Data Collection Tool for Compliance with the *Transition Record with Specified Elements Received by Discharged Patients* and *Timely Transmission of Transition Record* Measures 01-01-2018 (Q1 2018) through 12-31-2018 (Q4 2018)

This document is provided as an optional, informal mechanism to aid psychiatric facilities in the collection of information pertaining to the Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record measures. Data collected for these measures satisfy a requirement of the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program under the Centers for Medicare & Medicaid Services (CMS). The tool is designed to collect data abstracted from the patient medical record; however, once abstracted, the data will need to be compiled and reported to CMS in aggregate. It should be noted that skip logic is not contained within the data collection paper tool. 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@hcqis.org.

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.

Topic	Are the following elements included in the transition record?	Element Satisfied? Yes	No	Definition
Inpatient Care	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.
	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			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. This element can be met if one of the following **is documented**:

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Advance Care Plan	Advance Directives or surrogate decision maker documented OR documented reason for not providing advance care plan			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/en/inpatient-quality-reporting-programs/inpatient-psychiatric-facilities-quality-reporting-program/resources-and-tools/

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Topic	Are the following elements included in the transition record?	Element Satisfied? Yes	No	Definition
Contact Information/ Plan for Follow-Up Care (See NOTES on page 7.)	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 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.

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Topic	Are the following elements included in the transition record?	Element Satisfied? Yes	No	Definition
Contact Information/ Plan for Follow-Up Care (See NOTES on page 7.)	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.

Final Review of All Specified Elements Required for Transition Record Prior to Transmission	Yes	No
Are **ALL** specified elements included in the transition record?		
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 on page 7.)		

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Timely Transmission of Transition Record

The numerator includes patients for whom a transition record, as specified in the *Transition Record with Specified Elements Received by Discharged Patients* measure, was transmitted to the facility physician, 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 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 against medical advice (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 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.

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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, 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/caregiver
- Provided to the patient/caregiver either in hard copy or electronically, if the patient agrees
- Transmitted to the next provider within 24 hours of 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 and only highlight these four elements:
    - 24-hour/7-day contact information
    - Contact information for pending studies
    - Plan for follow-up care
    - Primary physician, other healthcare professional, or site designated for follow-up care
- Transmitted to the next provider within 24 hours of 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.