Inpatient Psychiatric Facility Quality Reporting Program

Support Contractor

Inpatient Psychiatric Facility Quality Reporting Program New Measures and Non-Measure Reporting – Part 2

Presentation Transcript

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Anthony Seabrook: Good afternoon and welcome to today's webinar. My name is Anthony Seabrook, and I'm going to be your host for today's event. I want to start off by covering a few introductory points. First of which, the audio is being achieved via the ReadyTalk® internet streaming, which means if you've done this as planned, you're listening to me via the computer speakers or your headphones, so no telephone line is required. However, we do know that situations change, so if you do need a dial-in number, please send us a message via the chat window. If you don't know where that is, I'll show you in a couple slides. As always, today's event is being recorded.

Technical issues: invariably during webinars there are a couple of things that can happen, and I do stress can or may happen. We've identified two fairly common things. The first is, if your audio becomes spotty or suddenly stops, as we're showing you here on this screen, press your Function 5 key, your F5 key, at the top of your keyboard. Or, if you feel comfortable, just click the Refresh icon as we're showing you here. Now, we're showing you Internet Explorer. On Chrome and Safari, the refresh icon is in the same place. If you're using Firefox, it's going to be on the left side of your address bar. But, if you press F5 or click the Refresh icon, that will clear up the spottiness with your audio.

The second problem that may occur is you'll hear an echo. If you start to hear an echo, we've identified that this typically happens when you have more than one browser window open for our singular event. If that's the case, just look at the top of your browser window. If you see duplicate windows, click the X button to close one of those, and that too should clear up the echo. Remember, if you still have technical issues, send us a message via the chat window, and we will provide you one of our dial-in numbers.

Now, submitting questions: so, in addition to requesting a dial-in number, you may have a comment or concern. We ask that you submit those via the chat window. So, noticing on the screen at the bottom left-hand corner, you would type your question or concern in that box, click Send, and one of our subject matter experts will respond to your question. If you have a dial-in line, all lines are muted. We are in what we call a listen-only mode. So again, submit those questions, and one of us will answer them. Now, this concludes my portion of the webinar, and I will now turn it over to our first speaker.

Evette Robinson: Hello, everyone, and welcome to today's IPFQR Program webinar. My name is Evette Robinson, and I am the project lead for – with the VIQR support contractor for the Inpatient Psychiatric Facility Quality Reporting Program. Today, I will be presenting our topic, *New Measures and Non-Measure Reporting – Part 2*. In attendance with us today, from CMS, is Dr. Jeff Buck, the IPFQR Program Lead. Before I begin today's webinar, I would like to remind those in attendance 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 the Quality Reporting Center website, at www.qualityreportingcenter.com. On the right side of the homepage, you will find a list of upcoming events. Click on the link for this event, scroll down to the bottom of the page, and there you will find the presentation slides available for download. As previously stated, this webinar is being recorded. The slides, transcript, webinar recordings, and questions and answers from this presentation will be posted on the *QualityNet* and Quality Reporting Center websites at a later date.

During this presentation, participants will learn about the measures pertaining to transition records, the Screening for Metabolic Disorders measure, and non-measure reporting requirements for the IPFQR program.

By the end of this presentation, attendees will understand the specifications, as well as the keys to implementing and abstracting data for the following measures: Transition Record with Specified Elements Received by Discharged Patients, Timely Transmission of Transition Record, and Screening for Metabolic Disorders Measure. Attendees will also understand the reporting requirements for these new measures and non-measure data.

Here is a list of acronyms for you to refer to. These will be referenced during this presentation.

Let's begin with a brief overview of the transition record measures.

The American Medical Association-Convened Physician Consortium for Performance Improvement is a national, physician-led initiative dedicated to improving patient health and safety. This consortium developed the transition record measures to prevent gaps in care transitions caused by the patient receiving inadequate or insufficient information that lead to avoidable adverse events and cost CMS approximately $15 billion due to avoidable patient readmissions.

The transition record measures focus on effective and timely communication of specified elements with patients and between treatment settings, thereby promoting care coordination and enhancing continuity of care. The transition measures provide detailed, personalized discharge information to the patient and/or the patient's caregiver in order to achieve the following: improve quality of care, decrease costs, increase beneficiary engagement, reduce avoidable readmissions, and increase patient safety.

Now let's take a look at the Transition Record with Specified Elements Received by Discharged Patients Measure in depth.

This measure replaces the HBIPS-6 Post-Discharge Continuing Care Plan measure, per the fiscal year 2016 IPF PPS Final Rule. This measure includes 11 required elements in the numerator, compared to four in the HBIPS-6 measure.

This measure assesses the percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregivers, who received a transition record, and with whom a review of all included information was documented at the time of discharge, including, at a minimum, all of the specified elements.

Now, this slide describes the numerator for this measure, and it's part one of the numerator description, in which we list out the required elements. The numerator for this measure includes patients or their caregivers who received a transition record and with whom a review of all included information was documented at the time of discharge including, at a minimum, all of the following eleven elements, six of which are listed on this slide. Now, under the first subheading, we have three of those elements: reason for inpatient admission, major procedures and tests performed during inpatient stay and summary of results, principal diagnosis at discharge. And then, under post-discharge/patient self-management, we have three additional elements there: current medication list, studies pending at discharge (such as laboratory or radiological test results), and patient instructions.

The remaining elements include, under the Advance Care Plan, either advanced directives or surrogate decision maker, must be documented, or a documented reason for not providing an advanced care plan. And then, under the subheading of contact information/plan for follow-up care, we have four elements: 24-hour/7-day contact information, including a physician for emergencies related to inpatient stay; contact information for obtaining results of studies pending at discharge; the plan for follow-up care; and the primary physician or other health care professional, or site designated for follow-up care. In just a few slides, I will begin to review several of these elements in greater detail, but for now...

... we'll first look at the denominator and its exclusions. The denominator for this measure includes all patients, regardless of age who were discharged from an inpatient facility to home or self-care or any other site of care, and this denominator excludes patients who died, who left against medical advice, or discontinued care.

Now among the keys to high performance for the transition record with specified elements received by discharged patient measure, it is to ensure that a transition record exists for each patient prior to discharge. It's also important that all specified elements for the measure are reviewed with the patient and/or caregiver, and that this review was clearly documented. In other words, content is key. A higher rate indicates better performance for this measure.

Now, the terms that are listed on this slide are pertinent to both of the transition record measures. The first 14 highlighted in bold font are particularly relevant to the transition record with specified elements received by discharged patient measure. We will discuss some of these terms in more detail in the next several slides. I would like to highlight that the definitions for all of these terms can be found in the latest version of the IPFQR Program manual, which is available on the Quality Reporting Center website, and can be accessed from the link on this slide. The latest manual contains additional information beyond what is currently available in the Final Rule, and on the American Medical Association's website concerning the interpretation of these terms, and the use of these measures in the inpatient psychiatric setting. We highly recommend that IPF's review the material found in the IPFQR program manual, as they develop their criteria for collecting the measured data.

The first term definition we'll describe here is the plan for follow-up care. A plan for follow-up care describes treatment and other supportive services to maintain or optimize health in alignment with patient goals. The plan should include dates, times and contact information for appointments for follow-up care, post-discharge therapy needed, any durable medical equipment needed, family/psychosocial/outpatient resources available for patient support, self-

care instructions, et cetera. The plan should be developed with consideration for the patient's goals of care and treatment preferences.

To meet the 24-hour/7-day contact information element, the transition record must include the name and contact information of a health care team member who has access to medical records and other information concerning the inpatient stay, and who could be contacted regarding emergencies related to that patient's stay. Please note that 800 numbers, crisis lines, or other general emergency contact numbers do not meet this requirement.

Now as described earlier, the transition record should contain all 11 elements, and this is the case regardless of where the patient is going. To satisfy this particular element, contact information plan for follow-up care, all eleven elements of the transition record are to be shared with the patient and/or caregiver for patients who are discharged to home. For patients discharged to an inpatient facility, the record should indicate that the following four elements were discussed by phone or otherwise communicated between the discharging and receiving facilities. And, those four elements include: the 24-hour/7-day contact information, including physician for emergencies related to inpatient stay; contact information for obtaining results for studies pending at discharge; the plan for follow-up care; as well as the primary physician, other health care professional, or site designated for follow-up care. In cases where the patient is discharged to an inpatient facility, again, these four elements, they do not have to be discussed with the patient or caregiver, but they must be documented that these four elements were discussed with the receiving facility in order to meet this requirement.

As described on slide 16 of this presentation, the specified element advanced care plan requires documentation of the patient's advanced directives, or the patient's surrogate decision maker, or a reason for not providing an advanced care plan. We will address this specified element by first describing and [then] providing resources pertinent to advanced directives. The term Advanced Directives is defined as a written, signed statement that details the patient's preferences for treatment should the patient become unable to make

such decisions, including for mental health reasons. It is a legal document that informs others about what treatment the patient would want or not want to receive from psychiatrists or other health professionals concerning both psychiatric and non-psychiatric care. The care plan may be in the form of two separate documents, or combined in a single document.

Additionally, the statement should identify a person, such as a health care surrogate, to whom the patient has given the authority to make decisions on his or her behalf. Advance directives should be compliant with state laws for the state in which the patient receives care.

We recognize that advanced directives vary from state to state as far as content requirements and level of detail, so we are not trying to prescribe exactly what should be included in this document, but rather the intent of this slide is to provide an idea of the type of information that is typically found in a traditional advance directive. Please consult with the legal department of your facility if there are any concerns regarding what should be included in the advanced directive. As described on this slide, a traditional advanced directive typically includes information in the following categories: medication instructions, facility preferences, emergency contacts, instructions for hospital staff, and other instructions and/or medical information. I'm sorry, I think I just misread that. So, as stated on this slide 25, we have listed here the designation of a healthcare surrogate, the medication instructions, the facility preferences, again, emergency contacts, as well as instructions for hospital staff. Two additional items here are the organ donation and execution of directives.

Here on slide 26, you can find a link to the National Hospice and Palliative Care Organization CaringInfo website, which has information on traditional advanced directives by state. And, you may access this link directly from the slides that you may have previously downloaded from the Quality Reporting website.

In addition to the categories typically found in a traditional advance directive, as described on slide 25, a psychiatric advanced directive may include the

following information as well: crisis symptoms, relapse risk factors, protective factors, and electroconvulsive therapy preferences.

Here on slide 28, you can also find a link to the National Resource Center on Psychiatric Advanced Directives website, where you may find additional information pertaining to psychiatric advanced directives.

To provide some additional guidance related to data abstraction for this measure, I will review a couple of scenarios that IPF may encounter. In the first scenario, the patient file includes documentation that the patient completed an advance care plan with only advance directives pertaining to psychiatric care. Does this discharge meet the Advance Directives requirement for the Transition Record with Specified Elements Received by Discharged Patients measure? If the facility only discussed completion of a psychiatric advance directive with the patient and did not discuss completing a medical advance directive with the patient, then this case would not meet the numerator requirement for this measure. The facility must discuss both the psychiatric and the medical advance directives with the patient.

In scenario two, the patient chart includes documentation that advanced directives were discussed with the patient. However, the patient does not wish to, or is unable to, complete an advance care plan. Does this case meet the Advance Directives requirement for the Transition Record with Specified Elements Received by Discharged Patients measure? Yes. If advance directives were discussed with the patient, but the patient does not wish to or is unable to complete an advance care plan, then this would qualify as a documented reason for not providing an advanced care plan. Please note again that this discussion would have to be documented in order to qualify for that option, which leads me to...

... the next term, Documented Reason for Not Providing Advanced Care Plan. This term pertains to documentation ascertaining that an advance directive or a surrogate decision maker was discussed with the patient but one of the following conditions applied: the patient did not wish, or was not able, to name a surrogate decision maker or provide, or complete, an advance

directive; or, the appropriate documentation indicates that the patient's cultural and/or spiritual beliefs preclude a discussion of advanced care planning or a surrogate decision maker. Any discussion for advance care is documented as adverse to the patient's beliefs, and thus harmful to the physician-patient relationship in this latter case.

The next required element that I will address is the Current Medication List. The Current Medication List should include prescription and over-the-counter medications and herbal products in the following categories. The first category are – includes medications that are to be taken by the patient.

These medications were prescribed or recommended prior to the IPF stay, and are to be continued after discharge. This will also include new medications started during the IPF stay to be continued after discharge.And finally, newly prescribed or recommended medications that are – that the patient should begin taking after discharge. The prescribed or recommended dosage, instructions, and intended duration must be included for each continued and new medication listed. For medications that fall into the category of those not to be taken by the patient, the medications which again, include prescription, over-the-counter, and herbal products, are those that are taken by patient before the inpatient stay but that should be discontinued or held after discharge. This category also includes medications administered during the inpatient stay that caused an allergic reaction. And finally, it includes medications with which current prescriptions may react.

The Primary Physician, Other Health Care Professional, or Site Designated for Follow-up Care element pertains to the primary care physician, medical specialist, psychiatrist or psychologist, or other physician or health care professional who will be responsible for appointments after the inpatient visit. A site of care may include a group practice specific to psychiatric care. However, please note that a hotline or general contact does not suffice for fulfilling the follow-up care requirement.

The Transition Record is a core, standardized set of data elements related to patient’s demographics, diagnosis, tobacco and alcohol use, treatment, and care plan that is discussed with and provided to the patient in a printed or

electronic format at each transition of care, and is transmitted to the facility, physician, or other health care professional providing follow-up care. The Transition Record may only be provided in electronic format if that format is acceptable to the patient.

Now, let's take a look at the specifications for another new measure, which is closely tied to the Transition Record with Specified Elements Received by Discharged Patient measure, and that measure is the Timely Transmission of Transition Record.

The Timely Transmission of Transition Record measure replaces the HBIPS-7 Post-Discharge Continuing Care Plan Transmitted to the Next Level of Care Provider Upon Discharge measure. This is – this was decided per the fiscal year 2016 IPF PPS Final Rule. The numerator for this measure includes patients with transmission of a transition record within 24 hours of discharge, compared to those transmitted within five days of discharge for the HBIPS-7 measure. It is important to note that this measure includes only transition records containing all of the elements that are required for the Transition Record with Specified Elements Received by Discharged Patients measure in the numerator.

This measure assesses the percentage of patients, regardless of age, that are discharged from an inpatient facility to home or any other site of care, for whom a transition record was transmitted to the facility or a primary physician or other healthcare professional designated for follow-up care within 24 hours of the patient's discharge.

The numerator for this measure includes the number of patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. And, all 11 transition record elements, as defined by the Transition Record with Specified Elements Received by Discharged Patients measure, must be captured and transmitted within 24 hours of discharge to satisfy the measure numerator. These measures work in tandem, such that the transition record, again, must include all of those specified elements in

order for it to be considered for the numerator of the Timely Transmission of of the Transition Record measure. In other words, in cases where a facility may follow the protocol that was previously used for HBIPS-6, the Post-Discharge Continuing Plan measure, but they send the care plan to the next level of care within 24 hours, those cases would not be included in the numerator of the Timely Transmission of Transition Record measure.

For the denominator of the Timely Transmission of Transition Record measure, it will include all patients, again, regardless of age that are discharged from an inpatient facility to home/self-care, or any other site of care. And, like the other – like the transition record measure, the denominator excludes patients who died, left against medical advice, or discontinued care.

To effectively implement the Timely Transmission of Transition Record measure, it is important to remember that the key to high performance for this measure is to ensure that the transition record for each patient is transmitted within 24 hours of discharge, and that confirmation of the time of record transmission is clearly documented in the transition record. So, as the name of the measure implies, timing is key. And a higher rate indicates better performance for this measure.

In the next couple of slides, I will review the last two terms as they relate to the Timely Transmission of Transition Record measure, and as a reminder, we highly recommend that IPFs review the material found in the IPFQR Program manual as they develop their criteria for collecting measured data.

The definition of the term Transmitted for this measure, it states that a transition record may be transmitted to the facility, or physician or other health care professional designated for follow-up care via fax, secure email, or mutual access to an electronic health record. Both the time and method of transmission of the transition record should be documented. It is important to note here also that this is concerning when the record was transmitted, not necessarily when it was received by the receiving facility. So, please note that.

In order to meet this measure requirement of Within 24 Hours of Discharge, the transition record must be transmitted within 24 hours of the patient's discharge from the index facility. So, within 24 hours of discharge, that's being calculated as 24 consecutive hours from the time the facility ordinarily records the patient discharge.

So again, to provide some additional guidance related to data abstraction for this measure, I will review a couple of scenarios. In the first scenario, the patient chart includes documentation that the transition record does not include all 11 specified elements, but the record was transmitted to the next care provider within 24 hours of discharge. Does this case meet the requirements for the Timely Transmission of Transition Record measure? I alluded to this scenario a few slides ago, but just to reiterate, all 11 transition record elements, as defined by the Transition Record with Specified Elements Received by Discharged Patients measure, must be captured and transmitted within 24 hours of discharge to satisfy the numerator for the Timely Transmission of Transition Record measure. In this scenario, this case would be included in the denominator but would not meet the numerator requirements.

In the second scenario, there is a facility that still creates post-discharge continuing care plans according to the specifications of the HBIPS-6 measure, as they transition their system to include the 11 required elements of the new transition record measure. Nonetheless, they have successfully transmitted the continuing care plans to the next care provider within 24 hours of discharge. So, would those cases meet the requirements for the Timely Transmission of Transition Record measure? Again, all 11 transition record elements must be captured and transmitted within 24 hours of discharge to satisfy the numerator for the Timely Transmission of Transition Record measure. So, if the transition records do not include all 11 of the required elements, then these cases would not be – would be included in the denominator but would not meet the numerator requirement.

The last measure that we will review today is the Screening for Metabolic Disorders measure. And so, in general, what is the Screening for Metabolic

Disorders measure? This measure is a chart-abstracted measure developed by CMS to assess the percentage of discharges from an IPF for which a structured, metabolic screening for four elements was completed in the last year. Please note that this measure applies only to patients discharged with one or more FDA-approved, routinely scheduled, antipsychotic medications during the measurement period.

So, what is the rationale for adopting this measure into the IPFQR program? Well, the Screening for Metabolic Disorders measure aligns with a consensus statement that was released by the American Diabetes Association, the American Psychiatric Association, the American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity. And, this consensus statement recommended that providers obtain baseline screening for metabolic syndrome prior to, or immediately after, the initiation of antipsychotics, to reduce the risk of preventable adverse events and improve the physical health status of the patient. Additional information regarding the clinical support for this measure may be found in the fiscal year 2016 IPPS Final Rule, and the link is found here on this slide.

Now, as previously stated, this measure is assessing the percentage of discharges from an IPF for which a structured metabolic screening for four elements was completed in the 12 months prior to discharge. And, this is essentially the same for the numerator statement. But, just to clarify, the numerator for this measure includes the total number of patients who received a metabolic screening in the 12 months prior to discharge, either prior to or during the index IPF stay. The denominator value will include the total number of patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period.

In past webinars several attendees have inquired about the four tests that are required for the metabolic screening. This slide lists the four screening elements. And, it is important to note that the medical record must provide documentation of the completion of all four of the following tests and measurements for inclusion in this measurement. The values for each of these tests must also be documented. And, those tests include: body mass

index, blood pressure, glucose or HbA1c, and a lipid panel that includes total cholesterol, triglycerides, high density lipoprotein, and LDL-C levels.

It is also important to understand the criteria for the metabolic screening as described on this slide. Again, screenings must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or another facility for which records are available to the reporting facility. And, the presence or absence of each screening element is determined by identifying the documentation of numeric lab results in the medical record. The numeric values may be in the lab results, or in the physician documentation.

There are two denominator exclusions for this measure, namely patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical or psychological condition. Another exclusion is for patients with a length of stay equal to or greater than 365 days, or less than 3 days.

This slide provides some additional details, and explains a bit of the rationale behind the denominator exclusion. First, the exclusion "due to the patient's enduring unstable medical or psychological condition" is harmonized with other screening measures developed by The Joint Commission. The patient stays of fewer than three days were excluded based on the rationale that IPFs could not be expected to complete all metabolic screening tests within the short time period. Since the look-back period for the screening is one year, patient stays equal to or greater than 365 days are excluded. Moreover, patients who refuse screening will be included in the denominator. CMS encourages providers to educate patients about the importance of metabolic screening.

A comprehensive list of routinely scheduled, FDA-approved antipsychotic medications can be found in the Specifications Manual for Joint Commission National Quality Core Measures, in Appendix C, Table Number 10.0 Antipsychotic Medication. The link to that specification – that particular manual is available on this slide. Please note that an updated version of the

Joint Commission's specifications manual with information relevant to discharges from July first, 2016, onward is expected to be published in February of this year. For patients who are on PRN, or as needed antipsychotic medications, or short-acting intramuscular antipsychotic medications, they do not count towards the denominator of this measure. Again, the key here is that to be included in the denominator, the patient should be on routinely scheduled antipsychotics – at least one routinely scheduled antipsychotic medication.

So, the key to high performance for the Screening for Metabolic Disorders measure is to ensure that results of a structured metabolic screening for the four elements in the 12 months prior to discharge, that they are clearly documented in the patient record, and that confirmation of when and where a structured metabolic screening was performed is clearly documented in the patient record. Both content and timing are key for this measure, in which a higher rate indicates better performance.

Before I go any further, I realized that I forgot to mention at the beginning of the webinar that due to the volume of the content within this presentation, we will exceed our usual one hour time frame, and we will be able to provide more than one CE credit for those who are able to attend. We anticipate that this webinar will probably exceed the usual hour by 15 to 30 minutes. So, if you are able to continue, and of course respond to the survey that will appear at the end of this webinar, then you will receive credit for attendance. My colleague Deb Price will go into that in much greater detail at the end of the webinar, but since we are getting close to the top of the hour, I did want to just mention that briefly. All right, so now let's take a look at allowable values for the metabolic tests. In general, the four metabolic tests share similar allowable values. In order to select allowable value Y, or yes, there must be documentation in the medical record for this stay or at any time during the 12 months prior to discharge, which includes the numerical value of the following tests: the BMI, blood pressure, blood glucose, and all four components of the lipid panel. In order to select allowable value N, or no, there must be documentation in the medical record for this stay, or at any time during the 12 months prior to discharge, that does not include numerical

values for the same metabolic tests. In the case of the lipid panel, this would also apply if one is unable to determine from the medical record documentation that it was completed in the 12 months prior to discharge.

Like the allowable values, the metabolic tests share similar notes for abstraction. Measure abstracters should review the medical record for the current patient stay. And, if one is not able to find evidence that one of the four required metabolic tests was documented during that stay, then review available medical records for the 12 months prior to the date of discharge. If the metabolic test values were from any time during the 12 months prior to discharge, documentation in the patient record for the indexed stay needs to include the original date which the value – in which the value was calculated, and the source of the information; for example, the medical record from a prior hospital stay, of information obtained from another provider and the name of that provider.

The Screening for Metabolic Disorders Measure has eight data elements. The data elements that are in bold italic font on this slide will be discussed in further detail in this presentation, and those data elements that are not highlighted either exist for other measures, such as the admission date and discharge date, or they are self-explanatory, such as blood pressure. Please note that in the next few slides, I will highlight the definitions and notes for abstraction for the highlighted data elements for this measure.

The body mass index, or BMI element, is defined as the weight-to-height ratio, calculated by dividing one's weight in kilograms by the square of one's height in meters. If the weight is in pounds, and height is in feet or inches in the patient record, conversion to the metric units is needed prior to the BMI calculation. An additional note for abstraction for the BMI data element is that documentation of height and weight only are not acceptable substitutes for the BMI. The actual calculation of the body mass index must be documented in the record.

The blood glucose data element is defined as a lab test of glucose levels in the blood that complies with the American Diabetes Association guidelines.

The guidelines currently recommend using the HbA1c, a fasting plasma glucose, or the 2-hour plasma glucose value after a 75 gram oral glucose tolerance test to test for diabetes. An additional note for abstraction for this particular data element, is that in order to meet the screening element for blood glucose value, the abstractor can either check for documentation of HBA1c, a fasting plasma glucose, or the 2-hour plasma glucose value after a 75 gram oral glucose tolerance test to test for diabetes.

The lipid panel data element is defined as a lab test that includes at least the following four components, total cholesterol, triglycerides, high density lipoprotein, and low density lipoprotein. In order to meet the screening element for lipid panel, numeric values for all four components of the lipid panel need to be documented in the medical record. If any one of the components is missing, select no for this particular metabolic screening test.

The reason for incomplete metabolic screening data element is defined as a statement made by the physician, the APN, or PA in the current medication record, which indicates that the screening elements could not be completed due to patient's enduring unstable medical or psychological condition. The allowable values for this data element are Yes, documentation in the medical record for this stay specifies that the metabolic screening cannot be completed due to patient's unstable medical or psychological condition, or No, documentation in the medical record for this stay does not specify that the patient's unstable medical or psychological condition was the reason that the metabolic screening cannot be completed or is unable to be completed – unable to be determined from medical record documentation.

Additional specifications for the Screening for Metabolic Disorders measure, including a data dictionary and algorithm, are in development and will be included in the next release of the IPFQR Program manual.

In this portion of the webinar, we will review reporting requirements for the IPFQR Program measures described in this presentation.

This slide details the reporting period and data submission period for the Transition Record with Specified Elements Received by Discharged Patients

measure, the Timely Transmission of Transition Record measure, and the Screening for Metabolic Disorder measure. IPF's will begin collecting data for these chart-abstracted measures starting later this year, July first 2016, through December thirty-first of 2016. The data will be submitted during the 2017 data submission period, and will impact the fiscal year 2018 annual payment update, or APU. Sampling is allowed for all three of these measures, and in the next couple of slides, I will address how these measures relate to the IPFQR Program's non-measure data collection requirement and sampling option.

Now, in part one of this two-part webinar series, we described the new requirement for IPF's to begin reporting non-measure data as an aggregate yearly count, starting with the data that will be submitted later this year in 2016, for the fiscal year 2017 payment determination. As a reminder, all of these data points will be submitted through the web-based data collection tool found on the *QualityNet Secure Portal*. For those of you who may have missed the previous webinar, part one of this two-part series that was held on October twenty-ninth, 2015, the slides and recording, as well as transcripts are available for download on the QualityReportingCenter.com website under IPFQR Program Archived Events.

For the purposes of today's presentation, I would like to focus on the non-measure data collection as it pertains to fiscal year 2018, with respect to the three new measures that were described earlier. In addition to the non-measure data that will be collected and reported as the total annual discharges by age strata, payer, and diagnostic categories, IPF's will also have the opportunity to report sample sizes for the measures listed in this slide. One noticeable difference between the sample size chart for fiscal year 2018 compared to fiscal year 2017 is the removal of HBIPS-6 and 7 and the addition of the three new measures that were discussed in today's webinar for which IPF's will begin collecting data, again July first of this year, as well as the addition of the SUB-2/-2a and TOB-3/-3a measures, which IPFs have started to collect for calendar year 2016.

As I previously mentioned, IPF's will have the option of sampling data collected for both of the transition record measures, and the screening for metabolic disorders measure using the uniform global sampling guidelines that are outlined in Table 26 of the IPFQR Program Final Rule. The annual global sampling option is described on pages 46,717 through 46,719 of the fiscal year 2016 IPF PPS Final Rule. And as a reminder, IPFs may choose not to sample and will thereby report all cases relevant to these measures during the data submission period. Again, sampling is optional.

In the next few slides, these contain additional information about helpful resources that are relevant to the measures that were discussed in today's webinar, as well as the IPFQR Program as a whole.

Future webinars will be posted on the events calendar found on the Quality Reporting Center website. Information about the upcoming webinars can be accessed from the QualityReportingCenter.com homepage under the events calendar, and of course we encourage you to sign up for the IPFQR Program ListServe, so that you may have notifications – receive notifications of upcoming events and other program related topics delivered directly to your email inbox. The next educational webinar is scheduled to take place in February. The date and time are being finalized and will be included in the registration ListServe email that will be distributed prior to the event. This webinar will provide a refresher for the NHSN registration and influenza vaccination among Healthcare Personnel, or HCP, measure data submission processes. In March, we aim to discuss the care transition measures, and the April educational webinar topic is being finalized. Again, we encourage all in attendance to sign up for the IPFQR ListServe to ensure that you receive notifications about these events, and we also encourage you to monitor the events calendar on the Quality Reporting Center website for updates, registration flyers, and links to webinar slides.

As I mentioned during the last webinar event, several IPFQR Program resources have been revised recently and are now available for download from the Quality Reporting Center website; specifically, the updated IPFQR Program manual, and measure abstraction tools for the measures listed on

this slide can be downloaded from the Quality Reporting Center website. The most notable updates to the program manual pertain to measure requirements and time lines for fiscal years 2017 and 2018, descriptions for new measures, and additional guidance for abstraction of data, or the Transition Record with Specified Elements Received by Discharged Patients, and the Timely Transmission of Transition Record measures. Additional specifications for the Screening for Metabolic Disorders measure, as I mentioned earlier, will be provided in the next release of the IPFQR Program manual. And again, we will notify all those who are part of the IPFQR ListServe when that next release is available. Again, these resources will be available on the qualitynet.org website at a later date.

This slide includes links to some of the resources that have helpful information pertaining to psychiatric advance directives, the PCPI® approved quality measures manual, and the fiscal year 2016 IPF PPS Final Rule.

Now, this slide includes active links that you can use to send us questions about the IPFQR Program, about specific measures, how to abstract data for those measures, et cetera. We recommend that you use the Q&A tool indicated in the top left, in particular, because it provides the best means by which we can track questions and answers, and it also delivers our responses to your email inbox. This is also a great way for you to let us know of any types of questions or topics that you would like for us to address in future webinars. We also want to remind all those in attendance that if you have any changes to key personnel, including leadership at the CEO or administrator level, as well as quality reporting contacts at your facility, to please inform the IPFQR Program support contractor, and the best way to do that again is either through the Q&A tool, or via the email support, which is linked at the top – the second icon at the top on the left. Another way to send us updates of this nature is to of course complete a hospital contact correction form and to submit that to us via secure fax. The hospital contact information form is located on the QualityReportingCenter.com website, where you'll click on Inpatient, then Resources and Tools, and the form is the first item listed on that page. We encourage you to utilize all available resources found on the *QualityNet* and Quality Reporting Center websites, as

they will help to ensure appropriate knowledge of the program requirements and deadlines.

Now at this time, I would like to review and respond to some of the questions that we have received pertaining to topics covered in today's webinar. And, while I will not be able to address all of the questions that have come through the chat tool, please remember that the question and answer transcript for this webinar will be available at a later date. So, the first few questions I want to address pertain specifically to the transition record measures.

Will a specific ICD-10 code be acceptable as a discharge diagnosis for the transition record? The answer is yes, as long as it is labeled as the discharge diagnosis, and is accompanied by the code description. Please remember that this information must be able to be understood by the patient or caregiver to whom this information is communicated.

All right, what if a patient doesn't have a PCP or anyone designated for follow-up care? Is it expected that the facility establish a new PCP or clinician for follow-up, and if no PCP is established, will this also affect the element plan for follow-up care in the list of 11 elements? So, for the requirements regarding contact information for primary physician, other healthcare professional, or site designated for follow-up care, the facility will need to provide contact information for the designated primary care physician, medical specialist, or other physician or healthcare professional who will be providing the follow-up care. Follow-up care may also be provided at a clinic, or other outpatient program, so contact information for the clinic or program in those cases should be provided.

What if a patient lives out of state and/or does not want a record to be sent? Does this – does this just need to be documented? If the transition record was not transmitted to the facility or primary physician designated for follow up care, then the case will not be in the numerator of the Timely Transition of Transmission Record measure. However, please note that refusal is not a denominator exclusion, therefore the case would be included in the denominator for the Timely Transmission of Transition Record measure.

OK, what constitutes major tests or procedures for the transition record measures? If you take a look at page 21 of the IPFQR Program manual, you will find that major tests are defined as all procedures and tests noteworthy and supporting patient's diagnosis, treatment, or discharge plan, as determined by the provider or facility. An example of this would include a complete blood count, medical – and metabolic panel, urinalysis, or radiological imaging. Again, the IPFQR Program manual can be found on the Quality Reporting Center website, and links to it are here within the slide deck.

Let's see. What should be documented to show that all 11 elements have been reviewed with the patient or caregiver? So, a checklist may be used to indicate that each of the 11 elements was discussed with the patient. We, as the VIQR support contractor,are developing a tool that could be used and included in the medical record to show compliance with the transition measures. We will alert you via ListServe once that tool is ready to go and available.

How do we know what is required for psychiatric advanced directives in our state? The NRCPAD website contains requirements for each state. If you go to the link on slide 28, you will find that on the website there is a drop-down menu that lists each state, and will link – provide a link to that state's specifications.

And, I've seen this come across the chat tool several times so far today, and I know I just addressed it, but again, when will data collection begin for these measures? Data collection for both the screening for metabolic – excuse me, for both the Screening for Metabolic Disorders measure, as well as both of the transition record measures will begin on July first of this year, 2016.

I have just a couple more questions here pertaining to screening for metabolic disorders. The first is, will documentation of a finger stick blood sugar in the current or past medical record satisfy the requirements for the blood glucose data elements? So, according to the American Diabetes Association guidelines, they currently recommend using the HBA-1 C, a fasting plasma

glucose, or the two-hour plasma glucose value, after a 75-gram oral glucose tolerance test to test for diabetes.

What if the patient refuses the metabolic screening tests? Will this patient be excluded? No. This case – in this case, if a patient refuses the tests, then this case would be included in the denominator; however, again, we strongly encourage providers to educate patients about the importance of metabolic screening.

What if the metabolic screening test results from a previous hospitalization are not available for review, but the physician knows and documents the results, will that documentation be acceptable? The physician will need to document the original date of those tests (the results for each of the metabolic screening tests, meaning the numeric values for each of those results, and the source of the original information), in order for it to be included in the screening for metabolic disorders measure.

OK, so now at this time I will turn the presentation over to Deb Price, who will discuss the CE credit process for this webinar.

Deb Price: Thank you, Evette. And now I'm going to review how to get your certificate. Please review these slides carefully. Today's webinar has been approved for 1.5 continuing education credits by the boards listed on this slide. We are now a nationally accredited nursing provider, and as such, all nurses report their own credits to their board using our national provider number on this slide. It's number 16578.

We now have an online CE certificate process where you can receive your CE certificate two separate ways. If you registered for the webinar through ReadyTalk®, a survey will automatically pop up after the webinar closes. This survey will allow you to get your certificate. If, however, you're in a room where only one person registered, within 48 hours another link will be sent out to all the registrants. Whoever registered, please send that link out to the other people in the room, and they will be able to get their certificate also. After completion of the survey, each person will click the Done button at the bottom of their screen, and another page will open up, then ask you to

register onto our learning management center. This is a completely separate registration than the one you used to get into ReadyTalk® and to listen to this webinar. Please remember that it is a separate registration. And, also keep in mind that many health facilities and most hospitals have firewalls up that prohibit our links from getting into your computer. So, we ask that you use a personal email like Yahoo or G-Mail, or whatever your personal email account is, when you register for your certificate.

This is what the survey looks like, and at the bottom of the screen, the very – the right-hand corner, you see a gray box that says Done, as soon as you click that button Done, this green will appear – excuse me. On the screen are two separate green links, the first one being the new user link, and the second is the existing user link. So, if you have never been able to receive a certificate, or if you've had problems before, then you need to click on the new user link.

This is the screen that will open up. On this screen, you see that you register your first name, your last name, and give us the email that you use for a personal email, and we also ask for a phone number in case we need to contact you.

If, however, you have been receiving our certificates up to now for all of our events, then you would click on that existing user link. This is the screen that comes up when you click on the existing user link. Your username is your complete email address, including whatever is after the @ sign, and of course your password that you registered with. And, this is it. I will now pass the webinar back to your webinar coordinator, Evette Robinson, who will end today's event. Evette?

Evette Robinson: Thank you, Deb. This concludes the IPFQR Program's *New Measure and Non-Measure Reporting – Part 2* webinar. We thank you for your time and attention.

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