Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Support Contractor

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

Questions & Answers

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More than half (54%) of the questions received during the May 18, 2017 IPFQR Program webinar titled *Navigating to Success: A Review of the Abstraction Process for the Transition Record Measures* were previously answered in the document found at the following link: IPFQR Program Frequently Asked Questions. The following list of question and answer pairs are those that are not addressed directly in the IPFQR Program Manual, optional paper tool for the transition record measures, or the aforementioned FAQs document. Submit any additional questions to the *QualityNet* Q&A tool found at the following link: https://cms-ip.custhelp.com/app/homeipf/p/831.

Transition Record with Specified Elements Received by Discharged Patients Measure

General Measure Abstraction

Question 1: **This element is for patients 18 years and older correct?**

The denominator for the transition record measures includes all patients, regardless of age. Refer to pages 20-21 of the IPFQR Program Manual (finalized June 13, 2017) and pages 1 and 6 of the optional Data Collection Tool for Compliance with the Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record Measures.

Measure Exclusions

Question 2: **Does the facility fail this measure if the patient goes absent without leave (AWOL's)?**

The denominator for the transition record measures excludes patients who discontinued care. Refer to pages 21 and 23 of the IPFQR Program Manual (finalized June 13, 2017) and pages 1, 5, and 6 of the optional Data Collection Tool for Compliance with the Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record Measures. A patient that goes AWOL would be considered an elopement situation in which the patient leaves the healthcare facility without staff's knowledge.

Patients Discharged to Home vs. Discharged to an Inpatient Facility

Question 3:

An inpatient facility is defined in the manual as a skilled nursing facility. When a patient is discharged to a nursing home we are told that is considered home and a verbal report does not need to be given to that receiving facility; however, how do we know if that patient will be receiving skilled care or not? How would we know when to call verbal report and when not to if the patient is discharged to a nursing home?

Discharge to a nursing home without skilled nursing orders would equate to the patient being discharged to "home." The physician discharge orders will specify whether the patient is being discharged to the skilled nursing unit within the nursing home. Discharge to a skilled nursing facility is considered discharge to another inpatient facility, not discharge to home, for the transition record measures. Therefore, in order to meet both measures, 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
  - Healthcare professional/site designated for follow-up care; and
- Transmitted to the next provider within 24 hours after discharge.

Reason for IPF Admission/Principal Diagnosis at Discharge

Question 4:

Reason for IPF Admission: Psychiatric patients often demonstrate preadmission behaviors he/she may not want to be available to family or friends (if provided in writing at time of discharge). Can you please clarify the specificity you are seeking?

You must follow the applicable laws for your state regarding release of information.

Question 5: **Can the "problem" or would a problem list be sufficient to meet the Reason for IPF Admission [element]?**

If the problem list contains documentation of the events the patient experienced prior to being admitted to the hospital, this is acceptable. We recommend that you review the IPFQR FAQ document that is available for download from the IPFQR Program Resources and Tools web page of the *Quality Reporting Center* website. If you do not find your answer in the FAQ document, please submit your question to the *QualityNet* Q&A tool found at the following link: https://cms-ip.custhelp.com/app/homeipf/p/831.

Question 6: **We have received conflicting answers to our QNet questions regarding reason[s] for IPF admission. Is suicidal ideation acceptable as a short synopsis describing the event the patient experienced prior to hospitalization? How about increased confusion? Increased depression? Can you please give us examples of what you are looking for as far as what you consider [a] "short synopsis?"**

According to section 30.2–Psychiatric Evaluation–of CMS' Medicare Benefit Policy Manual, "Each patient must receive a psychiatric evaluation that must… note the onset of illness and the circumstances leading to admission…" The definition for Reason for IPF Admission is described in the IPFQR Program Manual (finalized June 13, 2017). The definition is given as: "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." When creating the Transition Record, the Reason for IPF Admission will consist of descriptive narrative documentation, which may be found in the psychiatric evaluation portion of the medical record.

Note that a listing of symptoms is also not sufficient, as the synopsis should summarize the patient's behavior as well as the events and circumstances that led to hospitalization. Increased confusion is a symptom that can manifest in many different ways. An example of a synopsis for "Reason for IPF Admission" related to increased confusion could be as follows: "Patient was picked up by police while wandering around grocery store. When asked where he/she lived, the patient did not know. Patient was unable to identify primary care physician and current medications. Police brought patient to the emergency room and the patient was admitted to the IPF for increased confusion."

Question 7: **Can the final principal discharge diagnosis be documented in patient-centered language, or must it be verbatim from the physician discharge summary (usually clinical terminology)?**

The Principal Diagnosis at Discharge must be taken from physician documentation.

Major Procedures and Tests, Including Summary of Results

Question 8: **Are "Major Test" and "Studies Pending" the same thing?**

No. Although related, the elements are not the same. Refer to page 24 of the IPFQR Program Manual (finalized June 13, 2017) and pages 1 and 2 of the optional Data Collection Tool for Compliance with the Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record Measures for further clarification. The Major Procedures and Tests, Including Summary of Results element includes all procedures and tests noteworthy in supporting patient diagnosis, treatment, or discharge plan, as determined by provider or facility. The Studies Pending at Discharge element pertains to medical tests not concluded at discharge.

Question 9: **Is it necessary to include numerical lab values in the tests given to the patient? Does the transition record need to be separate from the discharge record for the patient [or can] we incorporate the elements into the discharge instructions?**

The IPF determines whether to include numerical lab values in the results given to the patient. A discharge record can be a transition record as long as it contains all the elements.

Question 10: **Does a patient actually have to be given a copy of all major tests & summary OR can it be documented that it was discussed with patient?**

The patient must receive a copy of the transition record containing all procedures and tests deemed noteworthy by the provider or facility and it must be documented that the transition record was discussed with the patient.

Question 11: **If [the] patient refuses [a] major test would this meet [the] element?**

If the patient refuses a major test and it was not performed during the hospitalization, then the transition record would need to reflect there were no major procedures or tests completed. This would satisfy the element.

Question 12: **If the patient's physician does not want any lab results sent to the next health care provider is that acceptable if it is documented as a discharge order?**

The provider determines the results that are noteworthy in supporting patient diagnosis, treatment or discharge plan. There must be documentation in the transition record indicating there are no significant lab results.

Question 13: **Can the discharge instructions state, "Please see attached lab work," then attach to the discharge instructions and review with patient and give all to the patient?**

Yes, attaching lab work as part of the transition record is acceptable to meet the Major procedures and tests, including summary of results element. To satisfy the Transition Record with Specified Elements Received by Discharged Patients measure, the transition record must include all 11 elements (which may consist of several forms/documents), reviewed with the patient.

Current Medication List

Question 14: **For the blanket statement pertaining to medication duration, continue until told to stop, do we need to specify the party responsible for telling the patient to stop?**

No, a specific provider does not need to be documented. 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.

Studies Pending at Discharge (or Documentation That No Studies Are Pending)

Question 15: **Why does this question continue to ask how to receive pending lab work when the patient doesn't have any pending labs?**

Please contact your vendor as this appears to be a programming issue within your electronic data collection tool.

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

Question 16: **If the patient is under the age of 18 and therefore has a legal guardian, do we choose--the patient has an appointed surrogate decision maker?**

There are a number of possible circumstances where an individual may not be offered or complete advance directives. The measure only requires that the IPF provide documentation as to why this occurred. Documenting that the patient is under 18 and has a legal guardian would be acceptable.

Question 17: **We are a child/adolescent psychiatric facility. We currently document not applicable to minor in the advance directive section. Is this sufficient?**

No. Documenting the patient is under the age of 18 and has a legal guardian is acceptable.

Question 18: **So if the patient has a [durable power of attorney] DPOA - we don't have to have any additional documentation regarding an [advanced directive] AD in the transition record?**

To satisfy the element, it must be documented in the transition record that the patient has a DPOA. This documentation will serve as the reason the patient did not complete advance directives.

Question 19: **To what extent is the facility expected to go to help the patient complete an advance directive? In our state there is no [psychiatric advanced directive] PAD and caregivers (anyone involved in care) cannot witness the document. Is providing an example document with written instructions satisfactory?**

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. For example, this may mean that a social worker or discharge planner meets with the patient, if requested. 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.

Question 20: **Option-c on slide 20 does not specifically indicate psychiatric advance directives. Can the general statement of advance directives be appropriate to meet the element?**

To satisfy this element, documentation must state that both the psychiatric and medical advance directive are addressed.

Question 21: **It is our hospital system's policy not to execute a PAD while a patient is admitted to the inpatient unit. [What can we do to meet this measure?]**

The facility must still assess for the presence of a PAD and non-psychiatric AD. If neither are present, a reason for not completing one must be documented.

24-Hour/7-Day Contact Information, Including Physician for Emergencies Related to Inpatient Stay

Question 22: **Does providing the main facility telephone number meet the 24 hour/7-day element?**

As stated on page 22 of the IPFQR Program Manual (finalized June 13, 2017) and page 4 of the optional Data Collection Tool for Compliance with the Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record Measures, "800 numbers, crisis lines, or other general emergency contact numbers **do not** meet this requirement **unless** personnel have access to the medical records and other information concerning the inpatient stay."

Contact Information for Obtaining Results of Studies Pending at Discharge

Question 23: **If studies are pending at discharge, is our Health Information Management Department number adequate to meet the element?**

Per the definition for this element, the contact number must be to a healthcare professional or facility where the patient can receive information on results of studies. If your HIM department meets this requirement, this is acceptable.

Plan for Follow-Up Care

Question 24: **How do we document transmittal when clinic follow-up will be walk-in?**

In this scenario, if the transition record cannot be faxed to a physician providing follow up care, this measure will not be met.

Question 25: **Regarding Plan for Follow-up Care, if the hospital provides the patient with several options for follow-up, but the patient declines to select prior to the discharge, will this pass the measure?**

Yes, if this information was provided to the patient this is acceptable. 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.

Question 26: **Does it matter where in the chart we document that the physician has electronic access when a patient is transferred to an acute medical unit? Can the plan for follow up care be that the patient will return to psychiatric treatment, especially if the patient's behavioral health issue has not been worked up totally?**

The transition record must have documentation that the next level of care provider has electronic access. The plan for follow up care will be that the patient will receive care for their medical issue.

Question 27: **A lot of times with our adolescents the aftercare provider wants the parent to make the appointment. We give the parent the information (place, phone number, and contact) and the social worker writes "parent will have set up appointment." In these cases, can we select yes to the aftercare question?**

For the element Plan for follow up care, an appointment is not required so providing the patient with the follow up information would suffice.

Primary Physician, Other Healthcare Professional, or Site Designated for Follow-up Care

Question 28: **For the element Primary physician, other healthcare professional, or site designated for follow-up care, must documentation include the name of the physician?**

The name of the physician should be included unless it is a site of care. The definition for this element states: The primary care physician (PCP), medical specialist, psychiatrist or psychologist, or other physician or healthcare professional who will be responsible for appointments after inpatient visit. A site of care may include a group practice specific to psychiatric care. A hotline or general contact does not suffice for follow-up care.

Question 29: **Many patients follow up with local agencies in our county that offer a variety of treatment services and are not mutually exclusive addiction treatment programs. Must documentation on the transition record regarding these programs specifically state they are for addiction follow up treatment, or is this documentation sufficient in other areas of the patient record?**

The documentation does not need to state the follow up is specifically for addiction treatment.

Discussion of Transition Record/Four Elements

Question 30: **Where can we find the four stated elements needed with the patient being transferred to an inpatient facility?**

This information is included on page 7 of the 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 and on page 23 of the IPFQR Program Manual (finalized June 13, 2017) in the definition of the term "Contact information/plan for follow-up care."

Question 31: **We have the following statement that the nurse can place on the transition record which is called an After Visit Summary (AVS): "The discharge information and instructions were reviewed with the patient and family. A copy was provided to the patient." We use one form for the transition record that contains all parts. Would this statement meet your requirement?**

If there is documentation that the transition record (or AVS) contains/addresses all 11 elements, it is sufficient to say the transition record was discussed and given to the patient.

Timely Transmission of Transition Record Measure

Date and Time Transition Record Was Transmitted

Question 32: **Does the patient discharge date and time, AND the transition record transmission date and time need to be documented on the transition record?**

Neither the patient discharge date and time, nor the transmission date and time need to be documented in the transition record. The timely transmission measure requires that the transition record be transmitted within 24 hours after discharge. Many vendors have programmed their electronic data collection tool to collect discharge date and time and transmission date and time in order to calculate whether the transition record was transmitted within 24 hours of discharge.

Question 33: **Does 24 hours from discharge mean within that time frame, or can the record be transmitted within the next day's date, which may be greater than 24 hours of the discharge?**

The transition record can be transmitted anytime up to 24 hours after the discharge time to meet the Timely Transmission of Transition Record measure.

Question 34: **Some providers request the transition record be sent via mail. If [it is] documented [in] the transition record [that it] was mailed to the next level provider within 24 hours, does this suffice?**

Yes.

Question 35: **If a member cannot find documentation that the transition record was transmitted, they will fail the Transition Record with Specified Elements Received by Discharged Patients and the Timely Transmission of Transition Record measures, correct?**

If there is documentation a complete transition record was reviewed with and provided to the patient but not transmitted, the case will only fail the Timely Transmission of Transition Record measure.

Method of Transmission/Record Transmitted Within 24 Hours of Discharge

Question 36: **Does the method of transmission need to be documented in order to satisfy the Timely Transmission of Transition record? If the transition record is faxed to [the] next level of care, are we required to have a copy of proof of fax or will facility/doctor contact info, date and time recorded in patient chart be enough?**

According to the IPFQR manual and the definition for "transmitted," the date, time and method of transmission must be documented in the medical record but not in the transition record. A copy of a proof of fax is not required.

Question 37: **If a patient refuses to sign a record release allowing us to fax/transmit documents to the next level of care provider do they fall into the exclusion of "discontinued care?"**

No. There is no provision for refusal; therefore, if the patient refuses, the timely transmission measure would not be satisfied.

IPFQR Program/Helpful Resources

Question 38: **Are IPF measures subject to validation by CMS?**

No. Validation is not part of the IPFQR Program at this time.

Question 39: **Is there a link to the 7-page paper tool?**

Yes. Here is a link to the 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.

Question 40: **CMS has encouraged hospitals to be electronic, but then recommends using a 7-page optional paper tool to help with this measure - seems backwards. Can CMS comment?**

The 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 is designed to assist IPFs and their vendors in the abstraction process by providing guidance that may help in the creation of electronic tools that will capture data in a timely and efficient manner.

Question 41: **There is information in the IPF Manual (updated 2-1-17) that is outdated. When will the links be updated so the correct information can be accessed from the manual?**

The IPFQR Program Manual, finalized June 13, 2017, is the latest version and contains updated information.