Data Collection Paper Tool for Compliance with the *Transition Record with Specified Elements Received by Discharged Patients* and *Timely Transmission of Transition Record* Measures 01-01-2019 (Q1 2019) through 12-31-2019 (Q4 2019)

This document is provided as an optional, informal mechanism to aid psychiatric facilities and hospital psychiatric units in the collection of data for the Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record measures for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program under the Centers for Medicare & Medicaid Services (CMS). The tool is designed to collect patient-specific data; however, once abstracted, the data will need to be compiled and reported to CMS in aggregate. If there are any questions or concerns regarding the use of this data collection paper tool, please contact the IPFQR Program Support Contractor at IPFQualityReporting@hsag.com.

Transition Record with Specified Elements Received by Discharged Patients

The **numerator** is comprised of patients or their caregiver(s) (or inpatient facilities in the case of patient transfer) 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.

> The elements of the Transition Record with Specified Elements Received by Discharged Patients measure must be abstracted from the transition record, **NOT** the medical chart.

Topic	Are the following elements included in the transition record?	Element Satisfied? Yes	Element Satisfied? No	Definition
Inpatient Care	Reason for IPF admission			Documentation of the events the patient experienced prior to this hospitalization; the reason for hospitalization must be documented as a short synopsis describing or listing the triggering or precipitating event. A diagnosis alone is not sufficient.
	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.

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Topic	Are the following elements included in the transition record?	Element Satisfied? Yes	No	Definition
Inpatient Care	Principal diagnosis at discharge			Documentation indicating the final principal diagnosis at the time of discharge. Documentation of the principal diagnosis at discharge in the physician's final progress note may be used.
Post-Discharge/ Patient Self-Management	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. If there are no medications to be discontinued, it is not necessary to document this in the transition record.

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Topic	Are the following elements included in the transition record?	Element Satisfied? Yes	No	Definition
Post-Discharge/ Patient Self-Management	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.
	Patient Instructions			Directions for patient and/or caregiver to follow upon discharge from the facility. Examples include medication information, dietary or activity restrictions, warning signs and symptoms associated with the condition, information regarding what to do if the patient experiences a relapse, etc. Instructions should be appropriate for the patient, including the use of language services.
Advance Care Plan	Advance Directives or surrogate decision maker documented OR documented reason for not providing advance care plan			An Advance Directive is 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 is 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.

Advance Care Plan	Advance Directives or surrogate decision maker documented OR documented reason for not providing advance care plan			A surrogate decision maker is a health care proxy who acts as the patient's advocate when he/she is legally incapacitated and unable to make decisions for him/herself about personal health care. To meet the intent of the transition record measures, the surrogate decision maker must be designated by the patient in a way that complies with the state's laws for the state in which the patient receives care and must have the authority to make all psychiatric and non-psychiatric decisions on behalf of the patient. The surrogate decision maker must be identified in the transition record by name and telephone number. 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.
Contact Information/ Plan for Follow-Up Care	24-hour/7-day contact information, including physician for emergencies related to inpatient stay			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. Crisis lines, 800 numbers, 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/ Plan for Follow-Up Care	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 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.
	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 of the patient's goals of care and treatment preferences.
	Primary physician, other healthcare professional, or site designated for follow-up care			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.

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Final Review of Requirements for the Transition Record Measure	Yes	No
A. Are **ALL** specified elements included in the transition record?		
B. Was the transition record discussed with and provided to the patient and/or caregiver?		
C. Is there documentation stating that the discharging clinician determined the patient was clinically unstable, or the patient and/or caregiver was unable to comprehend the information?		
D. If the answer to (C) is "Yes" AND the patient was transferred to an inpatient facility, is there documentation that the four elements listed below were discussed with the receiving inpatient facility? 1. 24-hour/7-day contact information 2. Contact information for pending studies 3. Plan for follow-up care 4. Primary physician, other healthcare professional, or site designated for follow-up care See **NOTES** on page 8 for additional guidance regarding the four elements listed above.		
Notes for Abstraction Include the case in the numerator for the Transition Record with Specified Elements Received by Discharged Patients measure in the following scenarios: • Patient discharged to home: "Yes" to (A) and (B). • Patient discharged to inpatient facility: "Yes" to (A) and (B) OR (A), (C), and (D).		

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Timely Transmission of Transition Record

The **numerator** includes patients for whom the transition record, as specified in the *Transition Record with Specified Elements Received by Discharged Patients* measure, was transmitted to the facility (including inpatient facilities) or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge. All 11 elements must be captured and transmitted within 24 hours to satisfy the measure numerator.

> The case **must** meet the numerator of the Transition Record with Specified Elements Received by Discharged Patients measure **to be included** in the numerator of the Timely Transmission of Transition Record measure. The numerator for the Timely Transmission of Transition Record measure **cannot** exceed the numerator for the Transition Record with Specified Elements Received by Discharged Patients measure.

The **denominator** includes all patients, regardless of age, discharged from an IPF to home/self-care or any other site of care. The measure excludes patients who died, left AMA, or discontinued care. Patients who discontinued care include those who eloped or failed to return from leave.

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 the transition record transmitted within 24 hours of discharge?	Yes	No	Calculated as 24 consecutive hours from the time the facility ordinarily records the patient discharge. This may include transmission prior to discharge, but the timeframe must end 24 hours after discharge.

> The date and time of discharge are to be used as the “trigger time” to determine if the transition record was transmitted within 24 hours after hospital discharge; therefore, use the date and time that the patient is “officially” discharged to begin calculating the 24-hour period.
> **Example**: The IPF discharge date and time are 6/2/2017 and 08:23 a.m. The transition record should be transmitted within 24 hours after that discharge date and time. Meaning, the facility should complete the transmission by 6/3/2017 at 08:23 a.m.

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Notes

Patient and/or Caregiver Receipt of the Transition Record in Electronic Format

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 and/or caregiver** 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.

Numerator Criteria for the Transition Record Measures

Transition Record with Specified Elements Received by Discharged Patients Measure

To satisfy the numerator for the Transition Record with Specified Elements Received by Discharged Patients measure, the following **must** occur:

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

- Created
- Discussed with the patient and/or caregiver
- Provided to the patient and/or caregiver either in hard copy or electronically, if the patient agrees.

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

- Created
- Discussed with the patient and/or caregiver **AND** the receiving facility.

If a patient is transferred to another inpatient facility and the discharging clinician determines that the patient is clinically unstable, or the patient and/or caregiver is unable to comprehend the information, then the discharging facility is **not** required to discuss and provide the transition record to the patient and/or caregiver; however, the following four elements **must** be discussed with the receiving facility for the case to be included in the numerator for the Transition Record with Specified Elements Received by Discharged Patients measure:

1. 24-hour/7-day contact information
2. Contact information for pending studies
3. Plan for follow-up care
4. Primary physician, other healthcare professional, or site designated for follow-up care

Timely Transmission of Transition Record Measure

To satisfy the numerator for the Timely Transmission of Transition Record measure, the transition record must be transmitted to the next provider within 24 hours of discharge. The case **must** meet the numerator of the Transition Record with Specified Elements Received by Discharged Patients measure **to be included** in the numerator of the Timely Transmission of Transition Record measure. The numerator for the Timely Transmission of Transition Record measure **cannot** exceed the numerator for the Transition Record with Specified Elements Received by Discharged Patients measure.

Definition of Discontinued Care

Patients who discontinued care include those who eloped or failed to return from leave, as defined in the notes below. 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.