Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Support Contractor

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

Presentation Transcript

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Louisa Heath: Hello, everyone, and welcome to today's presentation entitled, *Navigating to Success: A Review of the Abstraction Process for the Transition Record Measures*. My name is Louisa Heath. I'm a Project Manager for the Hospital Inpatient Outreach and Education Support Contractor. Primarily, I work in the Inpatient Psychiatric Facility Quality Reporting Program. I'm delighted to introduce you to our speaker for today's presentation, Evette Robinson.

Evette Robinson is the Project Lead for the IPFQR Program. She has over 17 years of cross-functional experience in the healthcare industry, ranging from biomedical clinical research, to strategic planning and revenue cycle management, consulting for a variety of healthcare providers.

Evette has served as lead for the IPFQR Program since the spring of 2015. She earned a Master of Public Health degree in Health Management and Policy from Emory University.

Before we proceed with today's webinar, I would like to remind attendees that the slides for this presentation were posted to the *Quality Reporting Center* website prior to the event. If you did not receive the slides beforehand, please go to www.qualityreportingcenter.com and on the right side of the home page, under Upcoming Events, click on the link for today's event. Next, scroll to the bottom of the page, and there you will find presentation slides available to download. As previously mentioned, this session is being recorded, and the slides, transcript, webinar recording, and questions and answers from this presentation will be posted on the *QualityNet* and *Quality Reporting Center* websites at a later date.

As a reminder, we do not recognize the raised-hand feature in the chat tool during webinars. Instead, you can submit any questions pertinent to the webinar topic to us via the chat tool. All questions received via the chat tool during this webinar that pertain to this webinar topic will be reviewed and the Q&A transcript will be made available at a later date.

To maximize the usefulness of the Q&A transcript, we will consolidate the questions received during this event and focus on the most important and frequently asked questions. Any questions received that are not related to the topic of the webinar will not be answered in the chat tool, nor on the questions-

and-answers transcript for the webinar. To obtain answers to the questions that were not specific to the content of this webinar, we recommend that you go to the *QualityNet* Q&A tool. You can access the Q&A tool using the link on this slide. There, you can search for questions unrelated to the current webinar topic. If you do not find your question there, then you can submit your question to us via the Q&A tool, which, again, you can access at the link on this slide.

This is the list of the acronyms that will be referenced in the presentation.

The purpose of today's 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.

By the end of the presentation, attendees will be able to accurately abstract data for the Transition Record with Specified Elements Received by Discharged Patients and the Timely Transmission of Transition Record measures, as well as, 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.

And now I will turn this presentation over to our speaker, Evette Robinson.

Evette Robinson: Thank you, Louisa. The IPFQR Program *New Measure and Non-Measure Reporting – Part 2* webinar held on January 21 of 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've made minor modifications in response to these recommendations that have been incorporated into the IPFQR Program manual and the optional data collection 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.

The transition record measures focus on safe and effective transitions between care settings from the inpatient setting to other sites of care. The graphic on this slide demonstrates how the transition record measures can positively impact patient care. By carrying out the processes described the six blue boxes, such as effective coordination and increasing engagement, providers can achieve successful outcomes for patients, including a reduction in redundant tests and procedures, and achievement of patient goals and preferences.

In the next portion of today's webinar, I will review how to abstract data for the transition record measures, using the tools that are currently available to measure abstractors.

First and foremost, to effectively abstract data for these measures, one must be aware of and know how to leverage the available resources.

CMS has provided information about the transition record measures in the three resources listed on this slide. The IPFQR Program manual is the main source of information, the primary source of information, which includes measure descriptions and definitions of terms in Section 2, on pages 20 – 25, as well as, an algorithm for identifying the initial patient population in Appendix C, starting on page 99.

The Data Collection Tool for Compliance with the Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record measures is a seven-page, optional paper tool, in which measure descriptions and definitions mirror those found in the IPFQR Program manual. The aim of this tool is to provide guidance for measure data abstraction.

A frequently asked questions document was recently published. This optional paper tool includes question-and-answer pairs pertinent to the transition record measures. The intent is to provide further clarification as requested from IPFQR Program stakeholders, which we will review in subsequent slides. The optional data collection tool is designed to provide measure abstraction guidance. Therefore, this review will focus on the content, in that tool, in light of frequently asked questions received over the last year for these measures.

As a reminder, here are the numerator and denominator statements for the Transition Record with Specified Elements Received by Discharged Patient measure as they appear in the data collection tool and in the IPFQR Program manual. 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 or self-care or any other site of care. The measure excludes patients who died, left against medical advice, or discontinued care. Patients who discontinued care include those who eloped or failed to return from leave, as defined in the Notes section of the data collection tool. Also included on this slide are sample question-and-answer pairs that appear in the frequently asked questions document relevant to the numerator and denominator statements. For example: "If one of the 11 required elements of the transact record is missing, will this case fail the entire measure?" The answer is: "Yes, all 11 elements must be completed and documented as discussed with the patient or caregiver to pass the measure." Another question is: "Does there need to be a statement that the patient was given this information in printed or electronic format?" And the answer is: "Yes. The transition record may only be provided in an electronic format if it is acceptable to the patient and only after all components have been discussed with the patient." Throughout the remainder of this portion of the presentation, I will use this format to review the abstraction guidance provided in the manual and data collection tool in light of the frequently asked questions document.

Definitions of the elements: "Reason for IPF admission" and "Principal diagnosis at discharge" are included in the data collection tool. We have received a number of questions concerning the difference between these two elements and aim to provide clarification, and the answers found in the frequently asked questions document. For example: "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?" The answer is: "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."

Another commonly asked question is: "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?" The answer is: "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. And this is reflected in the definition for this element as it is displayed in the IPFQR Program manual, as well as, the data collection paper tool for the transition record measures."

Abstraction guidance is included in the definition of the "Major procedures and tests, including summary of results" element, as indicated by the red bracket on this slide. If the transition record includes documentation that no major procedures or tests were performed, then one would select Yes in the element satisfied column of the data collection paper tool for this element.

Abstraction guidance pertaining to intended duration, can be found in the definition of the "Current medication list" element, again as indicated by the red bracket in this slide. And, as noted in the question-and-answer pair displayed on this slide, if there are no discontinued medications, then it is not necessary to document that no medications were discontinued.

Abstraction guidance is included in the definition of the "Studies pending at discharge (or documentation that no studies are pending)" element, which is indicated by the red bracket on this slide. Also presented on this slide is a question from the frequently asked questions document that pertains to this element, as well as, the "Major procedures and tests, including summary of results" element, that was described on the previous slide. And the question is: "If there were no studies or test 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?" The answer is: "Yes, both elements must be addressed in documentation." If using the optional paper tool, then you want to apply the following guidelines:

- If documentation exists in the transition record indicating that no major procedures or tests were performed, then select Yes in the element satisfied column for the major procedures and tests element.
- If documentation exists in the transition record indicating that no tests are pending at discharge, then select Yes in the element satisfied column for the studies pending at discharge (or documentation that no studies are pending) element.

The text in red bracket on this slide is included to address several questions received regarding how to accurately and appropriately abstract for this element of the transition record measures. Specifically, the advance directives or surrogate decision maker documented or documented reason for not providing advance care plan element. Before we review a few of the frequently asked questions surrounding this element, I want to first point out that copies of the advance directives do not need to be transmitted to the follow-up provider, and the patient does not need to create an advance directive to satisfy this. The advance care plan element can be met if (a), (b), or (c), listed on this slide, is documented in the transition record. Specifically, if

(a) The patient has an appointed surrogate decision maker then they will meet this element; or

(b) If the patient has a non-psychiatric advance directive and a psychiatric advance directive, it can meet this element; or

(c) If (a) or (b) was not met, and the patient was offered information about designating a surrogate decision maker or completing advance directives, and if the criteria for (a) and (b) were still not met, then a reason was documented in the transition record.

A common question we have received: "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 directive during the admission?" "No, given the patient, giving the patient information on advance directive does not satisfy the element. It is not required to have the advance directive completed during the admission; however, if they are not completed, a reason must be documented. This element will be met if one of the criteria outlined in this slide is documented in the transition

record." Now, in the next several slides I will review a few of the frequently asked questions specifically pertaining to this element, and answers provided for further clarification. And, of course, more question-and-answer pairs pertaining to this element and other elements of the transition record measures can be found in the frequent asked questions document.

Another question pertaining to this element that we have received is displayed on this slide, "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?" The answer is: "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."

Another question-and-answer pair that we will review pertains to the psychiatric advance directive or PAD. "Some states do not recognize psychiatric advance directives. The measure keeps referring to needing both a non-psychiatric advance directive and psychiatric advance directive, 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?" The answer is: "No, it would not be sufficient to assess the patient for the existence of a non-psychiatric advance directive to meet this element for the measure. 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 advance directive and a psychiatric advance directive. 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."

Abstraction guidance is included in the definition of the contact information for obtaining results of studies pending at discharge element, as indicated by the red bracket on this slide. A question we have received frequently is: "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 this 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 data collection paper tool. Abstraction guidance, as indicated by the red bracket on this slide, is part of the definition for the plan for follow-up care element. A commonly received question for this element: "Is an appointment date or time required for at least one provider or site for follow-up care, or can there just be a referral to the provider or site?" The answer is: "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."

Another frequently asked question we've received is: "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?'" The answer is: "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."

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 or their caregivers that are discharged home, or
- Discussed with the next inpatient provider for patients being transferred to an inpatient facility.

When a patient is transferred to an inpatient facility, there are four specific elements that need to be communicated to the next provider, and those are referenced in the Notes section of the data collection tool, which we will review a little bit later in the presentation. On the following slide we will review a couple of question-and-answer pairs relevant to this portion of the data collection tool.

The first question is: "Our facility goes over the transition record with the patient prior to discharge. It is signed by both the patient and the nurse. 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."

Another question we've received is: "Are we required to have the patient's signature on the transition record, or is attestation in the electronic health record that it was discussed and received sufficient?" "The transition record measures do not require a patient signature. Attestation in the electronic health record that a transition record covering all 11 elements was created and discussed with the patient or caregiver is adequate."

No additional abstraction guidance is included in the program manual or optional data collection tool regarding the Timely Transmission of Transition Record measure; however, the frequently asked questions document does address some of the questions that we've received over the last year, or so, concerning this measure. For example, several have inquired as to exactly when the 24-hour period begins. Is it when the patient is transferred to the medical facility for emergency treatment, or when the patient is admitted to the medical facility? And, if the transmission is performed, and what if the transmission is 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.

Another question received pertaining to discharge information is displayed on this slide. Quote: "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 release 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 to transmit a transition record without a release of information? 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'd like to clarify that we are not stating that the transition record should be transmitted to the next provider without the patient's permission. If the patient refuses, then 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.

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 frequently asked questions (FAQs) document includes question-and-answer pairs relevant to

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

For example, the Measure Exclusion section of the frequently asked questions document includes the following: "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 IPFQR Program manual to determine which codes are excluded from the transition record measures. Many

of these topics are described in the Notes section on the final page of the data collection tool, which we will briefly review on the next slide.

The last page of the data collection tool for the transition record measures is the Notes page, which provides clarification about what must occur to satisfy the numerator for both measures, whether the patient is discharged to home or to an inpatient facility. As mentioned in an earlier slide, patients who discontinued care include those who eloped, or failed to leave, to return from leave. These terms are defined at the bottom of this page.

This concludes my portion of today's presentation. I will now turn things over to Louisa.

Louisa Heath: Thank you, Evette. In the next several slides I will review helpful resources pertaining to the topics covered in today's webinar.

This slide includes links to various examples of discharge transition records that are currently available online. While CMS is not advocating these examples over others, note that even the examples provided may 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.

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 the links on this slide.

Our next event will be presented in June. During this presentation, we will provide inpatient psychiatric facilities with a detailed description of the FY 2018 IPFQR Program requirements, with *Keys to Successful Data Submission and Data Verification*. We do not have a webinar planned for the month of July. During the August webinar, we will discuss changes to the IPFQR Program as delineated in the fiscal year 2018 inpatient prospective payment system final rule. Future webinars will be posted on the Events Calendar, found on the *Quality Reporting Center* website. The Events Calendar can be accessed from the *QualityReportingCenter.com* home page, under Upcoming Events. And, of course, we encourage you to sign up for the IPFQR Program ListServe, so that

you may receive notifications of upcoming events and other program-related topics delivered directly to your email inbox.

This slide includes active links that you can click on to send us your questions about the IPFQR Program. We encourage you to use the Q&A tool, in particular, because it provides the best means by which we can track questions and answers, and also delivers our response to your email inbox. This is also a great way for you to let us know what types of questions and topics you would like us to address in future webinars.

We also recommend that you sign up for the IPFQR Program ListServe, if you have not already, so that you receive communications that we send out to the IPFQR community, pertaining to webinars, program updates or changes, and other announcements. You can sign up to be added to the ListServe on the *QualityNet* ListServe registration page. We encourage you to utilize available resources found on the *QualityNet* website in the inpatient psychiatric facility's dropdown menu, to ensure appropriate knowledge of the IPFQR Program requirements and deadlines.

This concludes today's webinar. We thank you for your time and attention.