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Transition Record with Specified Elements Received by Discharged Patients Measure

General Measure Abstraction

1. If one of the 11 required elements of the transition record is missing, will this case fail the entire measure?
   Yes, all 11 elements must be completed and documented as discussed with the patient or caregiver to pass the measure.

2. In regard to the requirement that the transition record be provided to the patient in a printed or electronic format at each transition of care, is the presence of the required elements of the transition record in the discharge instructions sufficient?
   If the discharge instructions given to the patient include all of the 11 required elements, then this would be sufficient with respect to providing documentation to the patient.
3. **Does there need to be a statement that the patient was given this information in printed or electronic format?**
   
   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.

4. **Is the abstractor supposed to use the checklist tool to locate the information in the medical record and therefore fill out the tool? Or does the hospital use the tool to create the transition record, and then the abstractor is either supposed to look for a checklist/summary of elements or for the actual transition record containing all 11 elements?**
   
   The abstractor should not need to search through the medical record for the elements of the transition record since the elements should have been compiled as part of the transition record and discussed with the patient during the discharge process. The optional paper tool may help in the discharge process to ensure that all elements are included in the transition record; however, it is intended to be used by the abstractor as a tool to verify that all elements are included in the transition record. It will also help determine if the transition record was transmitted within 24 hours of discharge.

**Measure Exclusions**

5. **If the patient was admitted less than one day to the inpatient psychiatric facility (IPF) and was transferred to another hospital, will this patient be excluded from the transition record denominator?**
   
   No. The specifications do not have a length-of-stay exclusion.

6. **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?**
   
   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.

7. **Will there be future consideration for exclusion of those patients who have an emergency transfer? All 11 elements may not be available as not all assessments have been completed, and the conversation with the receiving facility would focus on the patient’s condition, not necessarily the four required elements.**
   
   The American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI®) is the measure developer, and we (CMS) are not aware of future considerations for exclusion of those patients. All of the information for the transition...
record must be available at discharge to ensure an effective, coordinated transition, and it may include documentation that results are pending.

Patients Discharged to Home vs. Discharged to an Inpatient Facility

8. Please clarify for patients who are discharging to an inpatient facility if that means to an acute inpatient facility, or another inpatient psych facility, or either of these.

Inpatient facility is defined in the IPFQR Program manual as follows: “Site of care delivery to include hospital inpatient or observation, skilled nursing facility, rehabilitation facility, or inpatient psychiatric facility (IPF).” All require that a transition record be created.

9. When a patient is transferred from our IPF to another area of the hospital, such as the intensive care unit (ICU), does the transition record still need to be created and reviewed with the patient even though the entire patient record (including inpatient psychiatric care) is accessible to all caregivers in the hospital via the electronic health record? Since the sending and receiving facilities are the same in this case, would a blanket statement suffice to cover the four elements mentioned in the question above? And is the IPF required to discuss the transition record with the patient’s family?

Yes, the transition record must still be created and transmitted. No, a blanket statement will not suffice. In this scenario, the transition record does not need to be reviewed with the patient or caregiver; however, the four elements listed in the Notes section of the optional paper tool, and provided below for clarification, must be discussed with the receiving care team. Mutual access to the EHR must be listed as the transmission method and will meet the Timely Transmission of Transition Record measure.

“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.”
10. If a patient is transferred to a medical unit within the same facility and admitted, does the transition record need to include the four elements identified, or is it acceptable that the providers have access to the entire medical record as part of the same organization?

The transition record must be created that includes all 11 elements, but only four elements are discussed with the receiving facility. It can be done during verbal report when the patient transitions. If the follow-up healthcare professional has mutual access to the electronic health record (EHR), this must be documented as the transmission method to satisfy the Timely Transmission of Transition Record measure.

11. Our IPF provides acute, as well as, long-term inpatient psychiatric care, and there are several instances in which a patient is discharged from acute inpatient psychiatric treatment and readmitted to long-term inpatient psychiatric care within our facility. Is our IPF required to create and transmit a transition record for a patient if the patient’s level of care changes, but the patient’s location and medical team remain unchanged? Who would be the receiving provider if the medical team remains the same? According to the measure specifications, such patients would be included in the denominator due to the discharge code, but the patient is not going to another site of care.

Based on the initial patient population (IPP) algorithm described in the IPFQR Program manual, any patient who falls within the discharge billing codes described therein will be included in the denominator for the Transition Record with Specified Elements Received by Discharged Patients measure. However, it is possible that there may be rare circumstances in which there is no functional transition in patient care. In this instance, the measure is met because the medical team is the same and continues to have full access to the original medical record associated with the treatment. The patient’s medical record must state that a transition record was not created because there was no physical change to the patient’s location and medical team in order to satisfy the numerator for the transition record measure.

Reason for IPF Admission/Principal Diagnosis at Discharge

12. 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?

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.”
13. Would a transition record meet the measure if the reason for IPF admission was in the patient’s own words?
   The “Reason for IPF admission” element should incorporate the best available information concerning the reasons for the patient’s admission. This may include, for example, patient self-report, emergency room notes, information from family and caregivers, and police reports.

14. 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?
   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.

Major Procedures and Tests, Including Summary of Results

15. If there are no tests pending at discharge, must this be mentioned on the transition record?
   Yes, if no tests are pending, this must be documented in the transition record. If using the optional paper tool, select “Yes” that the element was satisfied.

Current Medication List

16. What needs to be documented for the duration of medications?
   Per the definition for this element as defined in the IPFQR Program manual: “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.”

17. If there are no discontinued medications, does there need to be documentation of “no discontinued medications”?
   It is not necessary to document that there are no discontinued medications.

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

18. 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?
   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 Directives or Surrogate Decision Maker Documented or Documented Reason for Not Providing Advance Care Plan

19. What are the requirements for meeting the Advance Care Plan 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 (AD) and a psychiatric advance directive (PAD).
   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.

   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.

20. Does the transition record have to address the medical advance directive, as well? It was my understanding that the measure only covered the PAD.
The measure element specifications for advance directives applies to both non-psychiatric (medical) and psychiatric advance directives. Addressing only one does not satisfy the element.

21. Is giving the patient information on the non-psychiatric advance directive and the psychiatric advance directive enough to satisfy the Advance Care Plan data element? Or do we have to get the patient to fill out the advance directives during the admission?
No, giving the patient information on advance directives does not satisfy the element. It is not required to have the advance directives completed during the admission; however, if they are not completed, a reason must be documented. 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 PAD.
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. 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.

22. Can this documentation that advance directives were addressed be a part of the patient record, or must it also be on the transition record? For example, if the patient declines information on advance directives, does this refusal need to be included on the transition record, or is documentation in the chart sufficient?

No, documentation in the chart is not sufficient. This information must be included in the transition record in order to meet the Advance Care Plan element of the Transition Record with Specified Elements Received by Discharged Patients measure.

23. 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?

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.

24. Does the specific question of do not resuscitate (DNR) and do not intubate (DNI) need to be asked, or is advance directive/healthcare proxy adequate?

Determining whether the patient has an advance directive/healthcare proxy is sufficient for the Advance Care Plan element. It is not required by the measure to ask the patient if he/she has a DNR in addition to a medical advance directive.

25. 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?

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, or
• 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.

26. What is the rationale for offering a PAD to the patient when it is not our state standard?
As stated on page 46702 of the FY 2016 IPF PPS Final Rule:

“This measure will inform patients of their status at discharge, empowering them to become active members in their care. Additionally, the inclusion in this measure of an advance care plan will support open communication of the patient’s, and his/her caregiver’s/surrogate’s, wishes, resulting in improved patient-provider communication.”

27. Concerning the advance directive portion of the transition record, our staff has been entering that the patient doesn’t have a power of attorney (POA) or advance directive, and then saying it is not applicable for this visit. Will this be enough?
No. Documentation of “not applicable for this visit” is not sufficient. 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.

28. Prior question and answer transcripts stated that the AD does not have to be transmitted to the next level of care. Is that correct?
That is correct. If the patient has an advance directive, that documentation in the transition record would suffice.
29. The transition record states that the patient does not have a non-psychiatric (medical) advance directive and psychiatric advance directive. In the transition record that the next provider receives, it states that the patient does not have advance directives and the reason documented is that the patient refused. Would the hospital of origin be compliant?

Yes. In order for the hospital of origin to be compliant, the reason why the patient does not have an appointed surrogate decision maker or the non-psychiatric and psychiatric advance directives must have been documented within the transition record.

30. The specifications related to the transition record specifically state that the 11 elements need to be “included” in the transition record; however, you are saying the non-psychiatric AD and PAD just need to be addressed? Are there any other elements that only need to be “addressed” and not necessarily “included” on the transition record?

The patient must be assessed for a non-psychiatric AD and a PAD, and these assessments are to be included in the transition record. It is not necessary to include the non-psychiatric AD and PAD. If the patient does not have a non-psychiatric AD and/or a PAD, a reason must be documented and included in the transition record. All 11 elements must be completed and included in the transition record. Please refer to the optional paper tool for the transition record measures located on the QualityNet and Quality Reporting Center websites.

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

31. Can we use the receiving facility as the 24/7 contact?

No, the receiving facility may not be used as the 24/7 contact. The definition of the 24-hour/7-day contact information, including physician for emergencies related to inpatient stay element states the following:

“Physician, healthcare team member, or other healthcare personnel who have access to medical records and other information concerning the inpatient stay and who could be contacted regarding emergencies related to the stay.”

Contact Information for Obtaining Results of Studies Pending at Discharge

32. 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?

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.
Plan for Follow-Up Care

33. 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”?

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.

34. If the patient is discharged to an inpatient facility for a medical reason, and the plan is for the patient to return to the discharging psychiatric facility, can discussion of the four elements (the 24/7 contact, plan for follow-up care, primary physician, contact information for pending studies) reflect that for those four elements, the plan is for the patient to return to the psychiatric facility once medically stable along with the provision of the unit/provider contact info? Would this be sufficient?

The statement “patient to return to the psychiatric facility once medically stable” would suffice for the element “Plan for follow-up care” **only**. For patients who are discharging to an inpatient facility (even within the same building/facility), a transition record with 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.

35. 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?

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 should still be at least one provider or site identified for follow-up care in the transition record.
Discussion of Transition Record/Four Elements

36. 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?

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

37. 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?

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 Measure

Date and Time Transition Record Was Transmitted

38. Our electronic medical record (EMR) has a patient’s discharge time documented as 01/25/2017 at 1416. The discharging registered nurse (RN) documented it as 1/25/2017 at 1950. Please advise as to which time I should abstract as the discharge time? I’m trying to determine if the transition record was transmitted within 24 hours of discharge.

Use the discharge time ordinarily used by the facility to record the patient’s discharge.

39. 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?

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.

40. If the transition record is transmitted prior to discharge, can we use the discharge time as the time transmitted?

Either time would be acceptable unless your electronic data collection tool does not allow entry of a time prior to discharge. If the electronic data collection tool does not allow entry of a time prior to discharge, then use the patient discharge time as the time that the transition record was transmitted.
Method of Transmission/Record Transmitted Within 24 Hours of Discharge

41. We do not have all 11 elements of the transition record on the same form. Do we fax all forms that make up the 11 elements of the transition record to the next provider of care?

Yes, the transition record should include all 11 elements and may consist of several forms/documents, which must be transmitted to the next provider.

42. “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 releases of information (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 Health Insurance Portability and Accountability Act (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?

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.

43. When documentation is present that the next level care provider has access to the electronic medical record (EMR), do all components of the transition record still need to be transmitted within 24 hours of discharge and documented as such; or is it sufficient to document “next level has access to electronic medical record”? For example, if there is documentation that advance directives [were] not addressed because [the] patient is confused, does this have to be transmitted to next level, or is it sufficient that it is accessible in the EMR that next level has access to?

If the next level of care provider has EMR access, this would be documented as the method of transmission, and would satisfy the Timely Transmission of Transition Record measure. To satisfy the Transition Record with Specified Elements Received by Discharged Patients measure, the transition record must still be created that includes all 11 elements, per the measure specifications. The documented reason, such as the patient is confused, would be within the transition record and accessible through the EMR for review by the next provider.
44. If a patient is discharged on the weekend and the discharge planner is unable to make an appointment due to the office not being open, is it acceptable to send to the next level of care as soon as the appointment is made on the next working day? The transition record must be transmitted to the next provider within 24 hours of discharge from the IPF to satisfy the timely transmission measure.

Screening for Metabolic Disorders Measure

45. Can an admitting diagnosis (such as schizophrenia) or patient refused blood draw for lipid panel be used as reason for not completing a metabolic screen? No. The only acceptable reason is explicit documentation that the screening could not be completed due to the patient’s enduring unstable medical or psychological condition. No other reason is acceptable for not completing a metabolic screening.

46. What if one of the required screening tests has been performed, but the results are still pending? Can we answer “Yes”? No. There must be documentation of a numerical value in the medical record to select “Yes.”

47. If the IPF physician pulls results from a previous stay, including date, time, and values, into the current EHR, and states, “all labs reviewed,” is this acceptable documentation for blood glucose, or must the documentation be disregarded as it did not pull through the name of the physician who originally ordered the test? The name of the physician is not required. If the clinician accessed the EMR and obtained blood glucose results from a previous stay or visit within the 12 months prior to the date of discharge, documentation in the current record must include the following:
   - Source of the result, e.g., medical record of prior hospital stay, EMR, or the name of the provider who ordered the test
   - Original date the glucose was measured
   - The numerical result

48. Must all the screening tests be performed to pass the measure? Yes, unless there is explicit documentation that the screening could not be completed due to the patient’s enduring unstable medical or psychological condition.
49. Does a glucose result from a basic metabolic panel (BMP) or a comprehensive metabolic panel (CMP) count? Does it have to be fasting? BMP/CMP are completed on the majority of admits to our behavior health facility, but are not required to be drawn as fasting labs.

If a glucose value is found within a BMP or a CMP, then documentation that the patient fasted prior to the test is required. If there is no indication that the patient fasted, then that test cannot be used for the Blood Glucose data element.