# Inpatient Psychiatric Facility Quality Reporting Program

## Support Contractor

## IPF: Inpatient Psychiatric Facility Quality Reporting Program New Measures and Non-Measure Reporting – Part 2 - 1.5 C.E.

## Questions and Answers

**Moderator/Speaker:**

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## Transition Measures

**Question 1:** **In the *Plan for follow-up care,* what about referral to a walk-in clinic where an appointment is not made in advance by the receiving facility?**

*Referral of a patient to a walk-in clinic without an appointment does not meet the element of "Plan for follow-up care" for the Transition Record with Specified Elements Received by Discharged Patients measure. In order to meet the element of "Plan for follow-up care:"*

> *"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/ psycho-social/outpatient resources available for patient support, self-care instructions, etc. The plan should be developed with consideration of the patient's goals of care and treatment preferences."*

**Question 2:** **Transmitting a record electronically or by fax seems risky when the patient is being referred to a walk-in clinic, and not to a specific provider. There is a confidentiality concern. Any comment?**

*Referral of a patient to a walk-in clinic without an appointment does not meet the element of "Plan for follow-up care" for the Transition Record with Specified Elements Received by Discharged Patients measure. See the answer to Question 1 for a definition of the element "Plan for follow-up care."*

*We agree that patient privacy while transmitting a record electronically or by fax is a valid concern. We expect that, as with other personal health information, the facility will conform to all state and federal requirements regarding transmission of personal health information to maintain patient confidentiality.*

**Question 3:** **Who should we transmit the Transition Record to if the patient has no next level of care provider?**

*You must first meet the numerator of the Transition Record with Specified Elements Received by Discharge Patients measure by establishing an appointment for follow-up care. If an appointment is not made, follow-up care cannot be documented and the transition record is incomplete. Transmitting an incomplete transition record will not meet the numerator for the Timely Transmission of Transition Record measure.*

**Question 4:** **In regard to the 24 hour contact information, we do not have emergency services. We have court-appointed admissions only, and they are all pre-scheduled. At discharge our patients are referred to the community mental health centers. The mental health centers have emergency numbers for the community mobile crisis teams. Would those numbers meet the intent of the emergency contact?**

*The requirement for 24-hour, 7-day contact information is not about the availability of emergency services but rather the availability of a person who can be contacted regarding concerns about the patient's inpatient stay. This person should be a healthcare team member who has access to medical records and other information concerning the **inpatient** stay. Please reference the numerator information for this measure in the IPFQR Program Manual.*

**Question 5:** **If there were multiple providers with whom a patient needed to follow-up, HBIPS-7 required the Continuing Care Plan to be transmitted to the provider who was managing the medications. Does this logic still apply?**

*Per the measure specifications, the discharging facility is expected to provide contact information to the healthcare professional primarily responsible for the patient's follow-up care. This may be the designated primary care physician (PCP), medical specialist, **OR** other health care professional. Although not required by the measure, it would be desirable for all relevant providers to receive a copy of the discharge information in order to facilitate optimal transitions of care.*

**Question 6:** **What are the definitions of the following terms:**

- **Discontinued care**
- **24 hours from the time the facility ordinarily records the patient discharge**

***Discontinued care*** *includes elopement and failure to return from leave. In each of the instances of discontinued care specified below, effective discharge planning cannot be accomplished:*

> ***Elopement:*** *The National Quality Forum (NQF) defines elopement as any situation in which an admitted patient leaves the healthcare facility without staff's knowledge.*
>
> ***Failure to return from leave:*** *This is 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*

***24 hours from the time the facility ordinarily records the patient discharge:*** *The transition record should be sent within 24 consecutive hours from the discharge time recorded in the patient's medical record.*

**Question 7:** **If the primary physician has access to a hospital's electronic medical record (EMR), is that automatic compliance with "Timely Transmission," or does something have to be documented?**

*According to the element "Transmitted," the time and method (including mutual access to the EHR) of transmission should be documented. This documentation will satisfy the Timely Transmission of Transition Record measure.*

**Question 8:** **If the patient is referred to the emergency room (ER) for an emergency in the interim of setting up follow-up provider pending insurance verification, does this suffice for follow-up care?**

*No.*

**Question 9:** **If a person is on Inpatient status but is an Emergency Department (ED) Boarder who is transferred to another inpatient facility, are we required to send a transition record to that next inpatient facility?**

*The measure applies to individuals who are discharged from an IPF.*

**Question 10:** **Does slide 34 mean that tobacco and alcohol use information needs to be on the transition record? On slide 34 why does it state that the transition record includes elements such as tobacco and alcohol use? These elements are not listed in the specifications of the 11 elements previously discussed.**

*Yes, tobacco and alcohol use are part of the definition of the "Transition Record" element, as described in the IPFQR Program Manual.*

**Question 11:** **What if a patient is transferred, within a facility, from the psychiatric facility to general Inpatient for medical care? How will we abstract for the transition record and transmission? If the patient is subsequently discharged from medical care and not transferred back to the psychiatric facility, how will these be abstracted?**

*The eligible population is determined by type of bill and discharge status as entered on the claim (UB-04). For measure information, please refer to the Physician Consortium for Performance Improvement® (PCPI®) approved Quality Measures Manual: http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI.*

**Question 12:** **What if a patient refuses a next level of care provider or refuses release of information? How is this handled for the transition record measures? Does refusal to sign a Release of Information (ROI) pull them out of the denominator? Are you are saying a patient cannot refuse to have information transmitted without it being counted against the facility?**

*There is no exclusion for patient refusal of next level of care provider or ROI.*

**Question 13:** **For a patient transferred to another facility, is sending the four elements documented on the discharge paperwork adequate if the paperwork is hand delivered to the receiving facility by EMS staff, or does a phone conversation have to take place between the sending and the receiving facilities?**

*All 11 elements must be included in the Transition Record and transmitted to the next facility. If the patient is discharged to home, all 11 elements must be discussed with the patient. If the patient is discharged to an inpatient facility, the requirement is that four elements be discussed with the receiving facility:*

- *24-hour/7-day contact information including physician for emergencies related to inpatient stay;*
- *Contact information for obtaining results of studies pending at discharge;*
- *Plan for follow-up care; and*
- *Primary physician, other health care professional, or site designated for follow-up care.*

*Additional clarification regarding the definition of "Transmitted" for the Timely Transmission of Transition Record measure will be addressed in the next iteration of the IPFQR Program Manual.*

**Question 14:** **What if a patient's residence is not in the US? How is this handled for transmission of transition record?**

*The requirements are the same regardless of a patient's residence.*

**Question 15:** **Is it acceptable to list the number for the hospital for 7-day contact information, including physician for emergencies related to the inpatient stay?**

*No, the phone number must be for a healthcare team member with access to the medical record concerning the inpatient stay and who is readily available to respond. The healthcare team member may be identified by title or function in the transition record. See question #3.*

## Advance Directives

**Question 16:** **Regarding the advance directives, does everyone have to have an Advance Directive (AD), or just be asked if they have one?**

*This element does not require that all patients have advanced directives. However, if a patient does not have advance directives or a surrogate decision maker, a reason must be documented.*

**Question 17:** **Are we now required to discuss with the patient an AD for psychiatric care, as well as a traditional, non-psychiatric care advance directive to meet the advance care plan element? Is it relevant to the state of the IPF or the state of the patient's residence? If our State does not have a requirement for a psychiatric advance directive, does it still need to be included in the Transition of Care measure?**

*IPFs are expected to provide patients the opportunity to complete both types of advance directives prior to discharge to the extent allowable by law in the state in which the IPF resides. No additional documentation needs to be transmitted and the patient need not create an advance directive to satisfy the measure.*

**Question 18:** **How is the Advance Directive executed when a patient is admitted involuntarily under Baker Act Law?**

*If the patient's legal status is such that the completion of an advance directive is contraindicated, that should be noted in the patient record.*

**Question 19:** **Can the advance directive conversation be completed by nursing or admitting staff?**

*Yes, recognizing that state laws or regulations may impose additional requirements for who may perform this function.*

**Question 20:** **I'm assuming if the patient has a guardian, the advanced directive is unnecessary? Does the advance directive requirement for the transition record pertain to patients under 21? I thought that they could not legally do an advanced directive-medical or psychiatric. Also I have been told that psych advance directives are not legal in the state of California.**

*In the absence of an advance directive, having a guardian would meet the requirement for a surrogate decision maker and therefore meet the requirement for the component, "Advance Care Plan." If a law or regulation prevents the completion of an advance directive or the designation of a surrogate decision maker, this should be documented as the reason for not completing an advance care plan for the patient. If the patient's legal status is such that the completion of an advance directive is contraindicated, then that should be noted in the patient record.*

**Question 21:** **Is there any flexibility for the provider to determine that discussion of the advanced care plan is not appropriate based on the clinical condition of the patient and determine that for the moment the patient is a full code?**

*If the patient's condition or status prohibits the conversation regarding advance directives and surrogate decision maker or the completion of an advance directive, this should be identified as the documented reason for the absence of an advance care plan.*

**Question 22:** **If advanced directives are discussed with the patient and they decline, which is documented in a progress note, does this declination also need to be included on their continuing care plan, or is having it in their medical record sufficient?**

*Yes, this declination must be included as part of the transition record.*

**Question 23:** **How would we abstract if the patient agrees to do a psychiatric advance directive but refuses a traditional advance directive?**

*In this scenario, the IPF would document the completion of the psychiatric advance directive, as well as the reason of patient refusal for the absence of the traditional medical advance directive.*

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## Screening for Metabolic Disorders Measure

**Question 24:** **Regarding screening for metabolic disorders, what if the lab results are not back prior to patient discharge?**

*To be included in the numerator, the metabolic screening tests must have been completed in the 12 months prior to discharge and the numeric values available to the clinician. As described on slide 55 of the January 21 IPFQR Program webinar, the results of structured metabolic screening tests for the four elements completed in the 12 months prior to discharge should be clearly documented in the patient record.*

To maximize the usefulness of the Q&A transcript, we consolidated questions received through the Chat feature during the event and focused on the most important and frequently asked questions. To obtain answers to questions that are not specific to the content of this webinar we recommend that you refer to the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Manual, the QualityNet Q&A tool, or call the Hospital Inpatient VIQR Outreach and Education SC at 866.800.8765 or 844.472.4477.