Definitions for Transition Record Measures

The following is a list of data elements and their definitions as they pertain to the Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record measures.

24-hour/7-day contact information including physician for emergencies related to inpatient stay - 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 the stay. 800 numbers, crisis lines, or other general emergency contact numbers do not meet this requirement.

Advance directives - 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. The statement 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. Additionally, it identifies a person to whom the patient has given the authority to make decisions on his/her behalf. Advance directives should be compliant with state laws for the state in which the patient receives care. More information on advance directives for non-psychiatric care can be found at: http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289. Information on psychiatric advance directives can be found at: http://www.nrc-pad.org/.

Contact information for obtaining results of studies pending at discharge - Health care professional or facility contact number at which patient can receive information on studies that were not concluded at discharge. Patient preference should be considered in sharing results of studies, including whether results should be provided on paper.

Contact information / plan for follow-up care - For patients discharged to home, the listed elements are to be shared with the patient and/or caregiver. For patients discharged to an inpatient facility, the transition record may indicate that the following four elements are to be discussed between the discharging and the "receiving" facilities.

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

Current medication list - The current medication list should include prescription and over-the-counter medications and herbal products in the following categories:

- Medications to be TAKEN by patient: Medications prescribed or recommended prior to IPF stay to be continued after discharge AND new medications started during the IPF stay to be continued after discharge AND newly prescribed or recommended medications to begin taking after discharge. Prescribed or recommended dosage, instructions, and intended duration must be included for each continued and new medication listed.
- Medications NOT to be taken by patient: Medications (prescription, over-the-counter and herbal products) taken by patient before the inpatient stay that should be discontinued or held after discharge AND medications administered during the inpatient stay that caused an allergic reaction, AND medications with which current prescriptions may react.
**Documented reason for not providing advance care plan** - Documentation that advance directive or surrogate decision maker was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance directive, OR documentation as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning or a surrogate decision maker as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship.

**Inpatient facility** - Site of care delivery to include hospital inpatient or observation, skilled nursing facility, rehabilitation facility, or inpatient psychiatric facility (IPF).

**Major procedures and tests performed during inpatient stay and summary of results** - All procedures and tests noteworthy in supporting patients’ diagnosis, treatment, or discharge plan as determined by provider or facility. Examples may include: complete blood count and metabolic panel, urinalysis, or radiological imaging.

**Patient instructions** - Directions for patient and/or caregiver to follow upon discharge from facility. Examples include: medication information, activity restrictions, warning signs and symptoms associated with the condition, information regarding what to do if symptoms occur, etc. Patient instructions should be appropriate for the patient, including the use of language services as appropriate.

**Plan for follow-up care** - A plan for follow-up care that describes treatment and other supportive services to maintain or optimize health in alignment with patient’s 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, etc. The plan should be developed with consideration of the patient’s goals of care and treatment preferences.

**Primary physician, other health care professional, or site designated for follow-up care** - The primary care physician (PCP), medical specialist, psychiatrist or psychologist, or other physician or health care professional who will be responsible for appointments after inpatient visit. A site of care may include a group practice specific to psychiatric care. A hotline or general contact does not suffice for follow-up care.

**Studies pending at discharge** - Medical tests not concluded at discharge. Examples include: complete blood count and metabolic panel, urinalysis, radiological imaging.

**Surrogate decision maker** - Health care proxy available as patient advocate when a patient is legally incapacitated and unable to make decisions for him/herself about personal health care. A surrogate decision maker must be designated by the patient in a way that complies with the state’s laws for the state in which the patient receives care.

**Transition record** - 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 transmitted to the facility/physician/other health care professional providing follow-up care. The transition record may only be provided in electronic format if acceptable to the patient.
**Transmitted** - Transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR). The time and method of transmission should be documented.

**Within 24 hours of discharge** - Calculated as 24 consecutive hours from the time the facility ordinarily records the patient discharge.