement informs others about what treatment the patient would or would not want to receive from psychiatrists and/or other health professionals concerning both psychiatric and non-psychiatric care. An Advance Directive identifies the person to whom the patient has given the authority to make decisions on his/her behalf, a surrogate decision maker. Copies of the Advance Directive do not need to be transmitted to the follow-up provider and the patient need not create an Advance Directive(s) to satisfy this element. This element can be met if one of the following **is documented**: a. The patient has an appointed surrogate decision maker. b. The patient has a non-psychiatric (medical) Advance Directive and a psychiatric Advance Directive. c. If (a) or (b) was not met, the patient was offered information about designating a surrogate decision maker or completing Advance Directives, and if the criteria for (a) or (b) still were not met, a reason was documented. Advance Directives must be compliant with the state laws for the state in which the patient receives care. Additional information on the Advance Care Plan element can be found in the IPFQR Program Manual at http://www.qualityreportingcenter.com/inpatient/ipf/tools/.

Advance Care Plan:

Advance Directives or Surrogate Decision Maker Documented OR Documented Reason for not Providing Advance Care Plan

Question: Does documentation that the patient is too confused to discuss advance directives and surrogate decision maker satisfy the measure as long as that information is transmitted to the next level of care within 24 hours of discharge?

Answer: Yes, if confusion is documented as the reason that the advance directives were not completed, the element is satisfied. If the optional paper tool is used, this documentation would satisfy letter “c” for this element, and “Yes” would be selected as having met the element because a reason has been documented.

Advance Care Plan:

Advance Directives or Surrogate Decision Maker Documented OR Documented Reason for not Providing Advance Care Plan

Question: Some states do not recognize PADs. The measure keeps referring to needing both a non-psychiatric AD and a PAD, and giving patient information on the PAD. Would assessing the patient for the existence of a non-psychiatric advance directive be sufficient to meet the Advance Care Plan element of the Transition Record with Specified Elements Received by Discharged Patients measure?

Answer: No, it would not be sufficient to assess the patient for the existence of a non-psychiatric advance directive to meet this element. It is true that not all states have PAD statutes; however, we are unaware of any states that prohibit facilities from

- Assessing the patient for a PAD,
- Providing the patient with information regarding the completion of a PAD,
- Assisting the patient with completing a PAD,
- Including a PAD as part of the record.

If the patient does not have an advance directive, the patient should be provided with information to complete a non-psychiatric AD and a PAD. After receiving information, the patient should be allowed the opportunity to appoint a surrogate decision maker or complete advance directives. If the patient does not appoint a surrogate decision maker or complete advance directives during the hospital stay, then reasons – such as patient refusal or patient confusion – must be documented.

Contact Information/Plan for Follow-Up Care:
Contact Information for Obtaining Results of Studies Pending at Discharge

Abstraction guidance is included in the definition of the “Contact information for obtaining results of studies pending at discharge” element.

Are the following elements included in the transition record?	Element Satisfied? Yes	No	Definition
Contact information for obtaining results of studies pending at discharge			Healthcare professional or facility contact number at which patient can receive information on studies that were not concluded at discharge. Patient preference should be considered in sharing results of studies, including whether or not results should be provided on paper. Select Yes in the Element Satisfied column if contact information for obtaining results of studies pending at discharge is in the transition record. If documentation exists in the transition record indicating that no tests are pending at discharge, then select Yes in the Element Satisfied column.

Question: If there is documentation showing that there are no studies pending at discharge, what value would the abstractor choose for the “Contact information for obtaining results of studies pending at discharge” element?

Answer: For the “Contact information for obtaining results of studies pending at discharge” element, if documentation exists in the transition record indicating that no tests are pending at discharge, select “Yes” in the Element Satisfied column in the optional paper tool.

Contact Information/Plan for Follow-Up Care:
Plan for follow-up care

Abstraction guidance is included in the definition of the “Plan for follow-up care” element.

Are the following elements included in the transition record?	Element Satisfied? Yes	No	Definition
Plan for follow-up care			A plan for follow-up care that describes treatment and other supportive services to maintain or optimize patient health. The plan should include post-discharge therapy needed, any durable medical equipment needed, family/psychosocial/outpatient resources available for patient support, self-care instructions, etc. The plan may also include other information, such as appointment with outpatient clinician (if available), follow-up for medical issues, social work and benefits follow-up, pending legal issues, and peer support, e.g., Alcoholics Anonymous, Narcotics Anonymous, and/or home-based services. The plan should be developed with consideration to the patient’s goals of care and treatment preferences.

Question: Is an appointment date/time required for at least one provider/site for follow-up care, or can there just be a referral to the provider/site?

Answer: No, an appointment date and time is not required. Ideally an appointment with a specific date and time would be made; however, in instances when this is not possible, there still should be at least one provider or site identified for follow-up care in the transition record.

Contact Information/Plan for Follow-Up Care:
Plan for follow-up care

Question: If a patient refuses to make a follow-up appointment, and declines all follow-up appointments, is that sufficient to answer “Yes” to “Does the transition record include a plan for follow-up care related to the inpatient stay?”

Answer: No, there is no provision for refusal. The facility is responsible for providing the patient with information regarding a primary physician, other healthcare professional, or site designated for follow-up care, whether or not the patient uses it. This information must still be conveyed to the patient in order to pass the measure.

Discussion of the Transition Record with All of the Specified Elements

To meet the Transition Record with Specified Elements Received by Discharged Patients measure, the measure abstractor must ensure that ALL 11 elements are included in the transition record and that the transition record was:

- Discussed with and provided to patients/caregivers that are discharged home, **OR**
- Discussed (at minimum, the four stated elements) with the next inpatient provider for patients being transferred **to an inpatient facility**

Are the following elements included in the transition record?	Element Satisfied? Yes	No
Was the transition record discussed with the patient or caregiver OR if the patient was transferred to an inpatient facility, were the four elements discussed with the receiving inpatient facility? (See NOTES below.)		

Discussion of the Transition Record with All of the Specified Elements

Question: Our facility goes over the transition record with the patient prior to discharge. It is signed by both the nurse and the patient. Must there still be specific documentation that all components were "discussed?" Or are the signatures okay?

Answer: Signatures are not required; however, documentation must sufficiently indicate that all elements of the transition record were reviewed with the patient.

Question: Are we required to have the patient's signature on the transition record, or is attestation in the EHR that it was discussed and received sufficient?

Answer: The transition record measures do not require a patient signature. Attestation in the EHR that a transition record covering 11 elements was created and discussed with the patient (or caregiver) is adequate.

Timely Transmission of Transition Record: Discharge Information

Discharge Information	Date and time patient was discharged from facility			
	Date and time transition record was transmitted			
	Method of transmission			Mail, fax, secure e-mail, or hard copy provided to transport personnel. If the follow-up healthcare professional has mutual access to the electronic health record (EHR), this must be documented as the transmission method.
	Was transition record transmitted within 24 hours of discharge?	Yes	No	Calculated as 24 consecutive hours or fewer from the date and time of discharge to the date and time of transmission.

Question: When does the 24-hour period begin: when the patient is transferred to the medical facility for emergency treatment, or when the patient is admitted to the medical facility? What if the transmission was performed on the day of discharge?

Answer: The 24-hour requirement for the timely transmission measure begins at the date and time the patient was discharged from the IPF. If the transition record was transmitted within 24 hours after discharge, the timely transmission measure has been met. If you use the optional paper tool, the date and time of transmission of the transition record would be collected.

Timely Transmission of Transition Record: Discharge Information

Question: “A transition record is necessary to ensure coordination and continuity in care when transitioning from one level to another.” We are in agreement that a transition record is necessary. Patients must sign individual ROIs for outpatient appointments. If a patient refuses aftercare, there is no transition. If, in the case the patient has a known outpatient provider, would it not violate the HIPAA to transmit a transition record without an ROI? Or, is there a special clause that allows for the transition of care for mental health patients that allows us to send to the next level of care without written consent?

Answer: We are not stating that the transition record should be transmitted to the next provider without the patient’s permission. If the patient refuses, the timely transmission measure would not be satisfied. The transition record with the required 11 elements must still be created and discussed with the patient to meet the intent of the Transition Record with Specified Elements Received by Discharged Patients measure.

Frequently Asked Questions Document: Other Topics

In addition to questions pertaining to the elements of the transition record, as well as the timing and method of transmission of the transition record, the FAQs document includes question and answer pairs relevant to

- General measure requirements
- Measure exclusions
- Patients discharged to home vs. discharged to an inpatient facility

Measure Exclusions

Question: If an involuntary patient is taken to his/her court hearing offsite, and then dismissed from court and not returned to the hospital, what components of the discharge plan still apply?

Answer: That will depend upon the discharge status code submitted on the claim. Please refer to the initial patient population algorithm in Appendix C of the Inpatient Psychiatric Facility Quality Reporting Program Manual to determine which codes are excluded from the transition record measures.

Transition Record Measures' Optional Paper Tool

Data Collection Tool for Compliance with the *Transition Record with Specified Elements Received by Discharged Patients* and *Timely Transmission of Transition Record* Measures

Notes

A **Transition Record** is defined as a core, standardized set of data elements related to a patient's demographics, diagnosis, treatment, and care plan that is **discussed with and provided to the patient/caregiver(s)** in a printed or electronic format at each transition of care and transmitted to the facility/physician/other healthcare professional providing follow-up care. The transition record may only be provided in an electronic format if acceptable to the patient and only after all components have been discussed with the patient.

To satisfy the numerator for both measures, this is what must occur:

For patients who are discharging to **home**, a transition record covering all 11 elements must be:

- Created;
- Discussed with the patient/caregiver;
- Provided to the patient/caregiver either in hard copy or electronically, if the patient agrees; and
- Transmitted to the next provider within 24 hours after discharge.

For patients who are discharging to an **inpatient facility**, a transition record covering all 11 elements must be:

- Created;
- Discussed with the receiving facility, but only highlighting these four elements:
  - 24-hour/7-day contact information;
  - Contact information for pending studies;
  - Plan for follow-up care; and
  - Primary physician, other healthcare professional, or site designated for follow-up care; and
- Transmitted to the next provider within 24 hours after discharge.

The National Quality Forum (NQF) defines **elopement** as any situation in which an admitted patient leaves the healthcare facility without staff's knowledge.

A **failure to return from leave** occurs when a patient does not return at the previously agreed-upon date and time for continued care. If the patient fails to return from leave, then the patient has left care without staff's knowledge.

Helpful Resources

Additional Guidance on the Transition Record

Listed below are links to a few different sites that include resources currently available online to assist you in the development of a transition record.

- Medicare Learning Network: Discharge Planning: IPF-specific content on pages 16-18
- Best Practices Manual for Discharge Planning: sample checklist on page 63
- Hospital Discharge Transition Record: sample two-page document

NOTE: CMS is not advocating these examples over others. The examples provided may need to be modified in some way to ensure that all 11 elements of the transition record are covered for the Transition Record with Specified Elements for Discharged Patients measure.

Helpful Resources
IPFQR Program Manual and Paper Tools

The IPFQR Program Manual, FAQs document, the optional paper tool for the transition record measures, and other helpful IPFQR Program resources and tools, can be found at:

- Quality Reporting Center > IPFQR Program > Resources and Tools (http://www.qualityreportingcenter.com/inpatient/ipf/tools/)
- QualityNet > Inpatient Psychiatric Facilities > Resources (https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772864255)

Helpful Resources
Save the Dates

Upcoming IPFQR Program educational webinars:

June 2017

Keys to Successful FY 2018 Data Submission

July 2017

No Webinar Planned

August 2017

FY 2018 Final Rule Changes to the IPFQR Program

Helpful Resources
IPFQR Program General Resources

Q & A Tool	Email Support	Website	Phone Support
https://cms-IP.custhelp.com	IPFQualityReporting@hcqis.org	www.QualityReportingCenter.com	(866) 800-8765
Monthly Web Conferences	**ListServes**	**Hospital Contact Change Form**	**Secure Fax**
www.QualityReportingCenter.com	www.QualityNet.org	Hospital Contact Change Form	(877) 789-4443

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