Inpatient Psychiatric Facility (IPFQR) Quality Reporting Program

Support Contractor

IPFQR Program New Measures and Non-Measure Reporting – Part 1

Questions and Answers

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Question 1: Are there specified data elements that need to be included in the "brief intervention" for patients that have a positive alcohol use screen? Is there certain verbiage that needs to be included in this documentation? If so, can you direct to the resource?

Answer 1: There is a single data element in the Hospital Inpatient Quality Reporting (HIQR) Specifications Manual located on www.QualityNet.org under [Hospitals-Inpatient/Specifications Manual]. This is the definition of Brief Intervention found in that Specifications Manual:

> *"A single interaction conducted by a qualified healthcare professional or trained peer support person with the patient, following a positive screening result for unhealthy alcohol use or alcohol use disorder (abuse or dependence)."*

A brief intervention focuses on increasing the patient's understanding of the impact of substance use on his or her health and motivating the patient to change risky behaviors. The components of the intervention include: feedback concerning the quantity and frequency of alcohol consumed by the patient in comparison with national norms; a discussion of negative physical, emotional, and occupational consequences; and a discussion of the overall severity of the problem. The qualified healthcare professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to. Brief intervention corresponds directly with the 5 A's (Ask, Advise, Assess, Assist, Arrange) recommended for alcohol dependence.

Question 2: Please define "light" smokers.

Answer 2: Per the data element, Tobacco Use Status (TOB-1), light smoking is: *less than 1/4 pack per day; and/or one who uses smokeless tobacco; and/or smokes cigarettes but not daily; and/or cigars but not daily; and/or pipes but not daily*. (See Value 2 from the data element, Tobacco Use Status).

Question 3: Must the cessation medication be a prescribed medication or can the tobacco cessation medication be over-the-counter (OTC) medication?

Answer 3: The cessation medication can be either prescription or over-the-counter medication. Per the data element, Prescription for Tobacco Cessation Medication in the Notes for Abstraction, the fourth bullet indicates:

> *"If the physician wishes the patient to continue on medication that does not require a prescription, for example, over-the-counter nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling such as the quit line, if the medication is listed on the discharge medication list, this would be sufficient to select Value 1."*

Question 4: When will data for SUB-2 and SUB-2a be required?

Answer 4: Collection of data for the SUB-2 and SUB-2a measures will begin January 1, 2016 for the IPFQR Program. The data submission period is July 1–August 15, 2017.

Question 5: Does the nicotine patch count as an FDA-approved cessation medication prescription?

Answer 5: Yes, the nicotine patch is an FDA-approved cessation medication. Please refer to Appendix C, Table 9.1 in the Specifications Manual for the list of FDA-approved tobacco cessation medications.

Question 6: Does a "referral" to outpatient counseling include advice to use the 1-800-QUIT-NOW hotline? Must [the patient] be enrolled, or simply advised to constitute a referral?

Answer 6: A referral to the *Quitline* includes either an appointment arranged via telephone, fax, or email prior to discharge. The faxed/emailed referral to the *Quitline* OR documentation that the caregiver was present while the patient contacted the *Quitline* is sufficient for the required documentation that a referral was made. This information can be found in the data element, Referral for Outpatient Tobacco Cessation Counseling.

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Question 7: Does the fax to the *Quitline* need to occur ***prior*** to the patient discharge, or can it occur the day after or later?

Answer 7: The referral to the *Quitline* (or any other outpatient counseling) must be done ***prior*** to discharge.

Question 8: What if a patient refused screening for Tobacco Use within the first three days, but agreed to it later, e.g., day six? Would they be excluded from TOB-3/-3a?

Answer 8: If the patient refused the assessment, select allowable value 4 for the data element, Tobacco Use Status. The case would be in the numerator for TOB-1, excluded from TOB-2/-2a, and excluded from TOB-3/-3a.

Question 9: For light smokers, do they require a prescription at discharge?

Answer 9: Light smokers should receive practical counseling during the hospital stay (TOB-2) but would not require cessation medication. If the patient (light smoker – value 2 for Tobacco Use Status) received a referral for outpatient (OP) counseling, the case passes TOB-3/-3a.

Question 10: Is there any exclusion for patients without access to a phone or who are homeless?

Answer 10: With respect to the data element, Referral for Outpatient Tobacco Cessation Counseling and TOB-3/3a, there is not an exclusion for patients without access to a phone or who are homeless. The facility's responsibility is to establish the referral for outpatient counseling while the patient is in the hospital.

Question 11: If we give the patient a website address on their discharge instructions for them to use for outpatient counseling, is this allowable?

Answer 11: If only a website is provided, the abstractor must select value 2 for the data element Referral for Outpatient Tobacco Cessation Counseling. Value 2 will send the case to the denominator for TOB-3/-3a and it will not pass the measure.

Question 12: If the cessation medication is an over-the-counter medication, is a prescription required or is the medication documentation on the discharge medication reconciliation sufficient?

Answer 12: Per the data element, Prescription for Tobacco Cessation Medication in the Notes for Abstraction, the fourth bullet indicates:

"If the physician wishes the patient to continue on medication that does not require a prescription, for example, over-the-counter nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling such as the quit line, if the medication is listed on the discharge medication list, this would be sufficient to select Value 1."

Question 13: Does signing the patient up for *Quitline* meet the referral requirement?

Answer 13: Documentation of a faxed or emailed referral to the *Quitline* OR assisting patient with the telephone call scheduling the appointment with the *Quitline* is sufficient. Simply providing the *Quitline* phone number to the patient is not sufficient.

Question 14: What about patients discharged to jail; are they excluded?

Answer 14: Patients discharged to jail have a discharge disposition of value 1, per the data element Discharge Disposition. They are not excluded from the TOB-3 measure.

Question 15: With smoking counseling that we are already doing, there is a 1-800 number for patients to call for support and further information. Can that count for OP counseling?

Answer 15: Per the data element Referral for Outpatient Tobacco Cessation Counseling, documentation must show a referral was made at discharge for outpatient counseling. An 800 number would not meet this requirement, unless the documentation indicates that the patient was referred to a *Quitline*. Facilities should assist the patient with the phone call before discharge or fax/email the referral to the Quitline. The *Quitline* will contact the patient to set-up the appointment. The fax or email is the equivalent of making an appointment.

Question 16: And what do we use for "chew, snuff"?

Answer 16: This is considered "smokeless tobacco" and would fall under the category of value 2 of the data element, Tobacco Use Status (TOB-1).

Question 17: Do light smokers require a cessation medication at discharge? (They didn't receive one as inpatient.)

Answer 17: Light smokers must receive a referral to outpatient counseling, but they do not require cessation medication at discharge.

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Question 18: Is Nursing allowed to provide SUB Brief Intervention?

Answer 18: The Brief Intervention must be provided by a person trained in Brief Intervention. A free online *Screening, Brief Intervention, and Referral to Treatment (SBIRT)* course is provided through Medscape (https://login.medscape.com/login/sso/getlogin?urlCache=aHR0cDovL3d3dy5tZWRzY2FwZS5vcmcvdmlld2FydGljbGUvODMwMzMx&ac=401), which addresses the basic principles of SBIRT. This continuing medical education/continuing education (CME/CE) course is intended for primary care physicians, pediatricians, psychiatrists, emergency physicians, dentists, chiropractors, social workers, nurses, nurse practitioners, and physician assistants. A free membership to Medscape is required to access the training. It is not required that the facility use SBIRT. The facility may choose which Brief Intervention training to use. SBIRT training is suggested simply because it is recommended by The Joint Commission and is free.

Question 19: Are nicotine patches, which are now available over the counter, considered to be approved cessation medication**?**

Answer 19: The list of FDA-Approved TOB cessation medications is in the HIQR Specifications Manual, Appendix C Table 9.1. Nicotine Transdermal is listed in the table. Here is the link to the current Specifications Manual: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228774725171.

Question 20: If no amount is listed, do we assume the highest amount and choose value 1?

Answer 20: Yes, per the data element, Tobacco Use Status, in the Notes for Abstraction, it states:

> *"If the medical record indicates the patient smokes cigarettes and the volume is not documented or is unknown, assume smoking at the heaviest level and select Allowable Value 1."*

Question 21: Can the appointment made for follow up with the psychiatrist/therapist be used for the referral?

Answer 21: Yes, please see the definition for the data element, Referral for Outpatient Tobacco Cessation Counseling:

> *"Documentation that a referral was made at discharge for ongoing evidence-based counseling with clinicians (physician or non-physician such as nurse, psychologist, or counselor). Outpatient counseling may include proactive telephone counseling,*

group counseling, individual counseling and/or e-health and internet intervention. A counseling referral may be defined as an appointment made by the healthcare provider or hospital either through telephone contact, fax or e-mail."

Question 22: Many patients state that they "sometimes smoke," or "smoke socially." Would this patient need nicotine replacement therapy (NRT)?

Answer 22: Only the patients identified as "heavy" tobacco users (Value 1 in the data element, Tobacco Use Status) are required to have the cessation medication.

Question 23: And for Social Workers providing the brief counseling, must he/she be licensed?

Answer 23: As long as a person is trained and guided by a healthcare professional, they do not have to be a licensed provider.

Question 24: What about patients who use E-cigarettes? Does the information provided today apply to those patients who use E-cigarettes?

Answer 24: No, this does not include e-cigarettes. E-cigarettes contain nicotine, not tobacco. If the patient uses e-cigarettes only, select value 3 for the data element, Tobacco Use Status.

Question 25: Where we can get the new tool for TOB?

Answer 25: The IPFQR Tobacco Screening and Treatment tool is available on the IPFQR Program Resources and Tools page of the Quality Reporting Center website: http://www.qualityreportingcenter.com/inpatient/ipf/tools/ This tool is an optional, informal mechanism to aid IPF's in the collection of tobacco use screening and treatment data for the Centers for Medicare & Medicaid Services (CMS).

Question 26: How are we measuring FDA-approved tobacco cessation products that do not need prescription, i.e., OTC products?

Answer 26: Per the data element, Prescription for Tobacco Cessation Medication in the Notes for Abstraction, the fourth bullet indicates:

"If the physician wishes the patient to continue on medication that does not require a prescription, for example, over-the-counter nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling such as the quit

line, if the medication is listed on the discharge medication list, this would be sufficient to select Value 1."

Question 27: Does the counseling need to be provided at discharge? Can it be bundled up with the initial smoking cessation counseling?

Answer 27: A referral for outpatient counseling can be made at any time prior to discharge. The prescription for cessation medication to be taken after discharge can be provided any time prior to discharge.

Question 28: What is the definition of evidence-based counseling? Would referral to a national number like 800 NOBUTTS be okay?

Answer 28: Evidence-based counseling is the application of treatment practices based on rigorous scientific empirical studies. Clinicians are responsible for using evidence-based interventions when providing tobacco cessation counseling.

The website link below contains a *Quick Reference Guide for Clinicians*, which is a summary of the Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update*. The guideline was developed using scientifically-based methodology and expert clinical judgment. Key points from this guide that should be used for treating tobacco use and dependence include:

- Using both print and web-based educational materials to facilitate quitting;
- Combining counseling and medication; and
- Utilizing motivational intervention techniques for patients who do not exhibit a willingness to quit.

The use of both over-the-counter medications (such as the nicotine lozenge) AND prescription medications (such as Varenicline) have been shown to be effective smoking cessation treatments. The interventions identified in the Quick Reference Guide are recommended for all individuals who use tobacco, except when medically contraindicated or with specific populations in which medication has not been shown to be effective (pregnant women, smokeless tobacco users, light smokers, and adolescents).

http://www.healthquality.va.gov/tuc/phs_2008_quickguide.pdf

The http://www.nobutts.org/ is a web-based structured program that meets the inclusion guidelines for abstracting the data element, Referral for Outpatient Tobacco Cessation Counseling. It provides a *Quitline* and has a web-based referral capacity.

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Question 29: What is a "qualified" health care professional?

Answer 29: A “qualified” health care professional refers to any clinician or trained peer support person that has been trained in Brief Intervention. A free online Screening, Brief Intervention, and Referral to Treatment (SBIRT) course provided through Medscape (https://login.medscape.com/login/sso/getlogin?urlCache=aHR0cDovL3d3dy5tZWRzY2FwZS5vcmcvdmlld2FydGljbGUvODMwMzMx&ac=401) addresses the basic principles of SBIRT. A free membership to Medscape is required to access the training. It is not required that the facility use SBIRT. The facility may choose which Brief Intervention training to use.

Question 30: For cognitive impairment in psychiatric patients, patients that are "not confused' may still be delusional. Is it acceptable documentation for cognitive impairment as patient is oriented x3 or not confused, however, they are disorganized, mute, angry, removing clothing, continuously talking about sex? Patients that are acutely psychotic may not be confused.

Answer 30 There is not an all-inclusive list of terms that can be used to determine cognitive impairment; however, examples of terms that equate to cognitive impairment in the data elements can be found on pages 1-25 through 1-26 for the substance use measures and 1-363 through 1-364 for the tobacco use measures in the Specifications Manual for National Hospital Inpatient Quality Measures, v5.0b. The Notes for Abstraction concerning cognitive impairment are being updated in the Specifications Manual for National Hospital Inpatient Quality Measures, v5.1 (July 2016), to provide additional clarification on the required documentation.

Question 31: Why would a physician write an RX for smoking cessation products that are available over the counter?

Answer 31: Per the data element, Prescription for Tobacco Cessation Medication in the Notes for Abstraction, the fourth bullet indicates:

> *"If the physician wishes the patient to continue on medication that does not require a prescription, for example, over-the-counter nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling such as the quit line, if the medication is listed on the discharge medication list, this would be sufficient to select Value 1."*

Question 32: What qualifies as brief alcohol TX?

Answer 32: There is a single data element in the Hospital IQR Specifications Manual located on www.QualityNet.org under [Hospitals-Inpatient/Specifications Manual].This is the definition of Brief Intervention found in that Specifications Manual:

> *"A single interaction conducted by a qualified healthcare professional or trained peer support person with the patient, following a positive screening result for unhealthy alcohol use or alcohol use disorder (abuse or dependence)."*

A brief intervention focuses on increasing the patient's understanding of the impact of substance use on his or her health and motivating the patient to change risky behaviors. The components of the intervention include feedback concerning the quantity and frequency of alcohol consumed by the patient in comparison with national norms; a discussion of negative physical, emotional, and occupational consequences; and a discussion of the overall severity of the problem. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to. Brief intervention corresponds directly with the 5 A's (Ask, Advise, Assess, Assist, Arrange) recommended for alcohol dependence.

Question 33: For TOB-3/-3a, population starts with users of tobacco products within the past 30 days. This is 30 days prior to discharge regardless of their use status on admission?

Answer 33: TOB-3/-3a uses the same data element as TOB-1 and TOB-2 to assess tobacco use. Tobacco Use Status is defined as tobacco use within the past 30 days prior to the day of hospital admission.

Question 34: Our emergency department (ED) has just implemented the SBIRT tool. Can we count completion of this tool in the ED for the measures? Does the SBIRT tool qualify for use for the SUB-2 and SUB-2a?

Answer 34: The facility must utilize a validated screening tool, such as AUDIT or AUDIT-C, that will provide a score and risk level. The risk level determines if they need a brief intervention. SBIRT screening is part of the process that can be used after it has been established that brief intervention is needed. It is not a validated tool to use for initial SUB-1 screening.

Question 35: Is the counseling on slide 30 (outpatient evidence-based counseling) the equivalent of the three practical counseling elements for TOB-2? What is

considered appropriate Evidence-Based behavioral counseling? How is that documented?

Answer 35: Practical counseling for TOB-2 requires interaction to address recognizing danger situations, developing coping skills, and providing basic information about quitting. The outpatient counseling for TOB-3 is more comprehensive. Evidence-based counseling is the application of treatment practices based on rigorous scientific empirical studies. Clinicians are responsible for using evidence-based interventions when providing tobacco cessation counseling.

The website link below contains a *Quick Reference Guide for Clinicians*, which is a summary of the Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update*. The guideline was developed using scientifically-based methodology and expert clinical judgment. Key points from this guide that should be used for treating tobacco use and dependence include:

- Using both print and web-based educational materials to facilitate quitting;
- Combining counseling and medication; and
- Utilizing motivational intervention techniques for patients who do not exhibit a willingness to quit.

The use of both over-the-counter medications (such as the nicotine lozenge) AND prescription medications (such as Varenicline) have been shown to be effective smoking cessation treatments. The interventions identified in the Quick Reference Guide are recommended for all individuals who use tobacco, except when medically contraindicated or with specific populations in which medication has not been shown to be effective (pregnant women, smokeless tobacco users, light smokers, and adolescents).

http://www.healthquality.va.gov/tuc/phs_2008_quickguide.pdf

The facility will not be able to document that the outpatient counseling provided outside the facility is evidence-based. This information is provided simply to define evidence-based counseling that should be conducted after discharge.

Question 36: Does the Evidence-Based outpatient counseling have to be specific to tobacco use or can it be focused on the psychiatric issues?

Answer 36: The outpatient counseling is not limited to tobacco cessation only, but should include interventions that target tobacco cessation.

Question 37: What if the patient cannot afford counseling post-discharge?

Answer 37: For patients that cannot afford or do not have insurance coverage for outpatient counseling, a referral to the *Quitline* should be made. All 50 U.S. states, the District of Columbia, Puerto Rico, and Guam operate *Quitlines* that can be accessed through the 1-800-QUIT-NOW Quitline (operated by the National Cancer Institute). This toll-free number automatically transfers callers to their state *Quitline*. Facilities should assist the patient with the phone call before discharge or fax/email the referral to the *Quitline*. The *Quitline* will contact the patient to set-up the appointment.

Question 38: How do you account for OTC cessation medication?

Answer 38: Per the data element, Prescription for Tobacco Cessation Medication in the Notes for Abstraction, the fourth bullet indicates:

> *"If the physician wishes the patient to continue on medication that does not require a prescription, for example, over-the-counter nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling such as the quit line, if the medication is listed on the discharge medication list, this would be sufficient to select Value 1."*

The list of FDA-Approved TOB cessation medications is in the HIQR Specifications Manual, Appendix C Table 9.1. Here is the link to the current Specifications Manual: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228774725171.

Question 39: If the Habitrol patch is listed on the patient's discharge instructions, can the abstractor indicate “yes, the patient was given a cessation medication?”

Answer 39: Yes, per the data element, Prescription for Tobacco Cessation Medication in the Notes for Abstraction, the fourth bullet indicates:

> *"If the physician wishes the patient to continue on medication that does not require a prescription, for example, over-the-counter nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling such as the quit line, if the medication is listed on the discharge medication list, this would be sufficient to select Value 1."*

Habitrol, an over-the-counter medication, is included in the list of 32 FDA-approved tobacco cessation medications associated with the TOB-3/-3a measure.

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Question 40: Do you have a slide with a table for all the new measures?

Answer 40: The IPFQR measures for FY 2017 and FY 2018 are available in table format at http://www.qualityreportingcenter.com/wp-content/uploads/2014/10/IPF_FY2017-2018_MeasuresTablesPopSampFY17_Tool_20151023_FINAL_508.pdf.

Question 41: Is OP Tobacco Cessation counseling a billable service for OP physician/Non-Physician providers?

Answer 41: Please contact your billing department.

Question 42: If there is conflicting documentation about the outpatient tobacco cessation counseling referral, which value would you select, for instance, documentation that the patient refused referral but there is also documentation that a referral was given but no appointment was made?

Answer 42: In this instance the patient would be included in the TOB-3 numerator because a referral was offered but refused. However, the patient would not be in the TOB-3a numerator because the patient did not accept a referral.

Question 43: Will a scanned image of a prescription of the FDA-approved cessation medication count for value 1 for "Prescription Tobacco Cessation Medication," or does there need to be actual documentation that the prescription was handed to the patient? Does calling the script into the pharmacy count for allowable value 1?

Answer 43: Yes, a scanned image in the medical record would be sufficient to indicate that a prescription for an FDA-approved tobacco cessation medication was given to the patient at hospital discharge. If there is documentation that the prescription was called into a pharmacy at discharge, this would also suffice.

Question 44: For Tobacco Cessation, would it be considered a referral if patient is given contact information about the *Quitline* with the expectation that the patient would follow up himself after discharge?

Answer 44: No, the provider should document that an outpatient counseling appointment was made, a fax or email referral was sent to the *Quitline*, or that the patient was assisted in directly calling the *Quitline*.

Question 45: Does New York State *Opt-to-Quit* satisfy to choose for AV, which is initiated while patient in the hospital?

Answer 45: New York State Opt-to-Quit (http://www.nysmokefree.com/download/OptToQuit™FAQs.pdf) meets the inclusion guidelines for the data element, Referral for Outpatient Tobacco Cessation Counseling. Use of this resource must be documented in the medical record to select value 1 for this data element.

Question 46: When you say daily use, do you mean that if they smoke five cigarettes or less daily they are light smokers, and if they smoke cigars once a week, they are light smokers?

Answer 46: Light smokers are patients who smoke four or fewer cigarettes per day or smoke cigars/pipes/cigarettes less than daily. Please see the data element Tobacco Use Status in the current Specifications Manual on *QualityNet*.

Question 47: If the referral is made but not the appointment before discharge, is this considered in compliance for outpatient tobacco counseling?

Answer 47: If the facility refers the patient to the *Quitline*, documentation must reflect that the referral was faxed or emailed to the *Quitline*. Simply providing the *Quitline* number is not sufficient.

Question 48: Internet structured programs – do we have to give patient website address or do we have to sign patient up?

Answer 48: Internet structured programs can be a component of outpatient counseling, but providing a website regarding quitting is not sufficient. Documentation must reflect that the patient has an appointment for outpatient counseling or that a referral to the *Quitline* was made. If the facility refers the patient to the *Quitline*, documentation must reflect that the referral was faxed or emailed to the *Quitline*. If the patient calls the *Quitline* prior to discharge, documentation must reflect that healthcare personnel were present during the call.

Question 49: What is the difference between e-health resources on a mobile phone and self-help interventions? Both are self-directed (slide 26).

Answer 49: E-health refers to health services and information delivered or enhanced through the Internet and related technologies, such as mobile devices. Self-help interventions include brochures, videotapes, audiotapes that the patient uses on their own. Both e-health and self-help interventions can be considered components of outpatient counseling, but they will not satisfy the requirements for TOB-3/-3a. Documentation must reflect that the patient has an appointment for outpatient counseling or that a referral to the *Quitline* was made to select

value 1 for the data element, Referral for Outpatient Tobacco Cessation Counseling.

Question 50: If a patient refuses a tobacco cessation medication during the hospital stay, TOB-2/-2a, are we required to offer it to them again at discharge for TOB-3/-3a?

Answer 50: Yes, a patient may have changed his/her mind between admission and just prior to discharge.

Question 51: Who can 'prescribe' tobacco cessation meds at discharge? Is it acceptable for a non-physician counselor to suggest meds to patient for discharge and document this plan or must it be a physician/NP or PA?

Answer 51: A state licensed, authorized clinician can prescribe cessation medications at discharge. A non-physician counselor can suggest medication use, but the physician would need to write a prescription or list it as a discharge medication.

Question 52: Will it be acceptable for a social worker to make the referral for ongoing counseling/treatment for the patient after discharge?

Answer 52: Yes, the data element, Referral for Outpatient Tobacco Cessation Counseling, is defined as "documentation that a referral was made at discharge for ongoing evidence-based counseling with clinicians (physician or non-physician such as nurse, psychologist, or counselor)."

Question 53: What about repeat admissions? If a patient was provided counseling at a recent previous admission, would that counseling need to be offered again at a readmission shortly thereafter or could the recent previous admission intervention be counted as compliant?

Answer 53: If the Tobacco Use Status reflects that the patient continues to use tobacco, practical counseling should be provided during the hospitalization again.

Question 54: Would a consult with AA or the like be considered a Brief Intervention if done and documented within the patient Hospital course? Can this be done in a group or must it be individual counselling?

Answer 54: A consult with AA would not be considered a Brief Intervention. Typically, 12 step programs are "support groups" that do not include staff specifically trained in brief intervention techniques. A 12-step program could be considered another resource after the patient receives a brief intervention.

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Question 55: If TOB cessation meds are not a prescription in some states, does the MD still have to write a prescription for the cessation med?

Answer 55: No, per the data element, Prescription for Tobacco Cessation Medication in the Notes for Abstraction, the fourth bullet indicates:

> *"If the physician wishes the patient to continue on medication that does not require a prescription, for example, over-the-counter nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling such as the quit line, if the medication is listed on the discharge medication list, this would be sufficient to select Value 1."*

Question 56: Is there a timeline in which the referral needs to be made?

Answer 56: A referral to evidence-based outpatient counselling should be made prior to the patient's discharge in order to pass the TOB-3 measure.

Question 57: Can the Admission RN's documentation of "not ready to quit" be an accepted reason for not prescribing meds or does it need to be addressed in MD's discharge summary?

Answer 57: No, that is not considered a reason for not prescribing medications. Documentation must reflect that the patient refused tobacco cessation medication. Without documentation of refusal, cessation medications should be prescribed.

Question 58: Approved Tobacco Cessation Medications? I only noticed Zyban listed beside Bupropion. What about Wellbutrin, Aplenzin, etcetera?

Answer 58: The FDA-approved tobacco cessation medications listed on slide 24 of the webinar encompasses the only FDA-approved tobacco cessation medications associated with the TOB-3/3a measure data element, Prescription for Tobacco cessation medication. Additional medications may be added in the future.

Question 59: If you fax in a *Quitline* referral and there is not an appointment made at that time and they just call the patient within a day, etc., how can I pass the measure if there is not a true "documented time" for referral?

Answer 59: A referral to the *Quitline* includes either an appointment arranged via telephone, fax, or email prior to discharge. The faxed/emailed referral to the *Quitline* OR documentation that the caregiver was present while the patient contacted the *Quitline* is sufficient for the required documentation that a referral was made.

This information can be found in the data element, Referral for Outpatient Tobacco Cessation Counseling.

Question 60: What are the documentation requirements if a patient refuses counseling or prescription to end tobacco use?

Answer 60: For TOB-3, please see the data elements, Referral for Outpatient Tobacco Cessation Counseling and Prescription for Tobacco Cessation Medication. Any documentation of patient refusal for each component allows the abstractor to select that the patient refused outpatient counseling or cessation medication at discharge.

Question 61: If a patient is intubated in medication induced coma x 3 days, can this be documented as cognitive impairment?

Answer 61: Yes, documentation that the patient is in a medically-induced coma would equate to cognitive impairment. Clarification is being added to a future manual regarding cognitive impairment.

Question 62: Regarding the Older Adult, what are the exclusion criteria in terms of cognitive status of the patient?

Answer 62: Please see the data element, Tobacco Use Status and the Notes for Abstraction regarding value 6. Cognitive impairment must be documented at all times during the first three days of the hospitalization in order to select value "6." If there is documentation in the medical record that a patient is cognitively impaired, and there is no additional documentation that the patient's mental status was normal at any other time during the first three days of the hospitalization, i.e., alert and oriented, the abstractor can select value "6."

Examples of cognitive impairment include:

- Altered Level of Consciousness (LOC)
- Altered Mental Status
- Cognitive Impairment
- Cognitively Impaired
- Confused
- Memory Loss
- Mentally Retarded
- Obtunded

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Question 63: For TOB-3/-3a, only the patients that are discharged home will be included in the population, correct?

Answer 63: Discharge dispositions that are not documented or unable to determine are also included in the measure. For the data element, Discharge Disposition, values 1 and 8 are included in the population for TOB-3/-3a.

Question 64: Would referral to Primary Care physician for smoking quit help be acceptable**?**

Answer 64: Yes, as long as the documentation includes communication to the patient of the confirmed date, time, and a provider for the scheduled appointment.

Question 65: Non-measure data collection, for the payer for Medicare, is that including all Medicare Patients regardless if just traditional vs. HMO/PPO Medicare**?**

Answer 65: Yes, the Medicare count includes managed care and non-managed care patients.

Question 66: How is the TOB data reported?

Answer 66: IPFs will submit TOB measure data via the web-based data collection tool.

Question 67: Will the new Transition Record and Screening for Metabolic Disorders also use the global sampling methodology?

Answer 67: IPFs will have the option to use the global sampling methodology for the two transition record measures, as well as the Screening for Metabolic Disorders measure starting with the 2017 data submission period, which will impact the FY 2018 annual payment update determination.

Question 68: Do we have to do the Global TOB/SUB in order to abstract the IPF TOB/SUB?

Answer 68: The new global sampling guidelines described in the webinar are optional.

Question 69: Where is Table 10.01?

Answer 69: Table 10.01 is found in the Specifications Manual for The Joint Commission National Quality Core Measures located here: https://manual.jointcommission.org/.

Question 70: Will global sampling include patients from non-inpatient psych areas in the hospital such as med-surg, or it is limited to inpatient psych patients only?

Answer 70: All measure data and sampling options apply only to inpatient psychiatric facility services.

Question 71: If a patient is transferred from an acute care setting to Inpatient Behavioral unit and while in the acute care setting had an appointment for *Quitline* referral or smoking cessation education arranged during that admission, if this referral was available during the IPF hospitalization, will this qualify for the educational referral after discharge? Or, if we document that this referral is already in place, will this meet the criteria for referral to evidence based counseling?

Answer 71: If the referral fax or email initiated in the acute care setting is available in the IPF medical record, then that is acceptable. Likewise, documentation in the IPF medical record that reflects that a referral was already made is acceptable.

Question 72: On slide 37, are these initial population volumes for an annual basis?

Answer 72: Yes, the values on slide 37 represent the annual global sampling guidelines as described in Table 26 on page 46,718 of the FY 2016 IPF PPS Final Rule.

Question 73: Please advise an acceptable documentation practice to capture the fax or email referral to a *Quitline*. What documentation is acceptable?

Answer 73: A copy of the fax or email can be placed in the medical record, but this is not necessary to select value 1 for the data element Referral for Outpatient Tobacco Cessation Counseling. Documentation that the referral was faxed or emailed is sufficient.

Question 74: Do we have to abstract 100% of HBIPS patients 65 years and older for CY 2016?

Answer 74: Sampling for the HBIPS measures is performed on a “pool” of cases that includes all age groups.

Question 75: What is the timeframe in which the brief intervention for unhealthy alcohol use must be done during the patient's admission (within the first three days, etc.)?

Answer 75: According to the data element, Brief Intervention, it can be performed any time prior to discharge.

Question 76: Will there be a review of the IPF IMM-2 abstraction and reporting requirements?

Support Contractor

Answer 76: You may refer to the April 16, 2015 *IPFQR-Influenza Vaccination of Healthcare Personnel and IMM-2 Measure* webinar materials located on the IPF Webinars/Calls – 2015 page on the *QualityNet* website and in the IPFQR Program Archived Events page on the *Quality Reporting Center* website. A refresher webinar pertaining to this topic is currently scheduled for February 2016. We recommend that you sign up for the IPFQR ListServe to receive e-mails about the upcoming educational webinar events.

Question 77: To clarify, an actual appointment must be documented. What if there are limited resources to set up an "appointment." It seems uncommon for *Quitlines* to set up appointments; rather they provide live chat at time of phone call.

Answer 77: The patient can be referred to a *Quitline* also. The *Quitline* will contact the patient to set-up the appointment. If the facility refers the patient to the *Quitline*, documentation must reflect that the referral was faxed or emailed to the *Quitline*. Simply providing the *Quitline* number is not sufficient. If the patient calls the *Quitline* prior to discharge, documentation must reflect that healthcare personnel were present during the call.

Question 78: So a healthcare professional does not have to have SBIRT training, only the peer support person, correct?

Answer 78: The person who performs the brief intervention must have received specialized training in brief intervention, including healthcare professionals. According to the Notes for Abstraction for the data element Brief Intervention:

- A qualified healthcare professional may be defined as a physician, nurse, certified addictions counselor, psychologist, social worker, or health educator with training in brief intervention; or
- A peer support person who has received specialized training in brief intervention may perform the brief intervention in lieu of a qualified healthcare professional.

Question 79: Our facility is CMS only, not Joint Commission, so for the IQR program, we do not do the substance abuse/tobacco measures. Will we need to do them for the IPFQR program?

Answer 79: Yes, all facilities that are eligible to participate in the IPFQR Program are required to meet the program requirements, including submission of measure data, prior to the annual data submission deadline. You may refer to the IPFQR Measures for FY 2017 and FY 2018 and Population Sampling table located on

the IPFQR Program Resources and Tools page of the *Quality Reporting Center* website (www.QualityReportingCenter.com).

Question 80: Is the FY 2017 Non-Measure Data Collection still starting in June–July 2016?

Answer 80: During the 2016 data submission period (July 1–August 15, 2016), IPFs will be required to submit non-measure data for calendar year 2015.

Question 81: When checking the hospital's compliance to the measures, it appears that the facility is penalized when the patient refuses education or medication and that this will be the same pattern if they refuse outpatient smoking cessation help. I am confused as to why the hospital would be noted out of compliance if it is the patient refusing help. Will this negatively affect the hospital's payment?

Answer 81: Measure validation and compliance auditing are not part of the IPFQR Program at this time; thus, measure results do not impact payment. The IPFQR Program is a pay-for-reporting program only.

Question 82: Is there a fax form for the *Quitline*?

Answer 82: Documentation that the referral was faxed or emailed is sufficient. A copy of the fax or email can be placed in the medical record, but this is not necessary to select value 1 for the data element Referral for Outpatient Tobacco Cessation Counseling. For information on *Quitline* contact and resources, see http://www.naquitline.org/.

Question 83: If an IPF record is validated by Clinical Data Abstraction Center (CDAC), how will the auditors know that the nurse who completed the Brief Intervention had received SBIRT training? Will that nurse's HR file showing training was completed need to be sent along with the record to CDAC?

Answer 83: There is no validation process for the measures in the IPFQR Program at this time. However, it would be expected that the IPF would retain documentation of necessary training.

Question 84: What is the specific time that patients need to be called? In regards to "three failed attempts," do all three calls need to be made within the specified time? How does a non-working phone number affect the outcomes?

Answer 84: The IPFQR Program is not collecting SUB-4 or TOB-4 at this time. Contact The Joint Commission for information on these measures.

Support Contractor

Question 85: When will data for SUB-2 and SUB-2a be required?

Answer 85: IPFs will begin collecting data for the SUB-2/2a measure on January 1, 2016. Data collected for the 2016 calendar year (January 1–December 31, 2016) will be submitted during the July 1–August 15, 2017 data submission period.