



# **Inpatient Psychiatric Facility Quality Reporting Program Manual**

This program manual is a resource for the Inpatient Psychiatric Facility Quality Reporting Program for the Centers for Medicare & Medicaid Services. **Version 6.1 – Publication date: December 18, 2020**

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**(All data that are to be reported to CMS in calendar year 2022)**

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# Section 1: Inpatient Psychiatric Facility Quality Reporting Program

## Overview

The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program was developed as mandated by section 1886(s)(4) of the Social Security Act and amended by Sections 3401(f) and 10322(a) of the Affordable Care Act (Pub. L. 111148). It was implemented on October 1, 2012, as a Centers for Medicare & Medicaid Services (CMS) pay-for-reporting program. As a pay-for-reporting program, eligible inpatient psychiatric facilities (IPFs) must meet all program requirements annually to obtain the full annual payment update (APU) for the upcoming fiscal year (FY). Eligible IPFs that do not meet all IPFQR Program requirements will be subject to a two-percentage point reduction to the APU.

The IPFQR Program is intended to equip consumers with quality of care information to make more informed decisions about health care options. It is also intended to encourage psychiatric facilities and clinicians to improve the quality of inpatient care provided to patients by ensuring that providers are aware of and reporting on best practices for their respective facilities and type of care. To meet the IPFQR Program requirements, IPFs are required to collect and submit all quality measures to CMS in the form, manner, and time as specified by the Secretary, which began with the FY 2014 APU and continues in subsequent fiscal years.

This program manual is intended for use as a reference to assist in the implementation of the program and is effective as of the date listed on the cover page of this document. Each section of the manual provides detailed instructions for completing the steps necessary for successful implementation of the IPFQR Program. The sections include the following:

- Measure Details
- *QualityNet* Registration
- Vendor Authorization
- Notice of Participation
- Data Accuracy and Completeness Acknowledgement
- Accessing and Reviewing Reports
- Public Reporting of IPFQR Program
- Resources
- Appendices

## QualityNet

Established by CMS, *QualityNet* provides health care quality improvement news, resources, and data reporting tools and applications used by health care providers and others. *QualityNet* is the only CMS-approved website for secure communications and health care quality data exchange between quality improvement organizations (QIOs), hospitals, physician offices, nursing homes, end-stage renal disease (ESRD) networks and facilities, and data vendors. The Hospital Quality Reporting (HQR) system is an application-based system accessible through the *QualityNet* website that integrates several resources, tools, data submission/retrieval platforms, and secure communication interfaces designed to support CMS' quality reporting programs and initiatives. Note that the URL for *QualityNet* webpages recently changed and have been updated throughout this document.

## **Criteria Required to Participate in the IPFQR Program**

All IPFs paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) are subject to the IPFQR Program requirements. The IPF PPS applies to inpatient psychiatric services furnished by Medicare participating entities in the United States that are classified as psychiatric hospitals or certified psychiatric units in acute care hospitals (ACHs), critical access hospitals (CAHs), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), and children's hospitals. This includes the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

## **Additional Program Information**

Additional information about the IPFQR Program can be found on *QualityNet* by selecting the Inpatient Psychiatric Facilities tab (direct link): <https://qualitynet.cms.gov/ipf>.

National Provider Webinars are provided by CMS and by the IPFQR Program Support Contractor on a routine basis. The slides from each of the education sessions are published to the *QualityNet* website and are available for review under the Inpatient Psychiatric Facilities tab by selecting the **Webinars** link from the top menu.

## **Glossary of Terms**

**24-hour/7-day contact information including physician for emergencies related to inpatient stay** – Physician, health care team member, or other health care personnel 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 unless personnel have access to the medical records and other information concerning the inpatient stay.

**Acute care hospital (ACH)** – A hospital providing inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).

**Advance directive** – A written, signed statement that details the patient's preferences for treatment should the patient be unable to make such decisions for him/herself, whether that incapacitation is due to psychiatric or non-psychiatric (medical) reasons. The statement informs others about what treatment the patient would or would not want to receive from psychiatrists and/or other health professionals concerning both psychiatric and non-psychiatric care.

Advance directives must be compliant with the 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/>.

The federal law regarding advance directives, the Patient Self-Determination Act of 1990, requires health care providers to advise individuals of their right to accept or reject medical treatment and their right to make advance directives or written instructions about their treatment in case they should become incapacitated.

Decisions to accept or reject life-sustaining treatments must be made voluntarily by a competent and informed patient or, if the patient is incapacitated, by another appropriately informed individual acting on the patient's behalf. Information on the Patient Self-Determination Act (PSDA) (<http://www.nrc-pad.org/images/stories/PDFs/fedaddirectives2a.pdf>), the components of a Psychiatric Advance Directive (PAD) (<http://www.samhsa.gov/section-223/governance-oversight/directives-behavioral-health>), and a sample PAD are in Appendix A of this manual.

**Advance directives or surrogate decision maker documented OR documented reason for not providing advance care plan** – This element can be met if one of the following is documented:

- A. The patient has an appointed surrogate decision maker.
- B. The patient has a non-psychiatric (medical) advance directive and a psychiatric advance directive.
- C. If (a) or (b) was not met, the patient was offered information about designating a surrogate decision maker or completing advance directives, and if the criteria for (a) or (b) still were not met, a reason was documented.

After receiving information, the patient should be allowed the opportunity to appoint a surrogate decision maker or complete non-psychiatric and psychiatric advance directives. If the patient does not appoint a surrogate decision maker or complete non-psychiatric and psychiatric advance directives during the hospital stay, then reasons—such as patient refusal— must be documented. This element does not require that all patients have non-psychiatric and psychiatric advance directives (i.e., the patient does not need to create any advance directives to satisfy this element and copies of the non-psychiatric and psychiatric advance directives do not need to be transmitted to the follow-up provider). Non-psychiatric and psychiatric advance directives must comply with the state laws for the state in which the patient receives care. Additional information can be found in the definition of the term “Advance Directive.”

**Aftercare** – (see next level of care) Inpatient or outpatient care that the patient will receive after discharge from the hospital.

**Against Medical Advice (AMA)** – When a patient checks himself/herself out of a hospital against the advice of his doctor.

**Aggregate (data)** – Aggregate data elements derived for a specific hospital from the results of each measures algorithm over a given time period (e.g., quarterly).

**Alphabetical Data Dictionary** – A comprehensive list of each of the data elements is provided along with the page number and a list of specific measures in which the data element is used. Many data elements are used for more than one measure or measure set.

**Algorithm** – An ordered sequence of data element retrieval and aggregation through which numerators and denominators are identified.

**Allowable Value** – A list of acceptable responses for a data element.

**Annual Payment Update (APU)** – The yearly percentage increase that CMS applies to Medicare reimbursement for eligible providers. If an IPF does not meet all IPFQR Program requirements, the IPF's APU is reduced by two percentage points for the applicable fiscal year.

**Augmentation of Clozapine** – The addition of a second antipsychotic medication for patients receiving clozapine.

**Calendar year** – Time period between January 1 and December 31 of a given year.

**Caregiver** – The patient’s family or any other person who will be responsible for care of the patient after discharge.

**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. If there is documentation in the transition record indicating that no tests are pending at discharge, then this will satisfy the element.

**Contact information/plan for follow-up care** – For patients discharged to home, all 11 elements are to be shared with the patient and/or caregiver. For patients discharged to an inpatient facility, all four of the following 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

**Critical Access Hospital (CAH)** – A small facility that gives limited outpatient and inpatient services to people in rural areas.

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

Medications to be TAKEN by patient: Medications prescribed 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 be taken after discharge. Prescribed or recommended dosage, special instructions/considerations, and intended duration must be included for each continued and new medication listed. A generalized statement regarding intended duration, such as a blanket statement indicating that the patient should continue the medications until told to stop, would be acceptable for routine medications.

Medications NOT to be taken by patient: Medications (prescription, over-the-counter and herbal products) taken by the patient before the inpatient stay that should be discontinued or withheld after discharge. If there are no medications to be discontinued, it is not necessary to document this in the transition record.

**Data Accuracy and Completeness Acknowledgement (DACA)** – A requirement for IPFQR Program participating facilities, the DACA is an electronic acknowledgement indicating that the data provided to meet the APU data submission requirements are accurate and complete to the best of the facility's knowledge at the time of data submission.

**Data collection** – The act or process of capturing raw or primary data from a single or number of sources, also called “data gathering.”

**Data Element** – A discrete piece of data, such as patient birthdate or principal diagnosis.

**Data Entry** – The process by which data are transcribed or transferred into an electronic format.

**Data Transmission** – The process by which data are electronically sent from one organization to another.

**Denominator** – The lower part of a fraction used to calculate a rate, proportion, or ratio.

**Denominator Statement** – Represents the population evaluated by the performance measure.

**Discontinued care** – This definition includes elopement and failure to return from leave, as defined below.

Elopement: When a patient wanders away, walks away, runs away, escapes, or otherwise leaves the hospital unsupervised, unnoticed, and/or prior to their scheduled discharge. In these cases, effective discharge planning cannot be performed.

Failure to return from leave: This occurs 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. In these cases, effective discharge planning cannot be accomplished.

**Documented reason for not providing advance care plan** – Documentation that having an advance directive or a 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.

**Episode of Care (EOC)** – An Episode of Care (EOC) is defined as the health care services given during a certain period of time, usually during a hospital stay (e.g., from the day of arrival or admission to the day of discharge).

**Excluded Populations** – Detailed information describing the populations that should not be included in the indicator. For example, specific age groups, ICD-9 or -10 procedure or diagnostic codes, or certain time periods could be excluded from the general population drawn upon by the indicator.

**Fiscal year (FY)** – For Medicare, a year-long period that runs from October 1st through September 30th of the next year.

**Format** – Specifies the character length of a specific data element; the type of information the data element contains; numeric, decimal, number, date, time, character, or alphanumeric; and the frequency with which the data element occurs.

**Healthcare Quality Information System (HCQIS)** – The software network that supports a variety of services on the *QualityNet Secure Portal*, including accounts needed to access the *QualityNet Secure Portal*.



**HCQIS Access, Roles, and Profile (HARP) system** – The secure identity management portal authentication method used to log in to a number of CMS applications, including the *QualityNet Secure Portal*. It streamlines the login process to allow access to all CMS Quality organizations resources and tools within one login.

**Hospital Based Inpatient Psychiatric Services (HBIPS) Core Measure Set** – A specific set of measures developed and maintained by The Joint Commission for the inpatient psychiatric population, some of which are used by CMS in the IPFQR Program. In 2007, The Joint Commission, the National Association of Psychiatric Health Systems, the National Association of State Mental Health Program Directors (NASMHPD), and the NASMHPD Research Institute, Inc. collaborated on the development of performance measures specific to hospital-based inpatient psychiatric services.

**Hospital Quality Reporting (HQR) system** – An application-based system that includes data submission interfaces, data results, reporting tools, and administrative forms for providers and facilities (including Inpatient Psychiatric Facilities), as well as platforms for secure information exchange between providers, facilities, vendors, quality improvement organizations (QIOs), end-stage renal disease (ESRD) networks and facilities, and contractors supporting CMS' quality reporting programs and initiatives.

**ICD-10 Codes** – The 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization, contains codes for diseases, signs of symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases and procedures.

**Initial Patient Populations** – Detailed information describing the population(s) that the indicator intends to measure. Details could include such information as specific age groups, diagnoses, ICD-9 or -10 diagnostic and procedure codes, CPT codes, revenue codes, enrollment periods, insurance and health plan groups, etc.

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

**Inpatient Psychiatric Facility (IPF)** – A psychiatric hospital or a certified unit in an acute care or CAH which is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons.

**Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)** – A payment system for psychiatric hospitals and certified psychiatric units in acute care hospitals established by Section 124 of the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA). The BBRA was amended by Section 405(g)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to extend the IPF PPS to certified psychiatric units in Critical Access Hospitals. The BBRA established a per diem prospective payment system for IPFs that includes an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and certified psychiatric units. Facilities paid under this system are required to report under the CMS IPFQR Program.

**Inpatient Psychiatric Services** – Inpatient psychiatric services include care provided to a patient for a mental disorder while hospitalized in a certified psychiatric unit of an acute care hospital,

CAH, or a free-standing psychiatric hospital. Services rendered to outpatients or “day treatment” patients are not considered inpatient psychiatric services.

**Leave day** – An authorized or unauthorized absence from a facility, excluding discharges, during which the patient is absent from the facility at the time of the daily census and is not under the direct supervision of facility staff while absent.

**Low-density Lipoprotein (LDL)** – Plasma protein provided by the liver, carrying relatively more cholesterol and triglycerides than protein. The high cholesterol content may account for its greater atherogenic potential. Also known as “bad cholesterol.”

**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. If there is documentation in the transition record indicating that no major procedures or tests were performed, then this will satisfy the element.

**Measure Information Form** – This tool provides specific clinical and technical information on a measure. The information contained includes measure set, performance measure name, description, rationale, type of measure, improvement noted as, numerator/ denominator/continuous variable statements, included populations, excluded populations, data elements, risk adjustment, data collection approach, data accuracy, measure analysis suggestions, sampling, data reported as, and selected references.

**Measure Information Algorithms** – Algorithms illustrate the calculation steps needed for a measure. Each algorithm provides the logical steps, data element evaluation, arithmetic calculations and data manipulation information required to calculate a measure. The algorithms are used by vendors to design software applications and are helpful as a visual aid. A narrative description of the algorithm immediately follows the algorithm diagram. The information is supplemental and explains the flow in less technical terms. It is not intended to be used for programming purposes; however, the narrative steps may be of assistance for abstractors in understanding how the algorithm functions.

**Medical record (data source)** – Data obtained from the records or documentation maintained on a patient in any health care setting (e.g., hospital, home care, long-term care, practitioner’s office); includes automated and paper medical record systems.

**Monotherapy** – The use of a single antipsychotic medication.

**Multiple Antipsychotic Medications** – Antipsychotic medications are drugs prescribed to treat certain mental disorders; if two or more of these medications are routinely administered or prescribed, this is considered multiple antipsychotic medications.

**Next Level of Care** – (see aftercare) Inpatient or outpatient care that the patient will receive after discharge from the hospital.

**Notes for Abstraction** – Provided to assist the abstractor in the selection of the correct Appropriate Value for the data element. The Notes section may include examples of documentation encountered in the medical record.

**Notice of Participation (NOP)** – A requirement for IPFQR Program participating facilities, the NOP indicates a facility’s agreement to participate in the program and to allow public reporting of its measure rates. The NOP has three options: agree to participate, do not agree to participate, and request to be withdrawn from participation.

**Numerator** – The upper portion of a fraction used to calculate a rate, proportion, or ratio.

**Numerator Statement** – Represents the portion of the denominator satisfying the conditions of the performance measure.

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

**Patient-level data** – Collection of data elements that depict the health care services provided to an individual (patient). Patient-level data are aggregated to generate data at the setting level (e.g., hospital) and/or comparison group data.

**Percentile** – A value on a scale of 100 that indicates the percentage of a distribution that is equal to or below it.

**Performance Measure** – A quantitative tool (e.g., rate, ratio, index, percentage) that provides an indication of an organization’s performance in relation to a specified process or outcome.

**Physical Restraint** – A physical restraint is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely when it is used as a restriction to manage a patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment for the patient’s medical or psychiatric condition.

**Plan for follow-up care** – A plan for follow-up care that describes treatment and other supportive services to maintain or optimize patient health. The plan should include post-discharge therapy needed, any durable medical equipment needed, family/psychosocial/outpatient resources available for patient support, self-care instructions, etc. The plan may also include other information, such as appointment with outpatient clinician (if available), follow-up for medical issues, social work and benefits follow-up, pending legal issues, peer support (e.g., Alcoholics Anonymous, Narcotics Anonymous), and home-based services. 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.

**Principal diagnosis at discharge** – The final principal diagnosis at the time of discharge. Documentation of the principal diagnosis at discharge from the physician’s final progress note may be included in the transition record to meet this element.

**Process** – An interrelated series of events, activities, actions, mechanisms, or steps that transform inputs into outputs.

**Range** – A measure of the spread of a data set. The difference between the smallest and largest observation.

**Rate** – Derived by dividing the numerator (e.g., cases that meet the criterion for good or poor care) by the denominator (e.g., all cases to which the criterion applies) within a given time frame.

**Ratio** – A relationship between two counted sets of data, which may have a value of zero or greater. In a ratio, the numerator is not necessarily a subset of the denominator.

**Reason for IPF admission** – A short synopsis that describes how and/or why the patient was admitted to the inpatient psychiatric facility, including any triggering or precipitating events. A diagnosis or a list of symptoms alone is not sufficient.

**Reporting Period** – The defined time period for medical record review.

**Risk Adjustment** – A statistical process for reducing, removing, or clarifying the influences of confounding factors that differ among comparison groups.

**Risk Factor** – A factor that produces or influences a result. In statistics, an independent variable used to identify membership of qualitatively different groups.

**Routinely Scheduled Medications** – Medications prescribed to be taken regularly after discharge from the hospital.

**Sampling Method** – Describes the process used to select a sample. Sampling approaches for the IPFQR Program are simple random sampling and systematic random sampling.

**Seclusion** – Seclusion is the involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving.

**Simple Random Sample** – A process in which a sample is selected from the total population in such a way that every case has a similar chance of being selected.

**Specifications Manual for Joint Commission National Quality Measures (Specifications Manual)** – A manual that contains the specifications for The Joint Commission measures used in the IPFQR Program. This manual includes detailed information about the HBIPS, SUB, TOB, and IMM measures, with a data dictionary and Measurement Information Forms.

**Studies pending at discharge** – Medical tests not concluded at discharge. Examples include complete blood count and metabolic panel, urinalysis, and radiological imaging. If there is documentation in the transition record indicating that no studies are pending at discharge, then this will satisfy the element.

**Subset Measure** – A subset measure contains overlapping sets of patients. For example, the patients in the TOB-2a measure are a subset of those in the TOB-2 measure (i.e., the two measures have overlapping populations).

**Suggested Data Sources** – Provides a list of source documents from which data can be identified, such as an administrative or medical record. The sources are usually listed alphabetically for guidance locating the information within records. The information listed is for suggested sources only; however, other sources may be used, unless otherwise noted.

**Surrogate Decision Maker** – Health care proxy who acts as the patient’s advocate when he/she is legally incapacitated and unable to make decisions for him/herself about personal health care. To meet the intent of the Transition Record measures, the surrogate decision maker must be designated by the patient in a way that complies with the laws for the state in which the patient receives care and must have the authority to make all psychiatric and non-psychiatric decisions on behalf of the patient. The surrogate decision maker must be identified in the transition record by name and telephone number.

**Systematic random sampling** – A process in which the starting case is selected randomly, and the next cases are selected according to a fixed interval based upon the number of cases in the population.

**Transition record** – A core, standardized set of data elements consolidated into a single document related to patient’s demographics, diagnosis, treatment, and care plan that is discussed with and provided to the patient and/or caregiver 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 and only after all components have been discussed with the patient.

If a patient is transferred to another inpatient facility and the discharging clinician documents in the patient record that the patient is clinically unstable, or the patient and/or caregiver is unable to comprehend the information at discharge, then the discharging facility is **not** required to discuss and provide the transition record to the patient and/or caregiver; however, all four of the following elements must be discussed with the receiving facility to be included in the numerator for the Transition Record with Specified Elements Received by Discharged Patients measure:

- 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

**Transmitted** – A transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via mail, fax, and secure email. If the follow up health care professional has access to the electronic health record (EHR), this must be documented as the transmission method. It is also acceptable to provide a hard copy of the transition record to the personnel transporting the patient to the receiving facility. The time and method of transmission must be documented.

**Unable to be determined (UTD)** – Each data element that is applicable per the algorithm for each of the measures within a topic must be “touched” by the abstractor. While there is an

expectation that all data elements are collected, it is recognized that in certain situations information may not be available (e.g., dates, times, codes). If, after due diligence, the abstractor determines that a value is not documented or is not able to determine the answer value, the abstractor must select “Unable to be Determined (UTD)” as the answer.

**Within 24 hours of discharge** – Calculated as 24 consecutive hours from the time the facility ordinarily records the patient discharge. This may include transmission prior to discharge, but the timeframe must end 24 hours after discharge.

The date and time of discharge are to be used as the “trigger time” to determine if the transition record was transmitted within 24 hours after hospital discharge; therefore, use the date and time that the patient is “officially” discharged to begin calculating the 24-hour period.

Example: The IPF discharge date and time are 6/2/2017 and 08:23 a.m. The transition record should be transmitted within 24 hours after that discharge date and time. This means the facility should complete the transmission by 6/3/2017 at 08:23 a.m.

## **Proposed Rule and Final Rule Publication Site**

Every year, CMS publishes proposed program and policy changes to the IPFQR Program in early spring. The proposed changes are published to the *Federal Register* and are open to the public for review and comment for 60 days. CMS also provides notices through the *QualityNet* website and the IPFQR Program Listserve to ensure broad awareness. Following the comment period, CMS summarizes the comments and responds to them in the final rule. The final rule is published in mid-summer.

The IPFQR Program was implemented with the FY 2013 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule, published August 31, 2012. Information for the IPFQR Program begins on page 53644 (direct download, 15.1 MB): <http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/FR-2012-08-31.pdf>.

The FY 2014 IPPS/LTCH PPS Final Rule was published August 19, 2013. The rule contained updated information applicable for FY 2015 and beyond. Information for the IPFQR Program begins on page 50887 (direct download, 12.5 MB): <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf>.

The FY 2015 IPF PPS Final Rule was published on August 6, 2014. The rule contained changes to the IPFQR Program applicable for FY 2016 and beyond. Information for the IPFQR Program begins on page 45961 (direct download, 718 KB): <http://www.gpo.gov/fdsys/pkg/FR-2014-08-06/pdf/2014-18329.pdf>.

The FY 2016 IPF PPS Final Rule was published on August 5, 2015. The rule contained changes to the IPFQR Program applicable for FY 2016 and beyond. Information for the IPFQR Program begins on page 46694 (direct download, 790 KB): <http://www.gpo.gov/fdsys/pkg/FR-2015-08-05/pdf/2015-18903.pdf>.

The FY 2017 IPPS/LTCH Final Rule was published on August 22, 2016. The rule contained changes to the IPFQR Program applicable for FY 2017 and beyond. Information for the IPFQR Program begins on page 56774 (direct download, 3.52 MB): <https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf>.

The FY 2018 IPFS/LTCH PPS Final Rule was published on August 14, 2017. The rule contained changes to the IPFQR Program applicable for FY 2018 and beyond. Information for the IPFQR Program begins on page 38461 (direct download, 7.53 MB): <https://www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf>.

The FY 2019 IPF PPS Final Rule was published on August 6, 2018. The rule contained changes to the IPFQR program applicable for FY 2019 and beyond. Information for the IPFQR Program begins on page 38576 (direct download, 685 KB): <https://www.gpo.gov/fdsys/pkg/FR-2018-08-06/pdf/2018-16518.pdf>.

The FY 2020 IPF PPS Final Rule was published on August 6, 2019. The rule contained changes to the IPFQR Program applicable for FY 2021 and beyond. Information for the IPFQR Program begins on page 38459 (direct download, 6.27 MB): <https://www.govinfo.gov/content/pkg/FR-2019-08-06/pdf/2019-16370.pdf>.

The FY 2021 IPF PPS Final Rule was published on August 4, 2020. The rule confirmed that no changes were made to the IPFQR Program for FY 2022 and beyond. Information for the IPFQR Program is on page 47043 (direct download, 2.96 MB): <https://www.govinfo.gov/content/pkg/FR-2020-08-04/pdf/2020-16990.pdf>.

## **IPFQR Program Requirements**

IPFQR Program requirements are listed below. Click on the hyperlink imbedded within the text to be directed to detailed instructions for each step, as necessary.

1. Complete the [QualityNet Registration](#).
  - This step must be accomplished for each [QualityNet Security Administrator \(SA\)/Security Official \(SO\)](#) and user who will access the [QualityNet Secure Portal](#).
  - Once registered, it is important that the SA(s)/SO(s) and user(s) maintain an active account by periodically logging into the system. CMS recommends that each IPF have at least two SAs/SOs, so one can serve as a backup.
2. Complete the IPFQR Program [Notice of Participation](#) (NOP), indicating participation status.
  - Newly eligible facilities have 180 days from the Medicare accept date to submit a NOP for the IPFQR Program.
  - An IPF NOP status of “Participating” must be on file in the [QualityNet Secure Portal](#) by the annual August 15 deadline to meet the NOP requirement, unless directed otherwise via the IPFQR Program Listserve. Once a participation status is selected, the status automatically carries over year after year.
  - Any eligible IPF that chooses not to participate in the program should contact the IPFQR Program VIQR Outreach and Education Project Lead by emailing [IPFQualityReporting@hsag.com](mailto:IPFQualityReporting@hsag.com).
3. Collect measure and non-measure data during the measure reporting period.
  - Newly participating facilities must start collecting measure and non-measure data at the beginning of the first quarter following submission of the NOP.

- The measure and non-measure reporting period is January 1 through December 31 for all chart-abstracted IPF quality measures, except the Influenza Immunization (IMM-2) measure. See next bullet for more information.
  - For the IMM-2 measure, the reporting period aligns with the influenza season, which is October 1 through March 31 of the following year.
4. Submit measure and non-measure data before the annual data submission deadlines.
- The chart-abstracted IPF quality measures data and non-measure data are due during the annual data submission period, held July 1 through August 15, unless directed otherwise via the IPFQR Program Listserve.  
**NOTE:** The claims-based measures will be calculated by CMS using Medicare fee-for-service (FFS) Parts A and B claims data; therefore, no action is required by IPFs for these measures.
5. Complete the DACA by the annual August 15 submission deadline, unless directed otherwise via the IPFQR Program Listserve.

### **CMS Response to COVID-19**

On April 14, 2020, a communication was delivered via the IPFQR Program Listserve to provide additional information regarding CMS' response to the COVID-19 public health emergency. The Extraordinary Circumstances Exceptions (ECE) policy excepted IPFs from reporting to CMS all chart-abstracted measure and non-measure data collected for discharges that occur January 1, 2020 through June 30, 2020, to be reported during the summer 2021 reporting period for the FY 2022 payment determination. The COVID-19 ECE does not apply to data collected for discharges that occurred in 2019, to be submitted during the summer 2020 data submission period for FY 2021 payment determination. The one exception to this concerns the IMM-2 measure, for which IPFs may elect to only report data for the measure that are collected during the last quarter of 2019 and exclude IMM-2 data that are collected during the period of January 1, 2020–March 31, 2020 (Q1 2020). Also, for claims-based measures, CMS will not include data from discharges that occur from January 1–June 30, 2020 in its calculation of the measure rates. More details about the ECE policy are outlined in the COVID-19 memo found at the following link: <https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf>.



## Section 2: Measure Details

Information for this program manual was developed for use by facilities participating in the CMS IPFQR Program. Measures adopted by CMS for the IPFQR Program are from a variety of sources and, unless otherwise indicated, the specifications are generally the same as those of the original measure steward. **This manual is not intended to provide direction for reporting to The Joint Commission and the National Committee for Quality Assurance (NCQA).**

The measure stewards periodically update the measure specifications. IPFs and vendors must update their documentation and software when applicable, based on the published manuals. In any program manual where the measure specifications are under other ownership, the IPFQR Program strives to provide sufficient information pertaining to the applicable reporting year. Changes made to measure specifications that affect measure collection and reporting for the IPFQR Program are published twice each year. This enables CMS to coordinate changes in IPFQR Program reporting with changes in reporting of identical measures to other entities, such as The Joint Commission.

When abstracting data, it is important for IPFs and vendors to use the specifications applicable to the time period for which the data are being abstracted. For example, for IPFQR Program reporting applicable to the FY 2022 annual payment update, the data collected are for CY 2020 for most measures. This requires the facility to reference the appropriate version of the [Specifications Manual for Joint Commission National Quality Measures](#) that applies to the data collection time period. Refer to the following table to access detailed measure specifications for current IPFQR Program measures.

**Table 1: Specification Resources for IPFQR Program Measures**

Specifications Resource as Defined by the Measure Steward	IPFQR Program Measures
<a href="#">Specifications Manual for Joint Commission National Quality Measures</a>	HBIPS-2, -3, -5, TOB, SUB, and IMM-2 measure sets
<a href="#">Care Transitions - Performance Measurement Set</a> (American Medical Association [AMA]-convened Physician Consortium for Performance Improvement® [PCPI])	Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record
<a href="#">IPFQR Program Claims-Based Measure Specifications</a>	Follow-Up After Hospitalization (FUH) for Mental Illness, 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF, and Medication Continuation Following Inpatient Psychiatric Discharge
<a href="#">IPFQR Program Manual - Appendix B</a>	Screening for Metabolic Disorders Measure

To compare content in this version of the IPFQR Program Manual to the previous version, review the Release Notes document associated with this version of the manual at the following websites:

- [QualityNet](#) > Inpatient Psychiatric Facilities > Resources > [IPFQR Program Manuals](#)
- [Quality Reporting Center](#) > Inpatient > IPFQR Program > [Resources and Tools](#)

## **General Measure Abstraction Guidance**

CMS requires the submission of aggregate numerator and denominator data. There are no patient-level data reported to CMS for the IPFQR Program. The intent of abstraction is to use only documentation that was part of the medical record during the hospitalization (i.e., is present upon discharge) and that is present at the time of abstraction. The medical record must be abstracted as documented (i.e., taken at “face value”). Information should not be added after the fact and assumptions should not be made to meet a measure.

Documentation is not to be added at the time of abstraction to ensure the passing of measures for the IPFQR Program.

If documentation is invalid, missing, or ambiguous with respect to the measure specifications, then the measure requirement in question has not been met. A third-party auditor or abstractor should be able to review documentation in the patient record and reach the same determination as the original abstractor.

## **Measure Removal and Retention Criteria**

CMS believes it is important to be transparent in identifying factors taken into consideration during the evaluation of measures for the IPFQR Program. In the FY 2018 IPPS/LTCH PPS Final Rule, CMS aligned the IPFQR Program criteria with the Hospital Inpatient Quality Reporting (IQR) Program regarding (1) measure removal factors; (2) criteria for determining when a measure is “topped out;” and (3) measure retention factors. In the FY 2019 IPF PPS Final Rule, CMS added measure removal Factor 8 to the IPFQR Program.

The following are the measure removal factors for the IPFQR Program:

1. Measure performance among IPFs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (i.e., topped-out measures).
2. The measure does not align with current clinical guidelines or practice.
3. The measure can be replaced by a more broadly applicable measure (across settings or populations) or a measure that is more proximal in time to desired patient outcomes for the topic.
4. Measure performance or improvement does not result in better patient outcomes.
5. The measure can be replaced by a measure that is more strongly associated with desired patient outcomes for the topic.
6. Measure collection or public reporting leads to negative unintended consequences other than patient harm.
7. The measure is not feasible to implement as specified.
8. The costs associated with a measure outweigh the benefit of its continued use in the program.

The criteria for determining that a measure is topped out are aligned with the Hospital IQR Program’s criteria (80 FR 49642), which states that a measure is topped out if there is statistically indistinguishable performance at the 75th and 90th percentiles and the truncated coefficient of variation is less than or equal to 0.10.

Furthermore, we recognize that there may be times when measures may meet some of the outlined factors for removal but continue to bring value to the program. The following factors for consideration are used to determine whether to retain a measure in the IPFQR Program, which also are based on factors established in the Hospital IQR Program (80 FR 49641 through 49642):

- The measure aligns with other CMS and HHS policy goals.
- The measure aligns with other CMS programs, including other quality reporting programs.
- The measure supports efforts to move IPFs towards reporting electronic measures.

CMS will consider these removal and retention factors when examining the benefits and drawbacks of removing measures on a case-by-case basis, but these factors do not necessarily preclude the use of other considerations in making such determinations. All factors considered in a proposal to remove a measure would be described in rulemaking.

## **Inpatient Psychiatric Facility Quality Measures**

### ***FY 2022 and Subsequent Years***

The following table lists all IPFQR Program measures for FY 2022 and subsequent years.

**Table 2: IPFQR Program Measures for FY 2022 and Subsequent Years**

<b>Measure ID</b>	<b>Measure Description</b>
HBIPS-2	Hours of Physical Restraint Use
HBIPS-3	Hours of Seclusion Use
HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
SUB-2/-2a	Alcohol Use Brief Intervention Provided or Offered and the subset Alcohol Use Brief Intervention
SUB-3/-3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and the subset measure Alcohol and Other Drug Use Disorder Treatment at Discharge
TOB-2/-2a	Tobacco Use Treatment Provided or Offered and the subset Tobacco Use Treatment
TOB-3/-3a	Tobacco Use Treatment Provided or Offered at Discharge and the subset Tobacco Use Treatment at Discharge
Transition Record with Specified Elements Received by Discharged Patients	Transition Record with Specified Elements Received by Discharged Patients
Timely Transmission of Transition Record	Timely Transmission of Transition Record
Screening for Metabolic Disorders	Screening for Metabolic Disorders
IMM-2	Influenza Immunization
FUH	Follow-Up After Hospitalization for Mental Illness
N/A	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)
N/A	Medication Continuation Following Inpatient Psychiatric Discharge

## **Identifying the IPFQR Program Patient Population**

The initial selection of cases (i.e., patient medical records) intended for data abstraction under the IPFQR Program must be all patients (i.e., Medicare and non-Medicare patients) receiving care in a psychiatric hospital or certified psychiatric unit paid under IPF PPS.

### **Identifying the Initial Patient Population**

For details regarding the Initial Patient Population (IPP), please refer to each measure's specifications:

- HBIPS, SUB, TOB, and IMM measure IPP details are found in the [Specifications Manual for Joint Commission National Quality Measures](#).
- Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record measures (collectively referred to as Transition Record measures) will use the entire population (all IPF discharges) for the IPP.
  - A list of codes for denominator inclusions (eligible population) and denominator exclusions can be found in the Technical Specifications: Administrative Data section of the [Care Transitions - Performance Measurement Set](#) document on pages 27–30.
  - These codes can be used to facilitate integration of the transition record measures into the EHR used by IPFs. As noted in the specifications on page 27, “Facilities are responsible for determining the appropriate use of codes.”
- Screening for Metabolic Disorders measure IPP is the denominator.

## **Sampling**

IPFs are *not* required to sample. IPFs submit data for either a complete population of cases or a random sample for each of the measure sets covered by the quality measures. Per the FY 2016 IPF PPS Final Rule, IPFs are no longer required to report measure data by quarter and age strata. If the IPP size does not exceed the minimum number of cases per year for the measure set, the facility must submit 100% of the IPP.

**NOTE:** Sampling is not allowed for the HBIPS-2 and HBIPS-3 measures.

### ***FY 2022 Payment Determination and Subsequent Years***

Data collected pertaining to IPF discharges during CY 2020 (except IMM-2 data which is collected October 2020 through March 2021) will be reported to CMS in 2021 and impact FY 2022 payment determination, unless directed otherwise via the IPFQR Program Listserve. IPFs will have two options for sampling measure data. Either sampling option may be used only after a measure's IPP is determined.

- Option 1:** IPFs may choose to continue referencing the sampling guidelines described in Section 5: Population and Sampling Specifications of the [Specifications Manual for Joint Commission National Quality Measures](#) for the HBIPS-5, SUB, TOB, IMM-2, Transition Record, and the Screening for Metabolic Disorders measures. **NOTE:** The sampling guidelines in the *Specifications Manual for Joint Commission National Quality Measures* can be applied to the Transition Record measures and Screening for Metabolic Disorders measures even though those measures are not listed in that manual.

**Option 2:** IPFs may choose to use the sampling guidelines described in the table below. This option was adopted in the FY 2016 IPF PPS Final Rule and went into effect for the FY 2018 payment determination year. The guidelines listed below in Table 3: IPFQR Program Measures Global Population and Sampling (FY 2016 IPF PPS Final Rule) can be applied to the following measures: HBIPS-5, SUB, TOB, IMM-2, Transition Record, and the Screening for Metabolic Disorders.

**Table 3: IPFQR Program Measures Global Population and Sampling (FY 2016 IPF PPS Final Rule)**

Total Number of Annual Discharges	Number of Records to be Sampled
≥ 6,117	1,224
3,057–6,116	20% of initial patient population
609–3,056	609
0–608	All cases

## **Chart Abstraction**

The facility may elect to use a vendor to electronically enter its data and obtain the aggregate data to manually enter in the CMS web-based measure tool via the *QualityNet Secure Portal*. The facility may authorize the vendor to enter the data on its behalf; however, the facility is responsible for the data. For facilities that do not have a vendor tool, a paper-based data collection tool is available for manual collection of the data elements for each case. The tool is arranged to follow the measure process flow, or algorithm, to assist in determining whether the case is included or excluded for the measure population and determining the measure outcome. The facility must also have access to the data definitions from the associated specifications manual to ensure the collection of valid and reliable data. Refer to [Section 9: Resources – Paper Tools](#) in this manual for more information about the paper-based measure abstraction and data collection tools.

### ***Chart-Based Measures: HBIPS-2, -3, and -5***

The HBIPS measure set was developed by The Joint Commission as part of a group of global measure sets. Although CMS is collecting the aggregate numerators and denominators for each HBIPS measure, it is necessary to collect the patient-level data for each measure as defined in the applicable specifications manual. The data dictionary provides important details about each of the data elements needed to determine the numerators and denominators of each measure.

#### **HBIPS-2: Hours of Physical Restraint Use**

The use of physical restraints increases a patient’s risk of physical and psychological harm. This intervention is intended for use only if a patient is in imminent danger to him/herself or others and if less restrictive interventions have failed. It is not intended to address staff shortages or to be used as a form of discipline or coercion. This measure evaluates the total number of hours that all patients admitted to the IPF were maintained in physical restraints.

The **numerator** is defined as the total number of hours that all psychiatric inpatients were maintained in physical restraint. The **denominator** is defined as the number of psychiatric inpatient hours overall. The denominator is calculated by subtracting the total number of leave days from the total number of inpatient days and multiplying the result by 24 to convert to hours.

However, when reporting data to CMS, IPFs should provide the denominator value for the HBIPS-2 measure in days. CMS will convert the data from days to hours prior to calculating the HBIPS-2 measure rate.

### **HBIPS-3: Hours of Seclusion Use**

The use of seclusion increases a patient's risk of physical and psychological harm. This intervention is intended for use only if a patient is in imminent danger to him/herself or others and if less restrictive interventions have failed. It is not intended to address staff shortages or to be used as a form of discipline or coercion. This measure is reported as the total number of hours of seclusion use for all patients admitted to an IPF.

The **numerator** is defined as the total number of hours all psychiatric inpatients were held in seclusion. The **denominator** is defined as the number of psychiatric inpatient hours overall. The denominator is calculated by subtracting the total number of leave days from the total number of inpatient days and multiplying the result by 24 to convert to hours. However, when reporting data to CMS, IPFs should provide the denominator value for the HBIPS-3 measure in days. CMS will convert the data from days to hours prior to calculating the HBIPS-3 measure rate.

### **HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification**

This measure's data are collected from those patients discharged on multiple antipsychotics and are reported as the rate of patients discharged on multiple antipsychotics with appropriate justification. The Joint Commission has identified the following justifications as appropriate reasons for discharging a patient on multiple antipsychotics:

- The medical record contains a documented minimum of three failed trials with monotherapy.
- The medical record contains documentation of either a plan that tapers to monotherapy or one that decreases the dosage of one or more antipsychotic medications while increasing the dosage of another to a level that manages the patient's symptoms with one antipsychotic medication (i.e., cross-tapering).
- The medical record contains documentation of augmentation of Clozapine.

Higher rates on HBIPS-5 indicate higher quality of care because documenting the reasons for assigning two or more antipsychotics suggests that careful consideration of the benefits of this course of treatment were weighed against the potential patient side effects.

The **numerator** statement is defined as psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification. The **denominator** is defined as psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications, with or without justification. The measure excludes patients who died, patients with an unplanned departure resulting in discharge due to elopement, patients with an unplanned departure resulting in discharge due to failing to return from leave, and patients with a length of stay (LOS) less than or equal to three days.

For detailed HBIPS measure information, including specific data element definitions, please refer to the [Specifications Manual for Joint Commission National Quality Measures](#). The measure information is contained in Section 1 – Measure Information Forms. The HBIPS data elements are located in Section 3 – Introduction to the Data Dictionary within the Alphabetical List of Data Elements.

### ***Chart-Based Measures: SUB, TOB, IMM-2, Transition Record, and Screening for Metabolic Disorders Measures***

As with the HBIPS measures, it is necessary to collect patient-level data, as defined in the applicable specifications manual. Facilities are required to submit aggregate data (one numerator and one denominator) for the entire reporting period.

#### **SUB-2: Alcohol Use Brief Intervention Provided or Offered and the subset SUB-2a: Alcohol Use Brief Intervention**

Clinical trials have demonstrated that brief interventions, especially prior to the onset of addiction, significantly improve health and reduce costs, and that similar benefits occur in those with addictive disorders who are referred to treatment.

The SUB-2 **numerator** is defined as the number of patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The SUB-2a **numerator** is defined as the number of patients who received a brief intervention. The **denominator** for both measures is the number of patients 18 years of age and older who screen positive for unhealthy alcohol use or an alcohol use disorder (alcohol abuse or alcohol dependence). The measure excludes patients who are less than 18 years of age, are cognitively impaired, patients who refused or were not screened for alcohol use during the hospital stay or have Comfort Measures Only documented. Exclusions based on LOS are determined using the current *Specifications Manual*.

#### **SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and the subset SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge**

Currently, less than one in 20 patients with an addiction are referred for treatment. Hospitalization provides a prime opportunity to address the entire spectrum of substance use problems within the health care system. Approximately 8% of general hospital inpatients and 40–60% of traumatically-injured inpatients and psychiatric inpatients have substance use disorders.

The SUB-3 **numerator** is defined as the number of patients who received or refused at discharge a prescription for medication for treatment of alcohol or drug use disorder OR received or refused a referral for addictions treatment. The SUB-3a **numerator** is defined as the number of patients who received a prescription at discharge for medication for treatment of alcohol or drug use disorder OR a referral for addictions treatment. The **denominator** for both measures is the number of hospitalized inpatients 18 years of age and older identified with an alcohol or drug use disorder. The measure excludes patients who are less than 18 years of age, are cognitively impaired, do not meet criteria for an alcohol use disorder, have Comfort Measures Only documented, or do not reside in the United States. Exclusions based on LOS are determined using the current *Specifications Manual*.

For SUB measure information, please refer to Substance Use Measures (SUB) in Section 1: Measure Information Forms of the [Specifications Manual for Joint Commission National Quality Measures](#).

### **TOB-2: Tobacco Use Treatment Provided or Offered and the subset TOB-2a: Tobacco Use Treatment**

The Tobacco Use Treatment Provided or Offered (TOB-2) chart-abstracted measure is reported as an overall rate that includes all patients to whom tobacco use treatment was provided or offered and refused. A second rate, Tobacco Use Treatment (TOB-2a), a subset of the first, includes only those patients who received tobacco use treatment.

The overall rate, TOB-2, assesses patients identified as tobacco product users who receive or refuse practical counseling to quit and receive or refuse Food and Drug Administration (FDA)-approved cessation medications. The **numerator** includes the number of patients who received or refused practical counseling to quit and received or refused FDA-approved cessation medications or had a reason for not receiving the medication.

The second rate, TOB-2a, assesses patients who received counseling and medication, as well as those who received counseling and had a reason for not receiving the medication. The **numerator** includes the number of patients who received practical counseling to quit and received FDA-approved cessation medications or had a reason for not receiving the medication.

The **denominator** for the TOB-2 measure includes the number of hospitalized patients 18 years of age and older identified as current tobacco users. The TOB-2a denominator is the same as that of the TOB-2 measure but excludes those not screened for tobacco use within the first day of admission (by the end of Day 1) or unable to determine the patient's tobacco use status from medical record documentation. Both measures exclude patients who are less than 18 years of age, are cognitively impaired, are not current tobacco users, refused or were not screened for tobacco use during the hospital stay or have Comfort Measures Only documented. Exclusions based on LOS are determined using the current *Specifications Manual*.

### **TOB-3: Tobacco Use Treatment Provided or Offered at Discharge and the subset TOB-3a: Tobacco Use Treatment at Discharge**

The overall rate, TOB-3, assesses patients identified as tobacco product users who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication upon discharge. The **numerator** includes patients who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge.

The second rate, TOB-3a, assesses patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication upon discharge as well as those who were referred to outpatient counseling and had a reason for not receiving a prescription for medication. The **numerator** includes patients who were referred to evidence-



based outpatient counseling AND received a prescription for FDA-approved cessation medication at discharge.

The **denominator** for both TOB-3 and TOB-3a includes the number of hospitalized patients 18 years of age and older identified as current tobacco users. The measure excludes patients who are less than 18 years of age, are cognitively impaired, are not current tobacco users, refused or were not screened for tobacco use during the hospital stay, have Comfort Measures Only documented, patients who expired, patients who left against medical advice, patients discharged to another hospital, patients discharged to another health care facility, patients discharged to home for hospice care, or patients who do not reside in the United States. Exclusions based on LOS are determined using the current *Specifications Manual*.

For TOB measure information, please refer to Tobacco Treatment Measures (TOB) in Section 1: Measure Information Forms of the [Specifications Manual for Joint Commission National Quality Measures](#).

### **IMM-2: Influenza Immunization**

Increasing influenza (flu) vaccination can reduce unnecessary hospitalizations and secondary complications, particularly among high risk populations such as the elderly. Each year, approximately 226,000 people in the U.S. are hospitalized with complications from influenza, and between 3,000 and 49,000 die from the disease and its complications. Vaccination is the most effective method for preventing influenza virus infection and its potentially severe complications, and vaccination is associated with reductions in influenza among all age groups.

This prevention measure addresses hospitalized inpatients age 6 months and older who were screened for seasonal influenza immunization status and were vaccinated prior to discharge if indicated. The **numerator** captures two activities: screening and the intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to the vaccine, patients who were offered and declined the vaccine, and patients who received the vaccine during the current year's influenza season (but prior to the current hospitalization) are captured as numerator events. The **denominator** is the number of inpatients age 6 months and older discharged during October, November, December, January, February, or March.

For IMM-2 measure information, including a list of exclusions, please refer to Immunization (IMM) in Section 1: Measure Information Forms of the [Specifications Manual for Joint Commission National Quality Measures](#).

### **Transition Record with Specified Elements Received by Discharged Patients**

Providing detailed discharge information enhances the preparation of patients to self-manage post-discharge care and comply with treatment plans. Additionally, randomized trials have shown that many hospital readmissions can be prevented by patient education, pre-discharge assessment, and domiciliary aftercare. One recent study found that patients participating in a hospital program providing detailed, personalized instructions at discharge, including a review of medication routines and assistance with arranging follow-up appointments, had 30% fewer subsequent emergency visits and hospital readmissions than patients who received usual care at discharge.

The Transition Record with Specified Elements Received by Discharged Patients measure assesses the percentage of patients, regardless of age, discharged from an IPF to home or any other site of

care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements. If a patient is transferred to another inpatient facility and the discharging clinician documents in the patient record that the patient is clinically unstable, or the patient and/or caregiver is unable to comprehend the information at discharge, then the discharging facility is **not** required to discuss and provide the transition record to the patient and/or caregiver; however, all four of the following elements must be discussed with the receiving facility to be included in the numerator for the Transition Record with Specified Elements Received by Discharged Patients measure:

- 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

The **numerator** is comprised of patients or their caregiver(s) (or inpatient facilities in the case of patient transfer) 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 the following elements:

- **Inpatient Care**
  - Reason for inpatient admission, AND
  - Major procedures and tests performed during inpatient stay and summary of results, AND
  - Principal diagnosis at discharge
- **Post-Discharge/ Patient Self-Management**
  - Current medication list, AND
  - Studies pending at discharge (e.g., laboratory, radiological), AND
  - Patient instructions
- **Advance Care Plan**
  - Advance directives or surrogate decision maker documented OR documented reason for not providing advance care plan
- **Contact Information/Plan for Follow-up Care**
  - 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

All eleven elements must be captured in the transition record to satisfy the measure numerator.

The **denominator** includes all patients, regardless of age, discharged from the inpatient facility to home/self-care or any other site of care. The measure excludes patients who died or left against medical advice (AMA) or discontinued care.

### **Timely Transmission of Transition Record**

The availability of the patient's discharge information at the first post-discharge physician visit improves the continuity of care and may be associated with a decreased risk of re-hospitalization.

The measure assesses the percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, rehabilitation facility) to home or any other site of care 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.

The **numerator** includes patients for whom the transition record, as specified in the Transition Record with Specified Elements Received by Discharged Patients measure, was transmitted to the facility (including inpatient facilities) or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. All 11 elements must be captured and transmitted within 24 hours to satisfy the measure numerator.

The case must meet the numerator of the Transition Record with Specified Elements Received by Discharged Patients measure to be included in the numerator of the Timely Transmission of Transition Record measure. Therefore, the numerator for the Timely Transmission of Transition Record measure cannot exceed the numerator for the Transition Record with Specified Elements Received by Discharged Patients measure.

The **denominator** includes all patients, regardless of age, discharged from an IPF to home/self-care or any other site of care. The measure excludes patients who died or left against medical advice (AMA) or discontinued care.

Please refer to the definitions provided in the [Glossary of Terms](#) section of this manual for additional guidance pertaining to the required elements for the Transition Record measures. For measure information, please refer to the measure specifications for the Transition Record of Specified Elements Received by Discharged Patients (NQF #0647) and Timely Transmission of Transition Record (NQF #0648) measures, which can be downloaded from the PCPI® website: <https://www.thepcpi.org/page/PCPIMeasures>.

### Screening for Metabolic Disorders

Studies show that antipsychotics increase the risk of metabolic syndrome.<sup>1</sup> Metabolic syndrome is a cluster of conditions that occur together, including excess body fat around the waist, high blood sugar, high cholesterol, and high blood pressure, all of which increase the risk of coronary artery disease, stroke, and type 2 diabetes.

In 2004, a consensus statement was released by the American Diabetes Association (ADA), the American Psychiatric Association (APA), the American Association of Clinical Endocrinologists (AACE), and the North American Association for the Study of Obesity (NAASO) regarding an association between the use of specific second generation antipsychotics (SGAs) and diabetes and obesity.<sup>1</sup>

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<sup>1</sup> The American Diabetes Association, American Psychological Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. *Diabetes Care*. 2004;27(596–601).

This group 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.

The Screening for Metabolic Disorders measure was developed to assess the percentage of patients discharged with at least one antipsychotic from an IPF for which a structured metabolic screening for four elements was completed in the past year.

The **numerator** is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) blood glucose or HbA1c; and (4) a lipid panel. The screening 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 at another facility for which records are available to the reporting facility.

The **denominator** includes IPF patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period. The measure excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical condition or enduring unstable psychological condition and patients with a LOS equal to or greater than 365 days or equal to or less than three days.

Additional details about the Screening for Metabolic Disorders measure, including a data dictionary and algorithm, are in [Appendix B](#) of this program manual.

## **Claims-Based Measures**

Claims-based measures are calculated by CMS. There are three such measures in the IPFQR Program. Calculation of these measures does not affect an IPF's payment determination.

### ***Claims-Based Measure: Follow-Up After Hospitalization for Mental Illness (FUH)***

This measure assesses the percentage of IPF hospitalizations for treatment of select mental health disorders that were followed by an outpatient mental health care encounter. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 7 days of discharge
- The percentage of discharges for which the patient received follow-up within 30 days of discharge

The reporting period used to identify cases in the denominator is 12 months. The reporting period begins on July 1 and ends on June 30 of the following year. Data from July 1 through July 30 of the following year are used to identify follow-up visits in the numerator.

CMS will calculate the measure using Part A and Part B claims data received by Medicare for payment purposes. CMS will calculate this measure by linking Medicare FFS claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges. This approach requires no additional data collection or reporting by IPFs.

### ***Claims-Based Measure: 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)***

This measure estimates an unplanned, 30-day, risk-standardized readmission rate for adult Medicare FFS patients with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. This measure reflects the quality of care provided to patients at IPFs by providing a reliable comparison between an individual IPF risk-standardized readmission rate and a national readmission rate.

The reporting period used to identify index admissions is 24 months. The reporting period begins on July 1 and ends on June 30 two years later. Data from July 1 through July 30 two years later are used to identify readmissions.

CMS will calculate the measure using Part A and Part B claims data received by Medicare for payment purposes. Part A data are used to identify index admissions, readmissions, and some risk factors. Part B data are used to identify additional risk factors. This approach requires no additional data collection or reporting by IPFs.

### ***Claims-Based Measure: Medication Continuation Following Inpatient Psychiatric Discharge***

This measure assesses whether adult Medicare FFS patients covered under Medicare Part D who were admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication during the follow-up period (within 2 days prior to discharge and 30 days post-discharge).

The reporting period for the measure is 24 months. The reporting period begins on July 1 and ends on June 30 two years later.

CMS will calculate the measure using Medicare FFS Part A, B, and D data, linking Medicare FFS claims submitted by IPFs with medication claims within 2 days prior to discharge and 30 days post discharge. Patients must be enrolled in Medicare FFS Part A and Part B during the index admission and Parts A, B, and D at least 30 days post-discharge to be included in the denominator. This approach requires no additional data collection or reporting by IPFs.

Refer to [Section 9: Resources - Claims-Based Measure Specifications](#) of this program manual for information on finding a claims-based measure specifications document on the [QualityNet](#) and [Quality Reporting Center](#) websites.

## **Data Submission**

The following tables list information pertinent to data submission for the FY 2022 and FY 2023 payment determinations.

**Table 4: IPFQR Program Measures for FY 2022 Payment Determination**

<b>Measure<sup>3</sup></b>	<b>Reporting Period</b>	<b>Submission Period<sup>4</sup></b>	<b>Measure Type</b>	<b>Sampling Allowed</b>
HBIPS-2: Hours of Physical Restraint Use	January 1– December 31, 2020	July 1– August 16, 2021	Chart- Abstracted	No
HBIPS-3: Hours of Seclusion Use	January 1– December 31, 2020	July 1– August 16, 2021	Chart- Abstracted	No
HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	January 1– December 31, 2020	July 1– August 16, 2021	Chart- Abstracted	Yes
Transition Record with Specified Elements Received by Discharged Patients	January 1– December 31, 2020	July 1– August 16, 2021	Chart- Abstracted	Yes
Timely Transmission of Transition Record	January 1– December 31, 2020	July 1– August 16, 2021	Chart- Abstracted	Yes
Screening for Metabolic Disorders	January 1– December 31, 2020	July 1– August 16, 2021	Chart- Abstracted	Yes
SUB-2: Alcohol Use Brief Intervention Provided or Offered and SUB-2a: Alcohol Use Brief Intervention	January 1– December 31, 2020	July 1– August 16, 2021	Chart- Abstracted	Yes

Measure <sup>3</sup>	Reporting Period	Submission Period <sup>4</sup>	Measure Type	Sampling Allowed
SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge) and SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge	January 1–December 31, 2020	July 1–August 16, 2021	Chart-Abstracted	Yes
TOB-2: Tobacco Use Treatment Provided or Offered and TOB-2a Tobacco Use Treatment	January 1–December 31, 2020	July 1–August 16, 2021	Chart-Abstracted	Yes
TOB-3: Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a: Tobacco Use Treatment at Discharge	January 1–December 31, 2020	July 1–August 16, 2021	Chart-Abstracted	Yes
IMM-2: Influenza Immunization <sup>5</sup>	October 1, 2020–March 31, 2021	July 1–August 16, 2021	Chart-Abstracted	Yes
FUH: Follow-Up After Hospitalization for Mental Illness	July 1, 2019–June 30, 2020	Calculated by CMS	Claims-Based	N/A
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF	July 1, 2018–June 30, 2020	Calculated by CMS	Claims-Based	N/A
Medication Continuation Following Inpatient Psychiatric Discharge	July 1, 2018–June 30, 2020	Calculated by CMS	Claims-Based	N/A

<sup>1</sup> Q1 and Q2 2020 data for all chart-abstracted and claims-based measures are excepted per the ECE policy outlined in the COVID-19 memo (<https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf>).

<sup>2</sup> The original submission period deadline of August 15, 2021, will be extended to August 17, 2021, due to August 15, 2021, falling on a weekend.

<sup>3</sup> The IMM-2 measure is the only chart-abstracted measure in which the reporting period crosses over two calendar years, from October 1, 2020, through March 31, 2021, for the FY 2022 payment determination.

**Table 5: IPFQR Program Measures for FY 2023 Payment Determination**

Measure <sup>4</sup>	Reporting Period	Submission Period <sup>4</sup>	Measure Type	Sampling Allowed
HBIPS-2: Hours of Physical Restraint Use	January 1–December 31, 2021	July 1–August 15, 2022	Chart-Abstracted	No
HBIPS-3: Hours of Seclusion Use	January 1–December 31, 2021	July 1–August 15, 2022	Chart-Abstracted	No

<b>Measure<sup>4</sup></b>	<b>Reporting Period</b>	<b>Submission Period<sup>4</sup></b>	<b>Measure Type</b>	<b>Sampling Allowed</b>
HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	January 1–December 31, 2021	July 1–August 15, 2022	Chart-Abstracted	Yes
Transition Record with Specified Elements Received by Discharged Patients	January 1–December 31, 2021	July 1–August 15, 2022	Chart-Abstracted	Yes
Timely Transmission of Transition Record	January 1–December 31, 2021	July 1–August 15, 2022	Chart-Abstracted	Yes
Screening for Metabolic Disorders	January 1–December 31, 2021	July 1–August 15, 2022	Chart-Abstracted	Yes
SUB-2: Alcohol Use Brief Intervention Provided or Offered and SUB-2a: Alcohol Use Brief Intervention	January 1–December 31, 2021	July 1–August 15, 2022	Chart-Abstracted	Yes
SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge) and SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge	January 1–December 31, 2021	July 1–August 15, 2022	Chart-Abstracted	Yes
TOB-2: Tobacco Use Treatment Provided or Offered and TOB-2a Tobacco Use Treatment	January 1–December 31, 2021	July 1–August 15, 2022	Chart-Abstracted	Yes
TOB-3: Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a: Tobacco Use Treatment at Discharge	January 1–December 31, 2021	July 1–August 15, 2022	Chart-Abstracted	Yes
IMM-2: Influenza Immunization <sup>5</sup>	October 1, 2021–March 31, 2022	July 1–August 15, 2022	Chart-Abstracted	Yes
FUH: Follow-Up After Hospitalization for Mental Illness	July 1, 2019–June 30, 2020	Calculated by CMS	Claims-Based	N/A
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF	July 1, 2018–June 30, 2020	Calculated by CMS	Claims-Based	N/A
Medication Continuation Following Inpatient Psychiatric Discharge	July 1, 2018–June 30, 2020	Calculated by CMS	Claims-Based	N/A

<sup>4</sup> The IMM-2 measure is the only chart-abstracted measure in which the reporting period crosses over two calendar years, from October 1, 2021, through March 31, 2022, for the FY 2023 payment determination.



## ***Submission of Non-Measure Data/Population Counts***

Beginning with the FY 2017 payment determination and subsequent years, CMS requires non-measure data as an aggregate, yearly count. It is vital for IPFs to accurately determine and submit general population data for CMS to assess data reporting completeness for their total population, both Medicare and non-Medicare. This information is expected to improve the ability of CMS to interpret measure results and assess the relevance and impact of potential future measures. Understanding that the size of subgroups of patients addressed by a particular measure varies over time could be helpful in assessing the stability of reported measure values and in subsequent decision-making concerning measure retention. Similarly, better understanding of the size of particular subgroups in the overall population will assist CMS in making choices among potential future measures specific to a particular subgroup (e.g., patients with depression).

IPFs are to acknowledge whether they used the global sampling methodology ([described on page 17 of this program manual](#)) to sample any of the applicable measures collected for submission in 2020. Per the FY 2019 IPF PPS Final Rule, IPFs are no longer required to submit an annual sample size count in the Non-Measure Data/Population Counts data entry page.

Refer to [Section 9: Resources – Paper Tools](#) of this program manual to find links to an optional non-measure data collection paper tool and other helpful resources on the [QualityNet](#) and [Quality Reporting Center](#) websites.

### ***Submission Information***

IPFs submit measure and non-measure data via the Simple Data Entry (SDE) tool located in the *QualityNet Secure Portal*. IPFs will also complete and submit the DACA form but in a separate location in the *QualityNet Secure Portal*. This is the only CMS-approved method for IPFQR Program data submission. CMS highly recommends that all IPFs ensure that at least two people with knowledge of the data verify the accuracy of the data entered in the *QualityNet Secure Portal*, even if data entry is done by a vendor.

**NOTE:** The claims-based measures, calculated by CMS, are not submitted via the SDE tool (FUH, the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF, and Medication Continuation Following Inpatient Psychiatric Discharge measures).

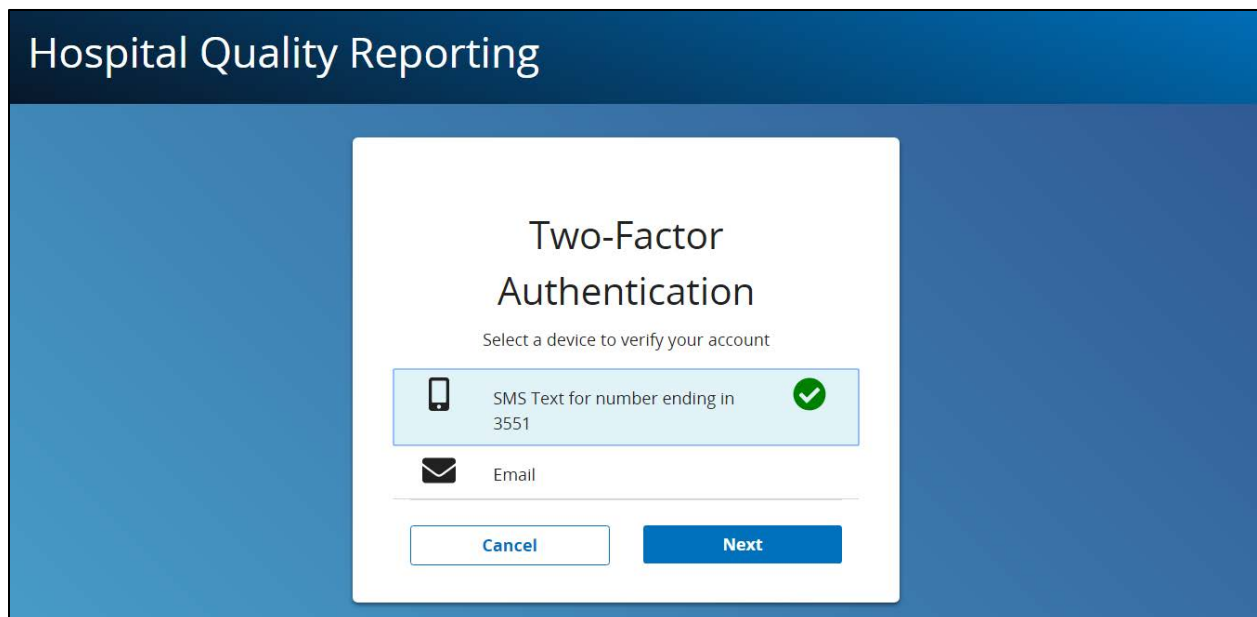
To begin the data submission process:

1. Access and log into the *QualityNet Secure Portal*.
  - a. Go to <https://hqr.cms.gov/hqrng/login>.
  - b. Enter your Healthcare Quality Information System (HCQIS) Access, Roles, and Profile (HARP) user ID and password and click “Login.”
    - i. If you do not have a HARP account, sign into Hospital Quality Reporting and follow instructions to create one.



The screenshot shows the 'Hospital Quality Reporting' header at the top. Below it is a white box titled 'HARP Sign In' with the instruction 'Enter your user ID and password to login.' A yellow warning box contains a triangle icon and the text: 'If you do NOT have a HARP account please sign in to the Hospital Quality Reporting on <https://www.qualitynet.org> to create one.' Below the warning are two input fields labeled 'User ID' and 'Password', and a 'Login' button at the bottom.

- c. Select either email or SMS text number for two-factor authentication to be sent to and click “Next.”



The screenshot shows the 'Hospital Quality Reporting' header at the top. Below it is a white box titled 'Two-Factor Authentication' with the instruction 'Select a device to verify your account'. There are two options: 'SMS Text for number ending in 3551' with a green checkmark icon, and 'Email' with an envelope icon. At the bottom are 'Cancel' and 'Next' buttons.

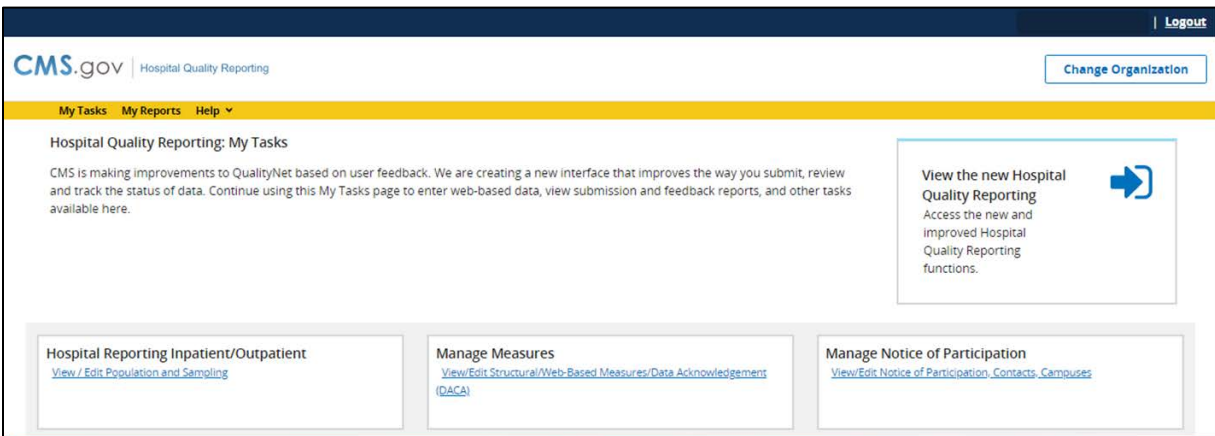
- d. Enter the code received and click “Continue.”

The screenshot shows a web interface for 'Hospital Quality Reporting'. The main heading is 'Two-Factor Authentication'. Below the heading, it states: 'For your security, we need to authenticate your request. We've sent a verification code via: **SMS Text** Please enter it below.' There is a text input field labeled 'Enter Code' containing the number '740477'. Below the input field is a blue button labeled 'Continue'. At the bottom of the form, there are two links: 'Resend Code' and 'Change two factor authentication'.

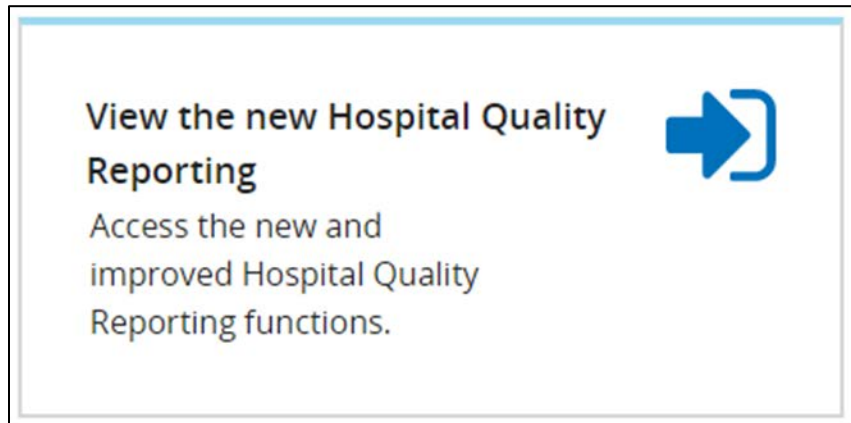
- e. Read the Terms & Conditions and click on “Accept.”

The screenshot shows a web interface for 'Hospital Quality Reporting'. The main heading is 'Terms & Conditions'. Below the heading, there is a scrollable text area containing the following text: 'time, and for any lawful Government purpose, the government may monitor, intercept, and search and seize any communication or data transiting or stored on this system. Any communication or data transiting or stored on this system may be disclosed or used for any lawful Government purpose.' Below the text area, there is a checkbox labeled 'I accept the above Terms and Conditions'. At the bottom of the form, there are two buttons: 'Cancel' and 'Accept'.

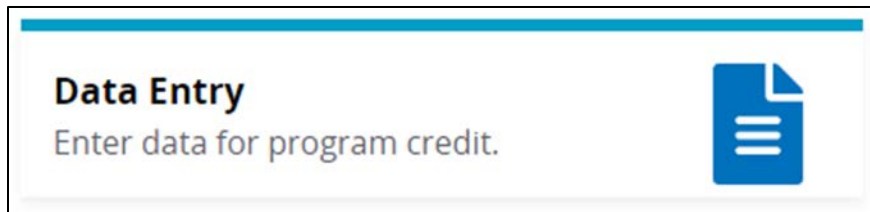
Once logged in, you will be taken to the “Hospital Quality Reporting: My Tasks” page



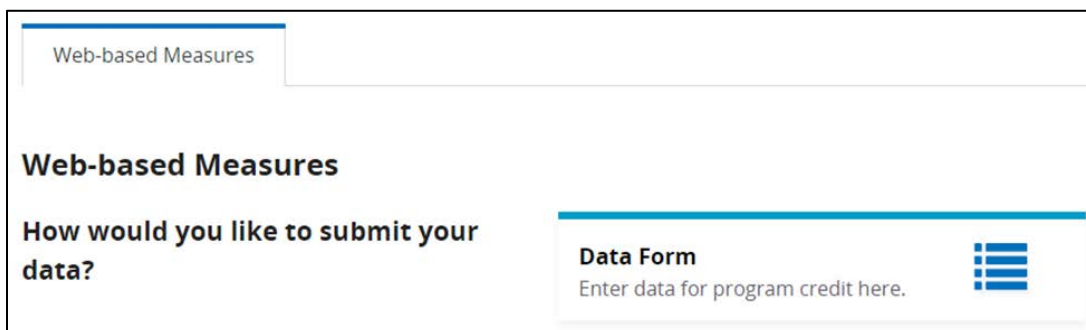
2. Click on the “View the new Hospital Quality Reporting” box on the upper right side of the page.



3. Select the “Data Entry” button.




4. Click the “Data Form” button.



5. Under the “Select the Data Form” sub-header, select “IPF” and click “Launch Data Form.”


## Select the Data Form

IPF


Launch Data Form 






- a. If you are a representative from an IPF, proceed to step 6.
- b. If you are a vendor submitting data on behalf of an IPF(s), you will be directed to a page with an alert instructing you to click the “Change Organization” button to select the IPF for which you will submit data. You will be able to submit data for one IPF at a time.

**Change Organization**



### Select a Provider

Search   Status

Organization 	Organization ID 
 ABCDE Health	CCN-XXXXXX
 ABCDE Community Hospital	CCN-XXXXXX
 ABCDE Medical Center	CCN-XXXXXX

6. On the landing page of the SDE tool, there is a “Start Measure” button next to each data submission page. Click the “Start Measure” button to begin entering data.

The screenshot displays a list of data entry categories, each with a description and a 'Start Measure' button:

- Non-Measure Data**: Non-Measure Data/Population Counts
- HBIPS-2 and HBIPS-3**: HBIPS-2: Hours of Physical Restraint Use and HBIPS-3: Hours of Seclusion Use
- HBIPS-5**: HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
- creening for Metabolic Disorders**
- Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record**: Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- SUB-2 and SUB-2a**: SUB-2 and SUB-2a: Alcohol Use Brief Intervention Provided or Offered/Alcohol Use Brief Intervention
- SUB-3 and SUB-3a**: SUB-3 and SUB-3a: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge/Alcohol and Other Drug Use Disorder Treatment at Discharge.
- TOB-2 and TOB-2a**: TOB-2 and TOB-2a: Tobacco Use Treatment Provided or Offered
- TOB-3 and TOB-3a**: TOB-3 and TOB-3a: Tobacco Use Treatment Provided or Offered at Discharge/ Tobacco Use Treatment at Discharge
- IMM-2**: IMM-2: Influenza Immunization Information  
 † Reporting Period: 10/01/19 – 03/31/20

At the bottom of the interface, there is a large green 'Start Measure' button and a smaller grey button labeled 'I'm ready to submit'.

- The bottom of each data entry page includes the options to **Cancel** or **Save & Return** the entered data.

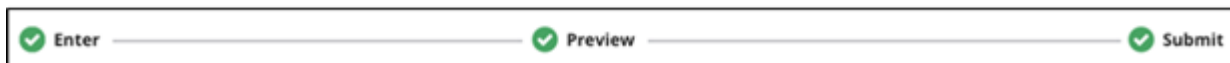
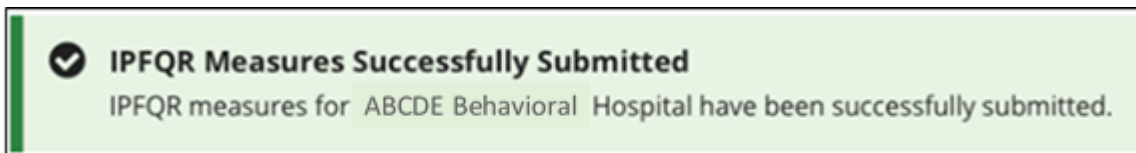


- If you click **Cancel**, the entered data will not be saved, and you will return to the previous page listing all measure and non-measure data entry pages.
- If you click **Save & Return** the entered data will be saved and you will return to the previous page listing all measure and non-measure data entry pages. As data are entered and saved for each data entry page, a check mark and the word “Complete” will appear next to the name of the data entry screen. You also have the option to edit the data by clicking on the “Edit Measure” hyperlink.

8. After data have been saved in all data entry fields, click the blue “I’m ready to submit” button at the bottom of the page.



9. Once all data have been successfully submitted, a green box will appear at the top of the page and completion of all three stages of the submission process (“Enter”, “Preview”, and “Submit”) will be marked with a green circle and checkmark.



- If you click the “Edit Measure” link for any of the data entry pages prior to the deadline you must ensure that you click the green “Save & Return” button followed by the blue “I’m ready to submit” button again, even if you do not make any changes to the data within those data entry pages.
- If you edit any of the data, be sure to also re-sign the DACA to acknowledge the accuracy and correctness of the edited data.
- Once the data are entered, you will have the option to export the data in PDF file as well as sign the data accuracy and correctness acknowledgement (DACA) form. Refer to Section 6: Data Accuracy and Correctness Acknowledgement for detailed instructions about submitting the DACA.

Screenshots of each data entry screen are below.

### *Non-Measure Data/Population Counts*

<p><b>Total Annual Discharges</b></p> <p>* Please enter an aggregate, yearly count of your facility's annual discharges.</p> <input type="text" value="Ex. 0,1,2,3,....,99999"/>
<p><b>Age Strata</b></p> <p>Please enter aggregate, yearly counts of your facility's annual discharges stratified by the following age groups:</p> <p><b>i</b> The sum of these values must equal the number of Total Annual Discharges, entered above, in order for your submission to be successful.</p> <p>* <b>Children (1 - 12 years)</b></p> <input type="text" value="Ex. 0,1,2,3,....,99999"/>
<p>* <b>Adolescent (13 - 17 years)</b></p> <input type="text" value="Ex. 0,1,2,3,....,99999"/>
<p>* <b>Adult (18 - 64 years)</b></p> <input type="text" value="Ex. 0,1,2,3,....,99999"/>
<p>* <b>Older Adult (65 and over)</b></p> <input type="text" value="Ex. 0,1,2,3,....,99999"/>
<p><b>Diagnostic Categories</b></p> <p>Please enter aggregate, yearly counts of your facility's annual discharges stratified by the following diagnostic categories:</p> <p><b>i</b> The sum of these values must equal the number of Total Annual Discharges, entered above, in order for your submission to be successful.</p> <p>* <b>Anxiety disorders (651)</b></p> <input type="text" value="Ex. 0,1,2,3,....,99999"/>
<p>* <b>Delirium, dementia, and amnestic and other cognitive disorders (653)</b></p> <input type="text" value="Ex. 0,1,2,3,....,99999"/>
<p>* <b>Mood disorders (657)</b></p> <input type="text" value="Ex. 0,1,2,3,....,99999"/>
<p>* <b>Schizophrenia and other psychotic disorders (659)</b></p> <input type="text" value="Ex. 0,1,2,3,....,99999"/>
<p>* <b>Substance-related disorders (661)</b></p> <input type="text" value="Ex. 0,1,2,3,....,99999"/>
<p>* <b>Other diagnosis - Not included in one of the above categories</b></p> <input type="text" value="Ex. 0,1,2,3,....,99999"/>



**Payer**

Please enter aggregate, yearly counts of your facility's annual discharges stratified by the following payers:

**i** The sum of these values must equal the number of Total Annual Discharges, entered above, in order for your submission to be successful.

\* Medicare

Ex. 0,1,2,3,....,99999

\* Non-Medicare

Ex. 0,1,2,3,....,99999

**Global Sample**

\* Did your facility use global sampling?

Yes

No

***HBIPS-2: Hours of Physical Restraint Use and HBIPS-3: Hours of Seclusion Use***

**HBIPS-2 and HBIPS-3**

HBIPS-2: Hours of Physical Restraint Use and HBIPS-3: Hours of Seclusion Use

**HBIPS-2 Numerator**

\* The total number of hours that all psychiatric inpatients were maintained in physical restraint:

Ex. 0 - 9999999.99

**HBIPS-3 Numerator**

\* The total number of hours that all psychiatric inpatients were held in seclusion:

Ex. 0 - 9999999.99

**HBIPS-2 and HBIPS-3 Denominator**

\* Number of psychiatric inpatient days:

Ex. 0,1,2,3,....,999999

***HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification***

**HBIPS-5**

HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification

**Numerator**

- \* **Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification:**

Ex. 0,1,2,3,...,99999

**Denominator**

- \* **Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications:**

Ex. 0,1,2,3,...,99999

***Screening for Metabolic Disorders***

**Screening for Metabolic Disorders**

**Numerator**

- \* **Total number of patients who received a metabolic screening either prior to, or during, the index IPFQR stay:**

Ex. 0,1,2,3,...,99999

**Denominator**

- \* **Number of patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period:**

Ex. 0,1,2,3,...,99999

***Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) and Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)***

**Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record**

Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

**Transition Record with Specified Elements Received by Discharged Patients**

**Numerator**

- \* Number of patients, regardless of age, discharged from an inpatient facility to home or any other site of care 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:

Ex. 0,1,2,3,...,99999

**Denominator**

- \* Number of patients, regardless of age, discharged from your facility to home or other site of care, or their caregiver(s):

Ex. 0,1,2,3,...,99999

**Timely Transmission of Transition Record**

**Numerator**

- \* Number of patients, regardless of age, discharged from your facility to home or other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge:

Ex. 0,1,2,3,...,99999

**Denominator**

- \* Number of patients, regardless of age, discharged from your facility to home or other site of care, or their caregiver(s):

Ex. 0,1,2,3,...,99999

**NOTE:** The new denominator statement for the SUB measures applicable for CY 2021 discharges will be updated in the SDE tool prior to the start of the data submission period in the summer of 2022.

***SUB-2/-2a: Alcohol Use Brief Intervention Provided or Offered/Alcohol Use Brief Intervention***

<p><b>SUB-2 and SUB-2a</b></p> <p>SUB-2 and SUB-2a: Alcohol Use Brief Intervention Provided or Offered/Alcohol Use Brief Intervention</p>
<p><b>SUB-2 Numerator</b></p> <p>* Number of patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay:</p> <input type="text" value="Ex. 0,1,2,3,...,99999"/>
<p><b>SUB-2a Numerator</b></p> <p>* Number of patients who received the brief intervention during the hospital stay:</p> <input type="text" value="Ex. 0,1,2,3,...,99999"/>
<p><b>SUB-2 and SUB-2a Denominator</b></p> <p>* Number of hospitalized patients 18 years of age and older who screened positive for unhealthy alcohol use or an alcohol use disorder (alcohol abuse or alcohol dependence):</p> <input type="text" value="Ex. 0,1,2,3,...,99999"/>

***SUB-3/-3a: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge/Alcohol and Other Drug Use Disorder Treatment at Discharge***

<p><b>SUB-3 and SUB-3a</b></p> <p>SUB-3 and SUB-3a: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge/Alcohol and Other Drug Use Disorder Treatment at Discharge.</p>
<p><b>SUB-3 Numerator</b></p> <p>* Number of patients who received or refused at discharge a prescription for medication for treatment of alcohol or drug use disorder OR received or refused a referral for addictions treatment:</p> <input type="text" value="Ex. 0,1,2,3,...,99999"/>
<p><b>SUB-3a Numerator</b></p> <p>* Number of patients who received at discharge a prescription for medication for treatment of alcohol or drug use disorder OR a referral for addictions treatment:</p> <input type="text" value="Ex. 0,1,2,3,...,99999"/>
<p><b>SUB-3 and SUB-3a Denominator</b></p> <p>* Number of hospitalized patients 18 years of age and older who screened positive for unhealthy alcohol use or an alcohol use disorder (alcohol abuse or alcohol dependence).</p> <input type="text" value="Ex. 0,1,2,3,...,99999"/>

**NOTE:** The new denominator statement for the TOB measures applicable for CY 2021 discharges will be updated in the SDE tool prior to the start of the data submission period in the summer of 2022.

***TOB-2/-2a Tobacco Use Treatment Provided or Offered***

<b>TOB-2 and TOB-2a</b>
TOB-2 and TOB-2a: Tobacco Use Treatment Provided or Offered
<b>TOB-2 Numerator</b> <b>* Number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications or had a reason for not receiving the medication during the first three days after admission:</b> <input type="text" value="Ex. 0,1,2,3,...,99999"/>
<b>TOB-2a Numerator</b> <b>* Number of patients who received practical counseling to quit AND received FDA-approved cessation medication or had a reason for not receiving the medication during the first three days after admission:</b> <input type="text" value="Ex. 0,1,2,3,...,99999"/>
<b>TOB-2 and TOB-2a Denominator</b> <b>* Number of hospitalized patients 18 years of age and older identified as current tobacco users:</b> <input type="text" value="Ex. 0,1,2,3,...,99999"/>

***TOB-3/-3a Tobacco Use Treatment Provided or Offered at Discharge/Tobacco Use Treatment at Discharge***

<b>TOB-3 and TOB-3a</b>
TOB-3 and TOB-3a: Tobacco Use Treatment Provided or Offered at Discharge/Tobacco Use Treatment at Discharge
<b>TOB-3 Numerator</b> <b>* Number of patients who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge:</b> <input type="text" value="Ex. 0,1,2,3,...,99999"/>
<b>TOB-3a Numerator</b> <b>* Number of patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication upon discharge as well as those who were referred to outpatient counseling and had reason for not receiving a prescription for medication:</b> <input type="text" value="Ex. 0,1,2,3,...,99999"/>
<b>TOB-3 and TOB-3a Denominator</b> <b>* Number of hospitalized patients 18 years of age and older identified as current tobacco users:</b> <input type="text" value="Ex. 0,1,2,3,...,99999"/>

## ***IMM-2: Influenza Immunization Information***

<b>IMM-2</b> IMM-2: Influenza Immunization Information
<b>Numerator</b>  * Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated:  <input type="text" value="Ex. 0,1,2,3,...,99999"/>
<b>Denominator</b>  * Inpatients age 6 months and older discharged during the months of October, November, December, January, February or March:  <input type="text" value="Ex. 0,1,2,3,...,99999"/>

### ***DACA***

The DACA form is updated annually to address the payment determination year impacted by the current data submission period. The updated form is accessible only during the annual data submission period (July 1–August 15). See instructions about completing the DACA form in Section 6: Data Accuracy and Completeness Acknowledgement.

## Section 3: *QualityNet* Registration

To participate and submit data for reporting in the IPFQR Program, facilities must obtain a *QualityNet* user account and register with the *QualityNet Secure Portal*. All users requesting access to the *QualityNet Secure Portal* must be individually approved and verified at the facility level and submitted to *QualityNet*. This mandatory registration process is used to maintain the confidentiality and security of health care information and data transmitted via the *QualityNet Secure Portal*. These are CMS-approved sites for secure health care quality data exchange for facility reporting.

To begin *QualityNet* Registration as a Security Administrator/Security Official:

1. Access the *QualityNet* website located at <http://qualitynet.cms.gov> from your web browser.

The screenshot shows the QualityNet website homepage. At the top, there is a navigation bar with the CMS.gov logo, a search bar, and links for Quality Programs, Help, Log into Secure Portal, and Register. The Register button is highlighted with a red box. Below the navigation bar is a large blue banner with the text 'Welcome to QualityNet! Your one-stop shop for CMS Quality Programs.' and two buttons: 'Subscribe to Email Updates' and 'Log Into QualityNet Secure Portal'. To the right of the banner is a 'Recent News' section with two news items. Below the news section is a dropdown menu and a section titled 'I am looking for quality information associated with...' with six category buttons: Hospitals - Inpatient, Hospitals - Outpatient, Ambulatory Surgical Centers, PPS-Exempt Cancer Hospitals, ESRD Facilities, and Inpatient Psychiatric Facilities.

2. Click the **Register** button on the top right of the homepage. The Getting Started with *QualityNet* page appears.
3. The *QualityNet* Registration page contains an overview of the registration process and helpful links for getting started with *QualityNet*.

CMS.gov | QualityNet  [Quality Programs](#) [Help](#) [Log into Secure Portal](#) [Register](#)

Home /

## Getting Started with QualityNet

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**Registration**

[New User Enrollment](#)

[Sign In Instructions](#)

[Security Statement & Policy](#)

### QualityNet Registration

All users requesting access to the QualityNet Secure Portal (formerly, My QualityNet) must be individually approved and verified. This mandatory registration process is used to maintain the confidentiality and security of healthcare information and data transmitted via the Secure Portal. The process begins with registration for a QualityNet account.

4. Scroll down the page to the **I am a Security Administrator** section and complete the steps to register.

### I am a Security Administrator

It is highly recommended that each organization designate two people as QualityNet Security Administrators.

To register as a QualityNet Security Administrator:

1. Download the QualityNet Security Administrator Registration Packet.
2. Follow the instructions for completing the Registration Form and Authorization Form. The Authorization Form must be completed by the highest level executive at your organization.
3. Email the completed, digitally signed forms to [QualityNet-Registration-Submission@hcqis.org](mailto:QualityNet-Registration-Submission@hcqis.org). If you are registering for an Ambulatory Surgical Center (ASC), email the completed, digitally signed forms to [OQRSupport@hsag.com](mailto:OQRSupport@hsag.com).

OR

4. Mail the original, completed forms (keeping a copy for your records) to:
  - o QualityNet Help Desk
  - o 12000 Ridgemont Drive
  - o Urbandale, IA 50323-2317

File Name	File Type	File Size	
QualityNet Security Administrator Registration Packet	PDF	78 KB	<a href="#">Download</a>

You will be notified by email when registration is complete and your QualityNet account has been activated. The email will also contain your User ID. A temporary password will be sent in a separate email. You will need both to complete enrollment for access to the QualityNet Secure Portal.

**Accessing the QualityNet Secure Portal**

For access to the QualityNet Secure Portal, complete the [New User Enrollment Process](#). (As part of the process, you'll be asked to change your password and answer a set of security questions.)



## **QualityNet Security Administrator/Security Official**

The IPFQR Program requires the facility to have at least one active *QualityNet* Security Administrator/Security Official.

**Best Practice:** We recommend facilities designate a minimum of two *QualityNet* Security Administrators/Security Officials (SAs/SOs), one to serve as the primary *QualityNet* SA/SO and the other to serve as the alternate SA/SO. To keep the facility's account active, your SA/SO should sign in at least once a month. If it becomes necessary to reactivate your account, call the *QualityNet* Help Desk at (866) 288-8912.

### ***Security Administrator/Security Official Responsibilities***

The Security Administrator/Security Official has the following responsibilities:

- Creating, approving, editing, and/or terminating *QualityNet* user accounts within the IPF
- Assigning user roles for basic users within the IPF to access the secure web-based applications
- Monitoring *QualityNet* usage at the IPF to ensure security and confidentiality is maintained
- Serving as a point of contact for information regarding *QualityNet*

### **Non-Administrative User**

Any user not designated as a *QualityNet* Security Administrator/Security Official or a *QualityNet* Security Designate is considered a Non-Administrative User (or Basic user). Various roles to fit job needs can be assigned to the Non-Administrative User.

If assigned the appropriate roles, the user may perform one or more of the following tasks:

- Access reports
- Authorize vendors to submit data
- Manage measures
- Manage security
- Manage Notice of Participation
- View/edit online forms

## Completing the *QualityNet* Registration Form

When completing the *QualityNet* Registration form, print the information legibly and completely in each of the applicable fields. For the “Specify Setting” section, check the Inpatient Psychiatric Facility box.

QualityNet Security Administrator Registration Form			
*NOTE: All fields marked with an asterisk are required and must be completed to obtain approval.			
Access Request			
*Request Date MM/DD/YYYY:	*First Name:	Middle Initial:	*Last Name:
*Business Email Address:			
*Job Title:			
*Business Name:			
*Specify Organization Type: (check all that apply)			
<input type="checkbox"/> ASC	<input type="checkbox"/> ESRD Network	<input type="checkbox"/> Hospital – Inpatient	
<input type="checkbox"/> CMS	<input type="checkbox"/> Healthcare System	<input type="checkbox"/> Hospital – Outpatient	
<input type="checkbox"/> EHR	<input type="checkbox"/> Long-Term Care Facility	<input type="checkbox"/> Physician Office	
<input type="checkbox"/> BFCC QIO	<input type="checkbox"/> QIN QIO	<input type="checkbox"/> State Agency	
<input type="checkbox"/> Inpatient Psychiatric Facility	<input type="checkbox"/> Long-Term Care Facility	<input type="checkbox"/> PPS-Exempt Cancer Hospital	
<input type="checkbox"/> Vendor: ASC	<input type="checkbox"/> Vendor: EHR	<input type="checkbox"/> Vendor: Hospital-HCAHPS	
<input type="checkbox"/> Vendor: Hospital – Inpatient	<input type="checkbox"/> Vendor: Hospital – Outpatient	<input type="checkbox"/> Vendor – Inpatient Psychiatric Facility	
<input type="checkbox"/> Other (Specify):			
CMS Certification Number (CCN):		Vendor ID Number: (If applicable)	
National Provider Identifier (Facility NPI): (For ASC use only)			
*Business Address:			
*City:	*State:	*Zip:	
*Work Phone:	Extension:	Fax:	
Signature Required			
*Applicant:			*Date MM/DD/YYYY:

Sign and date the *QualityNet Security Administrator Registration Form* in the presence of a Notary Public, obtaining the Notary’s stamp and seal on the form. Even though not all states require the stamp or seal of the notary, it is a requirement for *QualityNet*.

Have the highest-level executive at your location complete and sign the *QualityNet Security Administrator Executive Authorization Form*. Depending on the facility, this may be the Chief Executive Officer, Administrator, Medical Director, or other similar position.

QualityNet Security Administrator Executive Authorization Form	
I <input style="width: 100%;" type="text"/> (Name of highest-level Executive)	authorize <input style="width: 100%;" type="text"/> (Name of QualityNet Security Administrator)
to be the QualityNet Security Administrator for <input style="width: 100%;" type="text"/> (Name of organization)	
I understand that he/she will be responsible for the following:	
<ul style="list-style-type: none"> <li>• Creating, approving, editing, and/or terminating QualityNet user accounts within your organization</li> <li>• Performing In-Person Proofing for individuals who are unable to complete identity proofing through Experian</li> <li>• Monitoring QualityNet usage at your organization to ensure security and confidentiality is maintained</li> <li>• Serving as a point of contact for your organization for information regarding QualityNet</li> </ul>	
I understand that, as a security measure, I may be contacted on a future date by the QualityNet Help Desk to verify my position and whom I have authorized to be QualityNet Security Administrator(s). I may also be asked to verify those individuals that have been given access to QualityNet.	
<input style="width: 100%; height: 20px;" type="text"/> (Executive: Print Name)	<input style="width: 100%; height: 20px;" type="text"/> (Signature)
<input style="width: 100%; height: 20px;" type="text"/> (Title)	<input style="width: 100%; height: 20px;" type="text"/> (Date MM/DD/YYYY)
<input style="width: 100%; height: 20px;" type="text"/> (Phone #)	<input style="width: 100%; height: 20px;" type="text"/> (Email Address)
Please specify if this is a <b>New Administrator Registration</b> or an <b>Upgrade</b> from a Basic User:	
<input checked="" type="radio"/> New	
<input type="radio"/> Upgrade	

Refer to the information below for mailing instructions of the original, completed *QualityNet Security Administrator Registration Form* and the *QualityNet Security Administrator Executive Authorization Form*. Photocopies or faxes of the forms will not be accepted. The facility should retain a copy of all forms for their records.

**Mail the original completed form (not a copy) to the *QualityNet* Help Desk at this address:**

*QualityNet* Help Desk  
 12000 Ridgmont Drive  
 Urbandale, IA 50323-2317

For questions regarding the *QualityNet* Registration Form, contact:

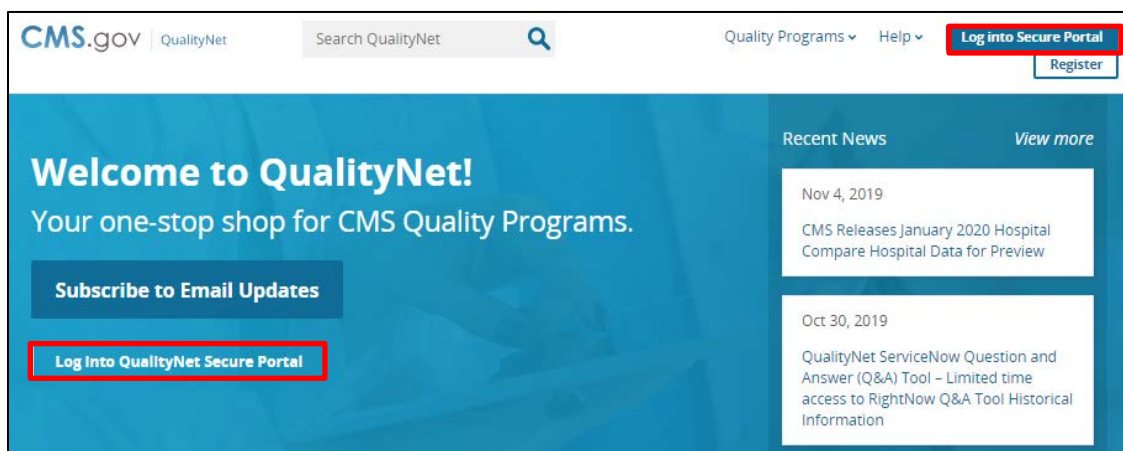
*QualityNet* Help Desk  
Monday through Friday  
7:00 a.m. to 7:00 p.m. Central Time  
E-mail: [QualityNet-Registration-Submission@hcqis.org](mailto:QualityNet-Registration-Submission@hcqis.org)  
Phone: (866) 288-8912  
TTY: (877) 715-6222

## **Activating the Security Administrator/Security Official Account**

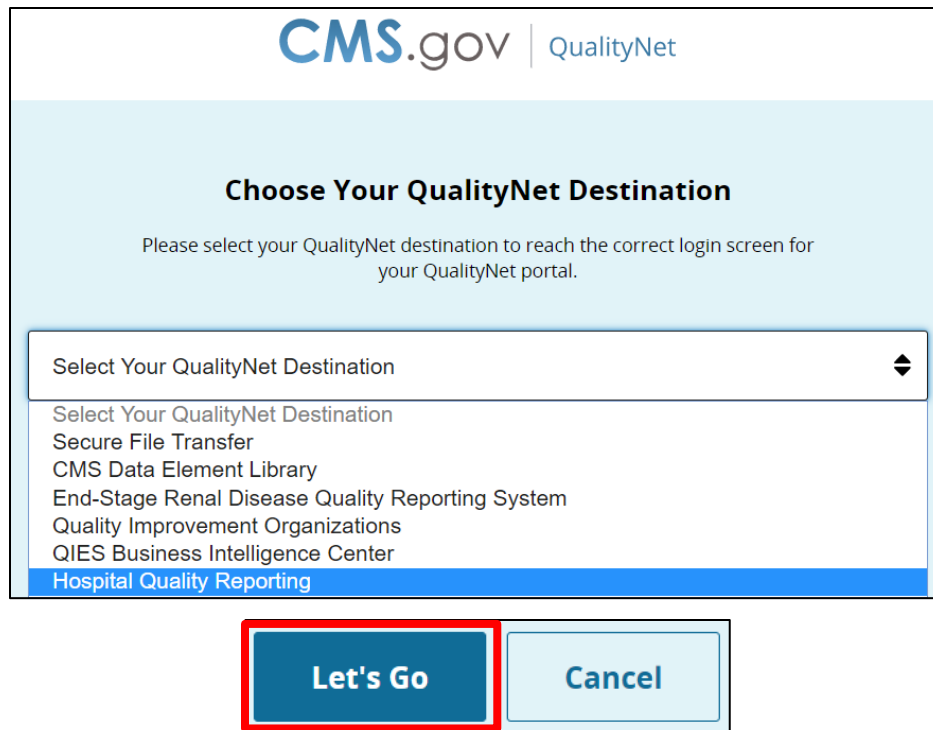
Once the *QualityNet* Registration Forms are processed by *QualityNet*, the approved Security Administrator(s)/Security Official(s) will receive an email notification with the individual assigned username and a temporary password.

To begin account activation:

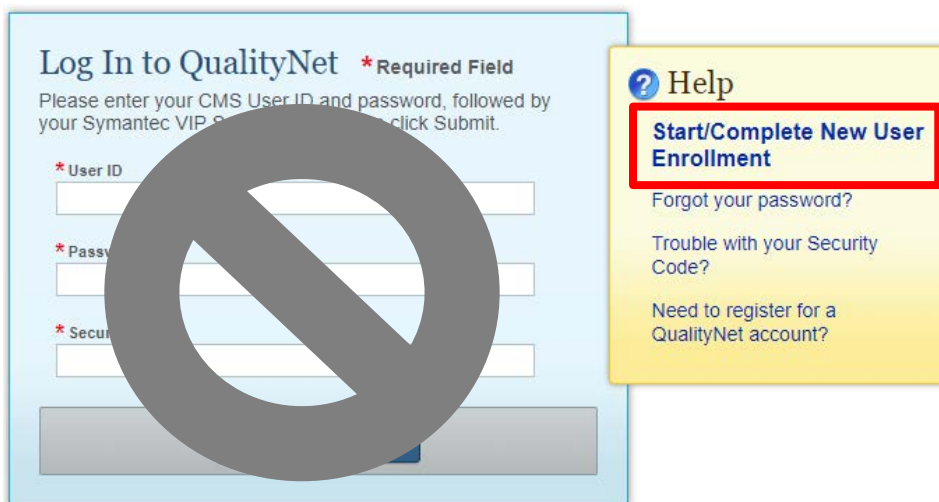
1. Access the *QualityNet* website located at <http://qualitynet.cms.gov> from your web browser.



2. Click either the **Log into Secure Portal** button located in the top right corner of the webpage or the **Log Into QualityNet Secure Portal** button located on the left side of the webpage.
3. The *Choose Your QualityNet Destination* page will open. From the *Select Your QualityNet Destination* drop-down menu, select **Hospital Quality Reporting** from the drop-down menu and click the **Let's Go** button.



4. Select the **Start/Complete New User Enrollment** link in the yellow box. (Do not enter information in the fields under Log In to QualityNet.)



5. Enter the individual assigned username and a temporary password provided via the email notification in the required fields and click the **SUBMIT** button.

**CMS.gov** | QualityNet  
Centers for Medicare & Medicaid Services

Progress Bar: Login (Active) | Verify Identity | Identity Questions | Identity Confirmed | Enroll Credential | Enrollment Confirmed

### Starting and Completing New User Enrollment

To complete enrollment for QualityNet, you will need the user ID and password provided to you by your Security Administrator. You also need to download the "two-factor authentication" credential to your computer or smartphone as instructed by your Security Administrator. Without these three components (user ID, password, and two-factor credential) you will not be able to complete the enrollment process.

On this screen you will log in with your user ID and password to start and/or complete the verification process, followed by a step to enroll your two-factor credential. To verify your identity, you will be asked to provide personal information that will be shared securely with an identity proofing service CMS has engaged. Second, you will be asked to enroll your two-factor authentication credential so that it will be recognized by QualityNet.

This six-step process should take no more than five minutes. You can note your progress against the progress bar at the top of the screen.

To get started, enter your user ID and password in the form to the right, then click Submit.

**Log In to QualityNet** \* Required Field

\* User ID

\* Password

CANCEL SUBMIT

? Help  
 Forgot your password?

6. Follow the instructions to establish a new password.

**NOTE:** After the password is established, the user must complete the enrollment to obtain access to the *QualityNet Secure Portal*. This establishes access to the web-based Notice of Participation (NOP), Web-Based Measures, Data Accuracy and Completeness Acknowledgement (DACA) applications, and IPFQR Program reports.

### ***QualityNet Secure Portal Access***

Before logging in to *QualityNet Secure Portal* for the first time, a user must complete the New User Enrollment Process. The prerequisites for this process are:

- A completed *QualityNet* Registration
- Receipt of the applicable user roles assigned by your facility security administrator
- A Symantec VeriSign ID Protection (VIP) multifactor credential application in order to obtain VeriSign, an authentication service that enables secure access to networks and applications.

To download the multifactor authentication application to a PC or tablet:

1. Access the *QualityNet* website located at <http://qualitynet.cms.gov> from your web browser.
2. Click the **Register** button on the top right of the homepage. The Getting Started with *QualityNet* page appears.

CMS.gov | QualityNet Search QualityNet Quality Programs Help Log into Secure Portal Register

# Welcome to QualityNet!

Your one-stop shop for CMS Quality Programs.

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CMS Releases January 2020 Hospital Compare Hospital Data for Preview

Oct 30, 2019  
QualityNet ServiceNow Question and Answer (Q&A) Tool – Limited time access to RightNow Q&A Tool Historical Information

I am looking for quality information associated with...

- Hospitals - Inpatient
- Hospitals - Outpatient
- Ambulatory Surgical Centers
- PPS-Exempt Cancer Hospitals
- ESRD Facilities
- Inpatient Psychiatric Facilities

- Select the “New User Enrollment” tab from the menu on the left side of the page and complete step 1 to download the **Symantec VIP Access Desktop** application.

## Getting Started with QualityNet

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- New User Enrollment**
- Sign In Instructions
- Security Statement & Policy
- Password Rules

Can't find what you're looking for? Visit the Question & Answer Tools.

### QualityNet Secure Portal New User Enrollment

The QualityNet Secure Portal houses various applications for the Center for Medicare & Medicaid Services' (CMS's) quality reporting programs.

To access the portal, you must first complete registration as a **QualityNet user**. After receiving your User ID and Temporary Password, sign in to the QualityNet Secure Portal to change your password and answer the security questions. The **User ID** and **Password** will be required for logging in to the portal.

Next, complete the New User Enrollment Process and first-time login procedure outlined below. (See Section 5 of the QualityNet User Guide for more detailed instructions.)

#### Enrollment, first-time login

To enroll for access to the QualityNet Secure Portal:

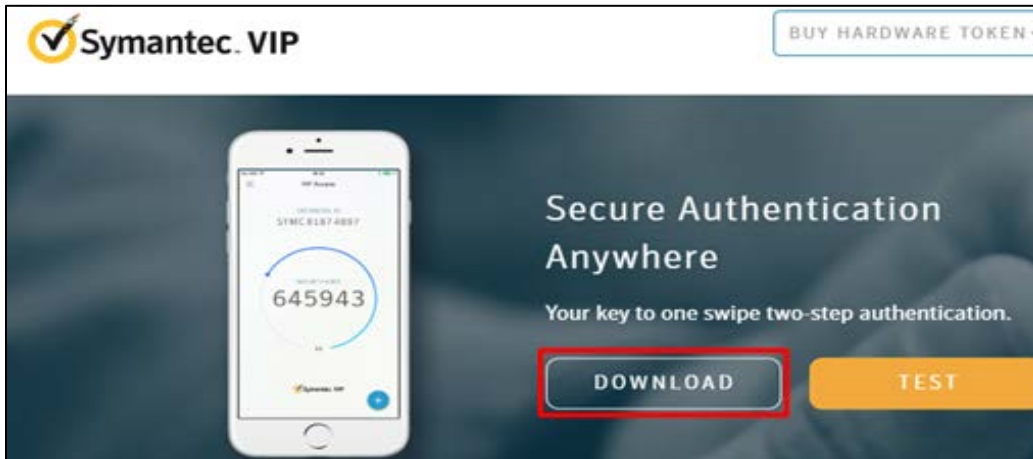
- From the Symantec ID Protection Center, download the **Symantec VIP Access Desktop application** to your computer, tablet, and/or smartphone. (Enter **m.vip.symantec.com** in the browser on your mobile device). This may require the approval and assistance of your organization's information technology staff. You will need the static Credential ID and the dynamic Security Code generated by this application to complete your enrollment.
- Log in to the QualityNet Secure Portal
- Click **Start/Complete New User Enrollment** in the yellow **Help** box.
- Follow the six-step process to verify your identity. You will use the PreciseID service from Experian, an external service selected by CMS, to confirm your identity by providing personal information via a safe, encrypted process that, in turn, produces verification questions. (See the Experian PreciseID<sup>SM</sup> website for more information on this verification process.)
- After completing identity verification, enter the **Credential ID** and the **Security Code** (within 30 seconds) generated by the Symantec VIP Access application. This will link your QualityNet user ID to your Symantec VIP Access credential.

You may now log in to the QualityNet Secure Portal.

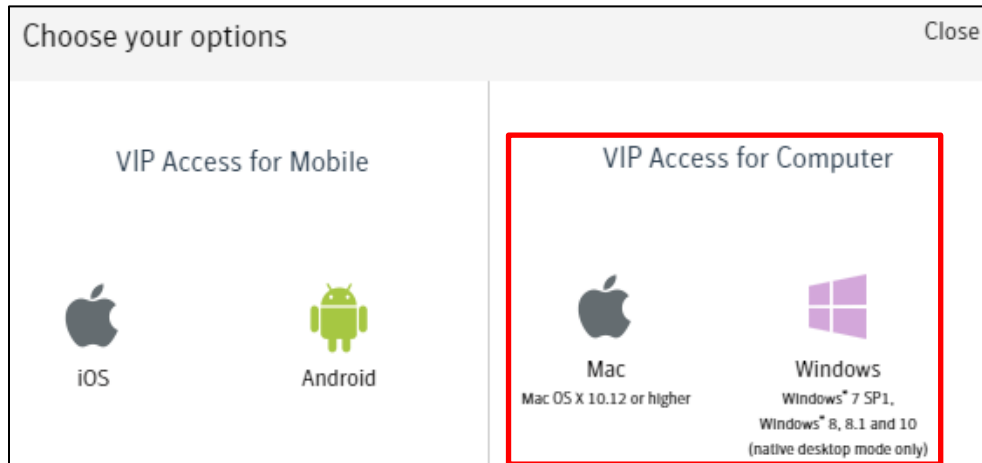
#### More information

For more detailed portal enrollment and login instructions, see the QualityNet Secure Portal New User Enrollment Training and Section 5 of the QualityNet User Guide.

The Symantec VeriSign ID Protection web page will appear.



4. Select the download option that is appropriate to the device being used, either for Windows® or Mac®.

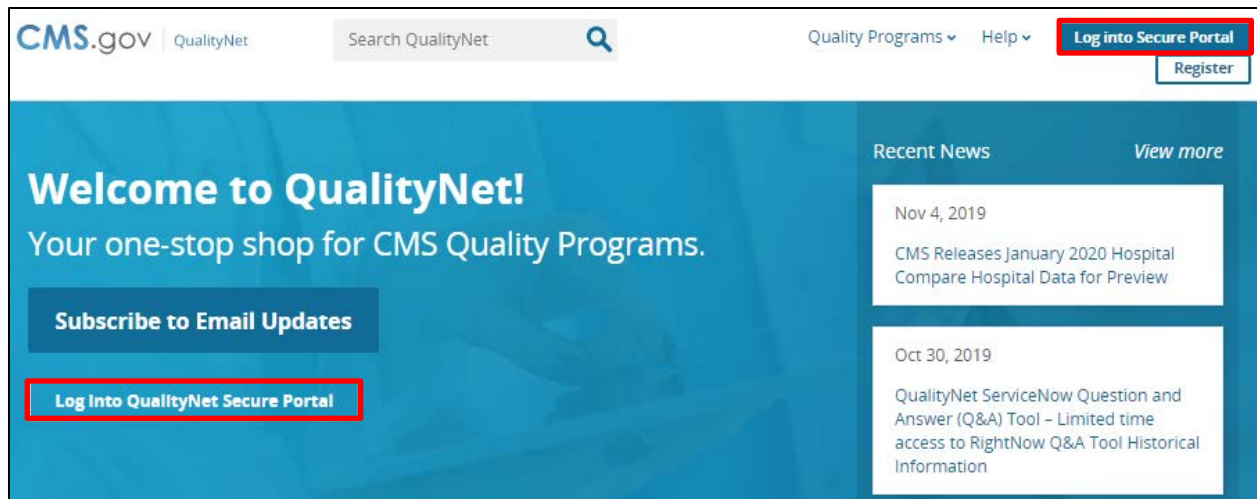


**NOTE:** It may be necessary to consult with your IT department before downloading the VeriSign ID to the PC due to system firewalls or other restrictions.

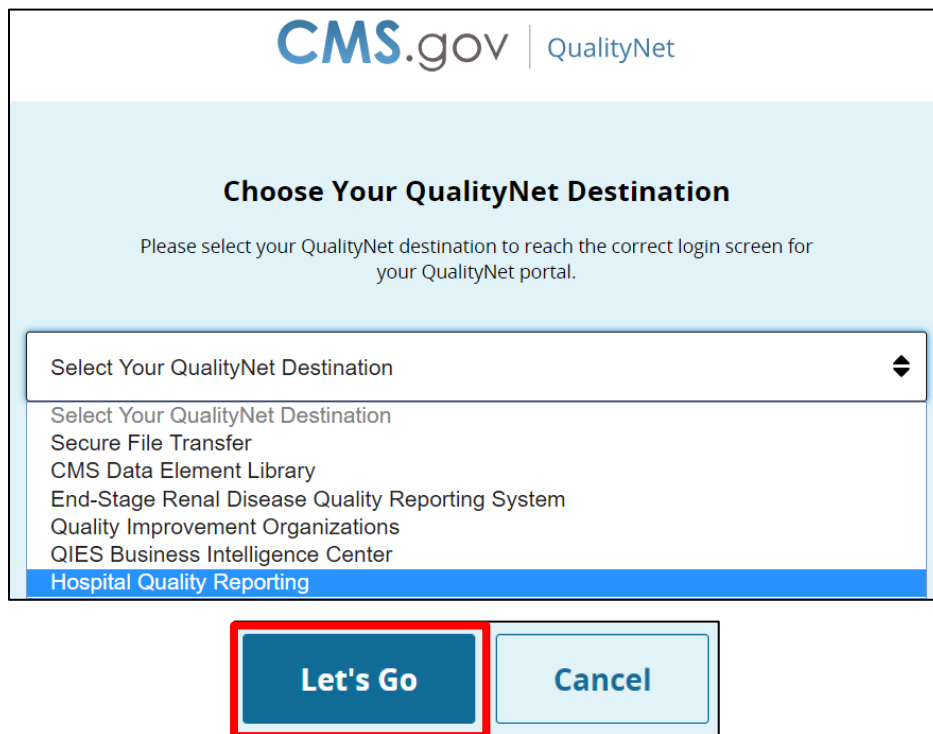
Once the Symantec multifactor authentication application download is on the computer, users are ready to access the *QualityNet Secure Portal*.

5. Access the *QualityNet Secure Portal* from the <http://qualitynet.cms.gov> website by clicking either the **Log into Secure Portal** button located in the top right corner of the webpage or the **Log into QualityNet Secure Portal** button located on the left side of the webpage.





6. The *Choose Your QualityNet Destination* page will open. From the *Select Your QualityNet Destination* drop-down menu, select **Hospital Quality Reporting** then the **Let's Go** button.



7. The *Log In to QualityNet* window appears.  
Each IPFQR user must complete the authenticating (proofing), required by the Federal Information Security Management Act (FISMA), for accessing government systems.
8. Select the link **Start/Complete New User Enrollment** on the login page to begin the enrollment process.

The *QualityNet Starting and Completing New User Enrollment* page appears.

9. Enter your User ID and Password and select Submit.
10. Follow the instructions for the enrollment process described in the following sections.

### ***Verifying Identity***

To verify a user's identity:

1. Access the *QualityNet Starting and Completing New User Enrollment* page and Log In.

The Verify Identity page appears.

The screenshot shows the 'Verify Your Identity' page on CMS.gov. The page header includes 'CMS.gov QualityNet' and 'Centers for Medicare & Medicaid Services'. A progress bar at the top indicates the current step is 'Verify Identity'. The main content area is titled 'Personal Information' and contains several input fields: First Name, Middle Name, Last Name, Suffix, Street Address, Additional Address Information, City, State/Province, ZIP/Postal Code, Country, Personal Phone Number, Full Social Security Number (highlighted with a red box), and Date of Birth. There is also a privacy notice and a 'SUBMIT' button.

2. Enter the required information within each field on the screen.

A Social Security number is required for users residing within the United States. A Social Security number is considered the most available source of identification that can be verified, as not all users have a driver's license or passport. When a user enters a Social Security number, the screen displays hash marks instead of numbers to protect privacy.

**NOTE:** You must enter your personal street address, NOT your associated facility's address.

CMS is aware of the privacy concerns regarding disclosure of personal data, including social security numbers. CMS is collecting the Personally Identifiable Information (PII) on this screen and on the identity question screen to verify identity only. Verifying a user's identity meets the National Institute of Standards and Technology (NIST) and the Federal Information Security Management Act (FISMA) requirements.

FISMA was passed as Title III of the E-Government Act (Public Law 107-347) in December 2002. FISMA requires each federal agency to develop, document, and implement an agency-wide program to provide information security for the information and information systems that support the operations and assets of the agency, including those provided or managed by another agency, contractor, or other source. This Act assigned NIST the responsibility to develop standards to be used by federal agencies to categorize information and information systems based on the objectives of providing appropriate levels of information security according to a range of risk levels.

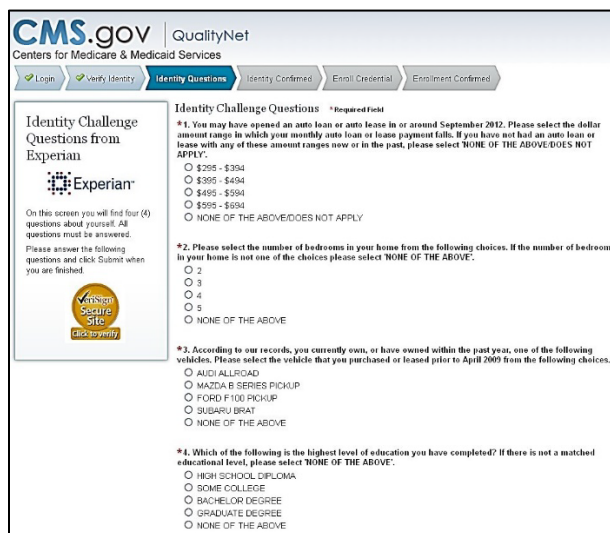
CMS is complying with the NIST standards by verifying a user's identity using Experian's Precise ID platform (an external authentication service provider). To maintain the privacy of users, Social Security numbers will be masked and encrypted during this transaction to ensure it is secure. Other than a name, none of the PII data collected in this process is retained by CMS.

- Once the required fields have been entered, check the privacy statement, and click **Submit**. The screen will display a message stating that the information has been sent to Experian and will instruct the user to wait as the information is being processed.



A set of questions will appear that will need to be answered. Example questions may be downloaded from the User Guide located on *QualityNet*. Typical types of identity proofing questions include:

- Verification of where you have lived (street address, city, and state)
- Verification of the type of car you own or have leased (color, make, license plate number)
- Verification of banking institutes that you may have used for banking or various types of loans
- Verification of phone numbers (home and cell)
- Verification of education completed
- Verification of where you have been employed
- Verification of dates associated with any of the above activities



4. Answer the identity challenge questions, and then select **Submit**. Once a user has completed the identity proofing questions correctly, the verification will display on the computer screen indicating successful completion of the CMS identity proofing.

CMS.gov | QualityNet  
Centers for Medicare & Medicaid Services

Login Verify Identity Identity Questions Identity Confirmed **Enroll Credential** Enrollment Confirmed

**Enroll Your Two-Factor Credential With QualityNet**

Please enter the two-factor credential ID you downloaded to your computer or phone, and your Symantec VIP Security Code.  
Click Submit to enroll your two-factor credential with QualityNet.

**Help**  
This is an example of the two-factor credential you downloaded to your smartphone or computer.

Account ID  
kj6207

\* Credential ID

\* Security Code

SUBMIT

CMS.gov | QualityNet  
Centers for Medicare & Medicaid Services

Login Verify Identity Identity Questions **Identity Confirmed** Enroll Credential Enrollment Confirmed

**You Have Successfully Completed CMS Identity Proofing**

Thank you for confirming your identity. You are now ready to enroll your two-factor credential ID with QualityNet portal.  
Please click Continue.

CONTINUE

If the questions are not answered accurately or if there is an alert on the credit report due to identity theft, the user will be prompted to call Experian to complete telephone verification.

A phone number will appear on the screen. If unsuccessful during the telephone verification, the user will be referred to the facility's Security Administrator/Security Official to complete a face-to-face verification.

**NOTE:** An individual user must have attempted both the online and telephone verification before a face-to-face verification can be done.

### ***Enrolling the Credentials***

To enroll credentials, access the *Enroll Your Two-Factor Credential with QualityNet* page. After, entering identity questions, the penultimate step is to *Enroll Your Credentials*.

Steps for enrolling the credentials are as follows:

1. Access the previously downloaded Symantec VIP Application from your desktop. The Symantec VIP window appears.
2. Enter the credential ID number in the first field.

3. Enter a security code within the 30-second freshness period.

**NOTE:** A counter will display a countdown of the seconds from 30 until the next code displays. The security code may be typed in the field or copied and pasted into the Security Code field.

4. Select **Submit**.

### ***Logging in to the QualityNet Secure Portal***

After completing all necessary paperwork and the New User Enrollment, the user will have access to the *QualityNet Secure Portal*. While the registration and login steps noted earlier in this section will allow you to access the *QualityNet Secure Portal*, it is important to note that in April 2020, CMS launched the Health Care Quality Information Systems (HCQIS) Access Roles, and Profile (HARP) system. This streamlined ID management security allows access to many HQR reporting systems using “One Login” functionality. Refer to the HARP User Guide at the following link for more information: <https://qualitynet.cms.gov/training-guides%23tab2#tab2>.

1. Access and log into the *QualityNet Secure Portal* by going to <https://hqr.cms.gov/hqrng/login>
2. Enter your Healthcare Quality Information System (HCQIS) Access, Roles, and Profile (HARP) user ID and password and click “Login”
  - a. If you do not have a HARP account, sign into Hospital Quality Reporting and follow instructions to create one
  - b. If you are unable to complete this step, contact the *QualityNet* Help Desk for assistance

Hospital Quality Reporting

### HARP Sign In

Enter your user ID and password to login.

**⚠** If you do NOT have a HARP account please sign in to the Hospital Quality Reporting on <https://www.qualitynet.org> to create one.

User ID

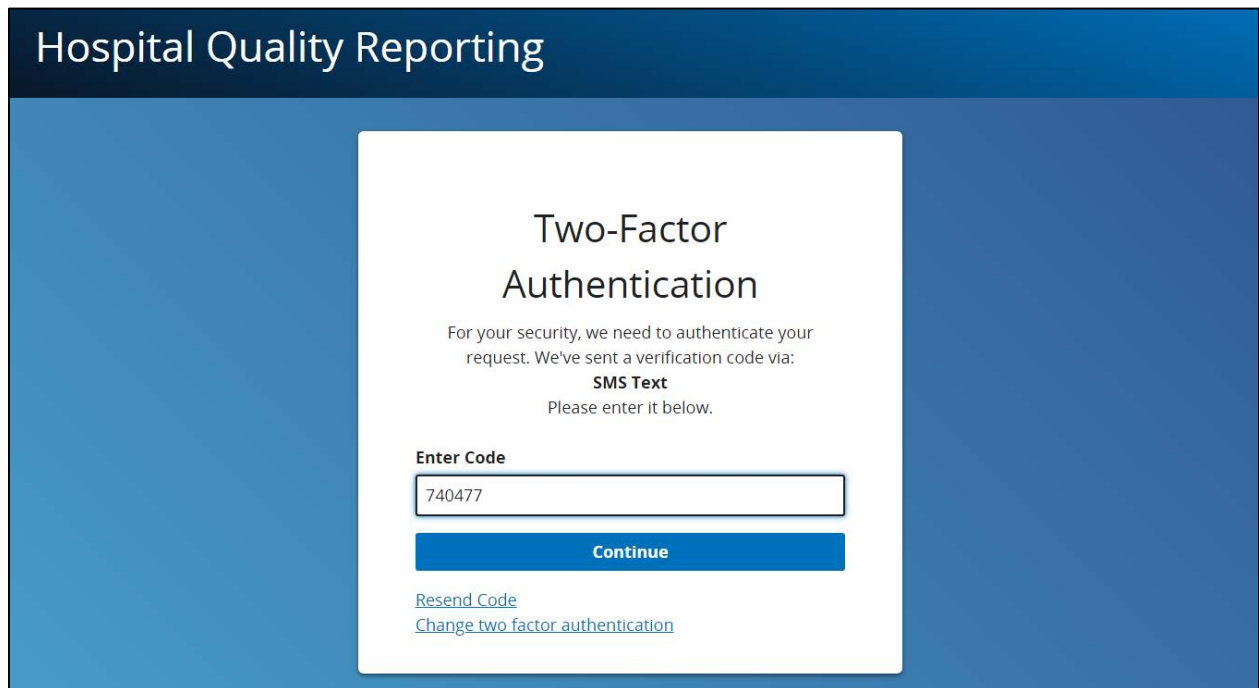
Password

Login

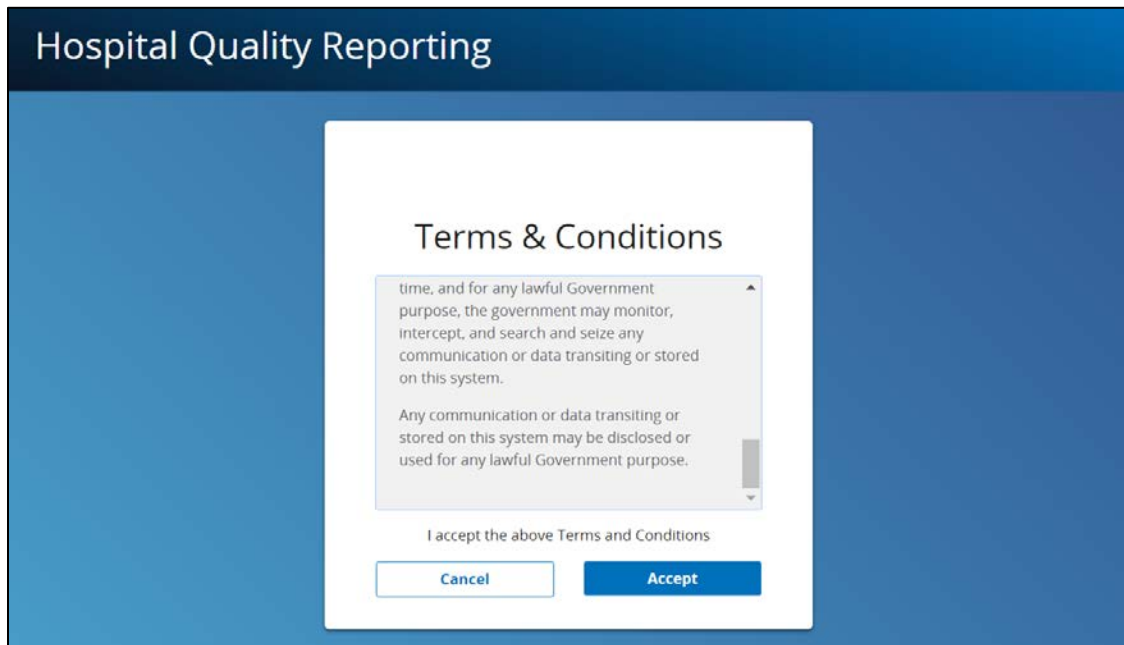
3. Select either email or SMS text number for two-factor authentication to be sent to and click “Next”.



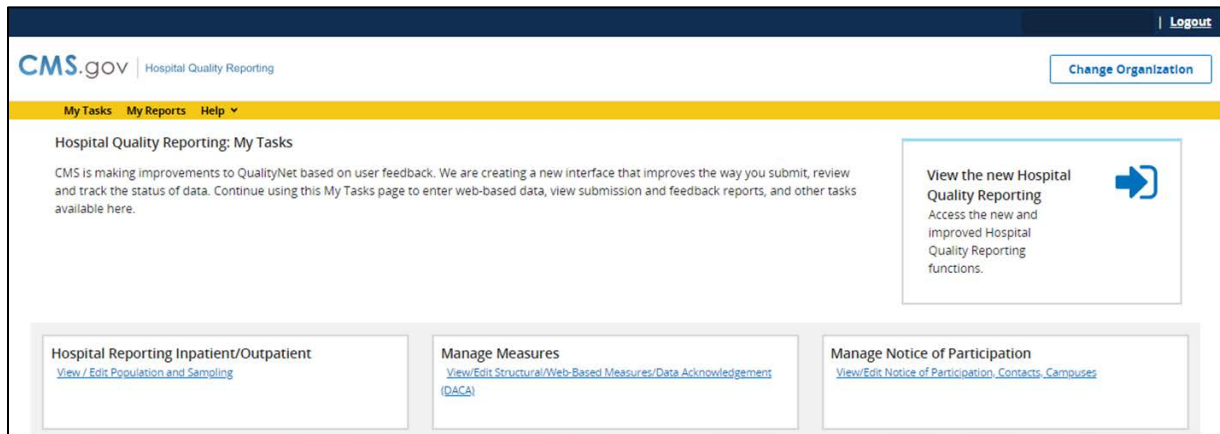
4. Enter the code received and click “Continue”



5. Read the Terms & Conditions and click on “Accept”



Once logged in, you will be taken to the “Hospital Quality Reporting: My Tasks” page



The content of the My Tasks page is dependent upon the user roles assigned to the individual. If assigned the appropriate roles, the user may perform one or more of the following tasks as they relate to the IPFQR Program:

- Manage measures – View/Edit Structural/Web-Based Measures/Data Acknowledgement (DACA)
- Manage Notice of Participation – View/Edit Notice of Participation, Contacts, Campuses
- Access reports from the My Reports link in the top menu
- Report Authorizations – View/Request/Approve Access
- Vendor Authorization – Authorize vendors to submit data
- Manage security



## ***User Roles***

For the IPFQR Program, there are two types of user roles that may be assigned. Those roles are the “Read Only” role and the “Update” role. The “Update” role allows the user to edit information within the application, whereas the “read only” role allows the user to view the information only. For more information regarding roles, refer to the earlier sections of this part of the manual, [Section 3 \*QualityNet\* Registration](#). Below is a list of roles that must be assigned to a user.

### **IPFQR Notice of Participation**

- IPFQR Notice of Participation Read
- IPFQR Notice of Participation Update

### **IPFQR Web-Based Measure/DACA Application**

- IPFQR Web-Based MSR DACA Read
- IPFQR Web-Based MSR DACA Update

### **IPFQR Reports**

- IPFQR Reports Read
- IPFQR Reports Update

### **IPFQR Vendor Authorization**

- IPF Vendor Authorization
- Hospital Reporting Feedback - IPFQR

### **File Exchange**

- File Search and Exchange

## Section 4: Vendor Authorization

Facilities may elect to use a vendor to collect and submit data on their behalf. A vendor must have an assigned vendor ID and be authorized to submit data prior to the IPF authorizing them to submit data or to have access to their facility's data and/or reports.

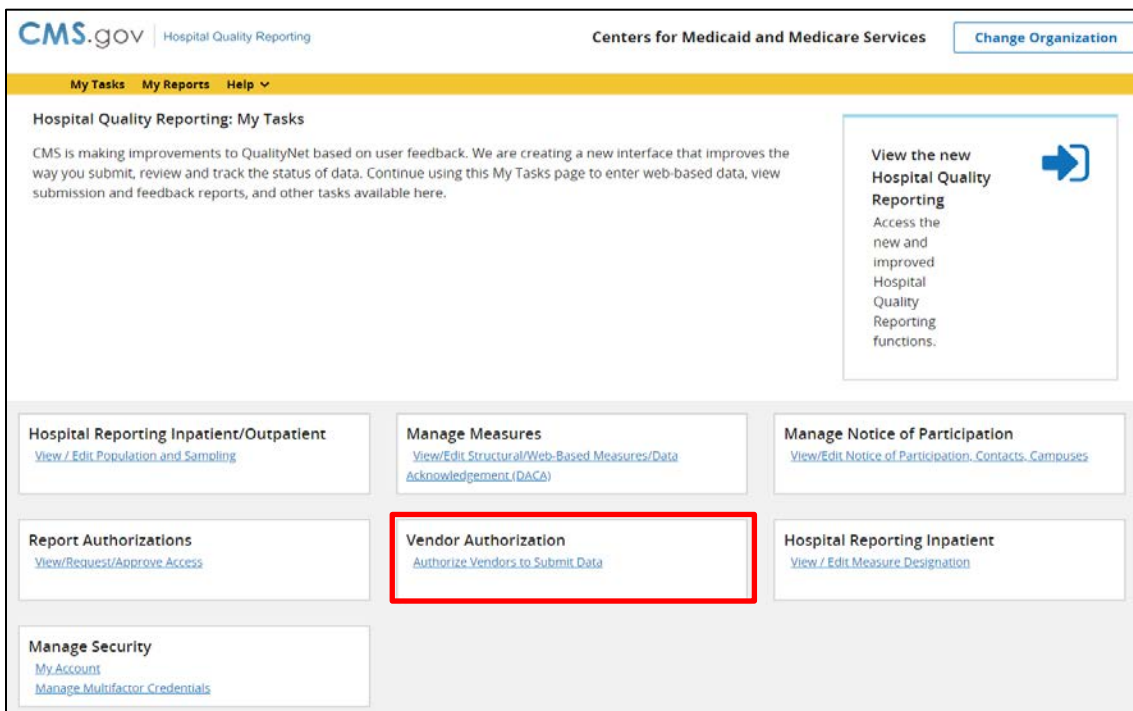
To receive the vendor registration information, the vendor may submit an email request to one of the following email addresses: [vendorreg@hcqis.org](mailto:vendorreg@hcqis.org) or [qnetssupport@hcqis.org](mailto:qnetssupport@hcqis.org).

**NOTE:** IPFs may authorize a vendor to submit data on behalf of the facility. However, CMS maintains that **an IPF is responsible for ALL data submission, even when contracting with a vendor.**

Vendors must be authorized to submit data on behalf of providers. The Authorize Vendors to Submit Data option enables providers to authorize vendors to submit web-based measure information. It also enables providers to update existing authorizations.

IPFs must have the IPF Vendor Authorization role to access the **Vendor Authorization** link.

1. Log in to the *QualityNet Secure Portal* and from the “Hospital Quality Reporting: My Tasks” page, select the *Authorize vendors to Submit Data* link in the box labeled **Vendor Authorization**.



2. The *Vendor Authorization* screen appears.

3. Select the Inpatient Psychiatric Facility program from the drop-down box and click **Submit**. The *Provider Information* screen appears.

4. Select either the **Add New Vendor Authorization** or the **Update Vendor Authorization** link.

All vendors that have been allowed to submit clinical data on the institution’s behalf are automatically authorized to submit web-based measures for the data submission period beginning July 1.

5. Select a vendor from the list and verify the correct vendor is displayed. Click the Continue button.

**NOTE:** Use the **Cancel** button to return to the previous page to make a vendor change, if necessary.

6. The **Add Dates to Selected Vendor** screen will appear.
7. The **Add Dates to Selected Vendor** screen will appear.

Select the **Calendar** icon to choose a Discharge/Encounter Date > Start and then Data Transmission Date > Start for the measures.

Both start dates are required, but end dates are not. The Discharge/Encounter Date > Start Date must be the first day of a quarter. The Data Transmission Date > Start Date must be equal to or greater than the current date.

### Recommendations

Do not enter end dates unless it is known that a specific vendor will not submit data after the specified end dates or if you are converting from one CMS Certification Number (CCN) to a new CCN. The Discharge/Encounter Date > End Date must be the last day of a quarter.

If you are terminating a vendor relationship at the end of a submission period, CMS recommends that you do not enter the submission deadline date as the Data Transmission

Date > End Date due to the possibility of a submission date extension. CMS recommends that you enter the Data Transmission Date > End Date when all data have been transmitted.

If more than one vendor is authorized for the same topic and timeframe, a message indicating there is more than one vendor authorized to submit data for the same measure set and time period will display. You will be able to proceed but will need to verify that the dates entered are correct.

8. Decide if the vendor selections are correct.
  - Select **Cancel** to return to the vendor's currently authorized page without saving.
  - Select **Continue** to proceed.

The Confirmation: Vendor Authorization Successful or Approve Updated Vendor Authorization page appears.

The screenshot shows a navigation bar with four steps: 'Select Vendor to Update', 'Update Dates', 'Approve Authorization Update', and 'Confirmation'. The 'Confirmation' step is highlighted. Below the navigation bar is a 'Provider Information' section with fields for 'Provider', 'CCN', and 'NPI'. A red box highlights the text 'CONFIRMATION: VENDOR AUTHORIZATION SUCCESSFUL' and a 'PRINT' button. Below this is a 'Vendor Name' and 'Vendor ID' section. A message states 'The vendor is to be authorized for the following measure set(s):'. A table shows the measure set 'IPF' with 'Discharge Date' (Start: 10/01/2012, End: 12/31/2018) and 'Data Transmission Date' (Start: 07/11/2013, End: End). At the bottom are buttons for 'ADD NEW VENDOR' and 'UPDATE VENDOR'.

The screenshot shows a navigation bar with four steps: 'Select Vendor to Update', 'Update Dates', 'Approve Authorization Update', and 'Confirmation'. The 'Approve Authorization Update' step is highlighted. Below the navigation bar is a 'Provider Information' section with fields for 'Provider', 'CCN', and 'NPI'. A red box highlights the text 'Approve Updated Vendor Authorization' and a 'PRINT' button. Below this is a 'Vendor Name' and 'Vendor ID' section. A message states 'The vendor is to be authorized for the following measure set(s):'. A table shows the measure set 'IPF' with 'Discharge Date' (Start: 10/01/2012, End: 12/31/2018) and 'Data Transmission Date' (Start: 07/11/2013, End: End). At the bottom are buttons for 'CANCEL', 'PREVIOUS', and 'CONFIRM AND SUBMIT'.

9. Verify that the vendor information and authorized dates are correct.
  - Select **Submit** if the information is as desired
  - Select **Edit** to return to the previous page to make any date changes.

**NOTE:** Once an authorization has been submitted, the only dates that can be modified are future dates. If incorrect dates were entered and need to be modified, please send an email to [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org) or call (866) 288-8912.

The Vendor Authorization Complete page will display and summarize the submitted Vendor Authorization.

10. Select **Print** for a printer-friendly copy of the authorization.

## Section 5: Notice of Participation

To participate in the IPFQR Program, each facility must complete a Notice of Participation (NOP). Once completed, the NOP remains in effect until an IPF decides to withdraw from the program or there is a change in their eligibility status.

Facilities that completed a NOP and plan to continue to participate in the IPFQR Program do not need to complete a NOP for subsequent years. The system will automatically update their NOP and populate the screen with the next fiscal year and annually thereafter. To verify the NOP was updated, it is recommended that the facility log in to the NOP application. It is also recommended that facilities log in to the NOP application to update their facility contacts, since this information was not available if a facility completed the paper NOP form.

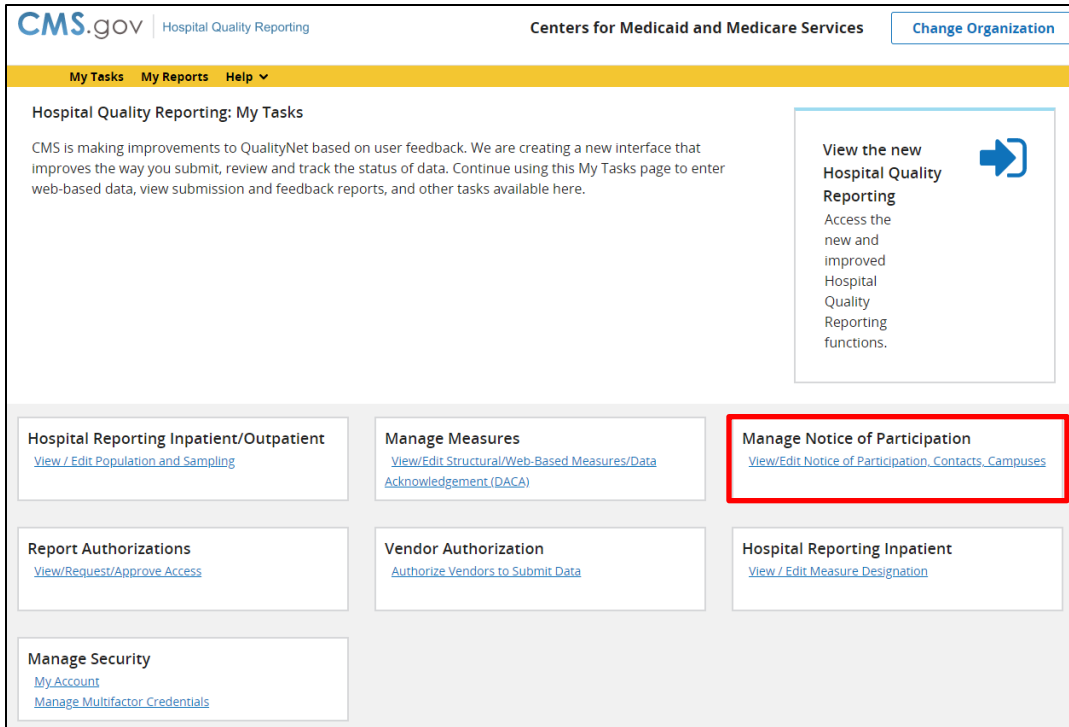
Eligible facilities that did not participate in the IPFQR Program previously may complete an online NOP at any time; however, new facilities must complete the NOP no more than 180 days from the Medicare Accept Date. All IPFs that are eligible to receive full APU for a given fiscal year must have an IPFQR Program NOP status of “Participating” by the annual August deadline (typically August 15). For example, IPFs must ensure that the NOP status is “Participating” by August 15, 2020, to meet the NOP requirement for the FY 2021 payment determination.

**NOTE:** Once an IPF has submitted a NOP status of “Participating,” the IPF is considered an active IPFQR Program participant and is subject to the IPFQR Program requirements to obtain full APU until the IPF submits a withdrawal of participation or until there is a change in the eligibility status of the IPF.

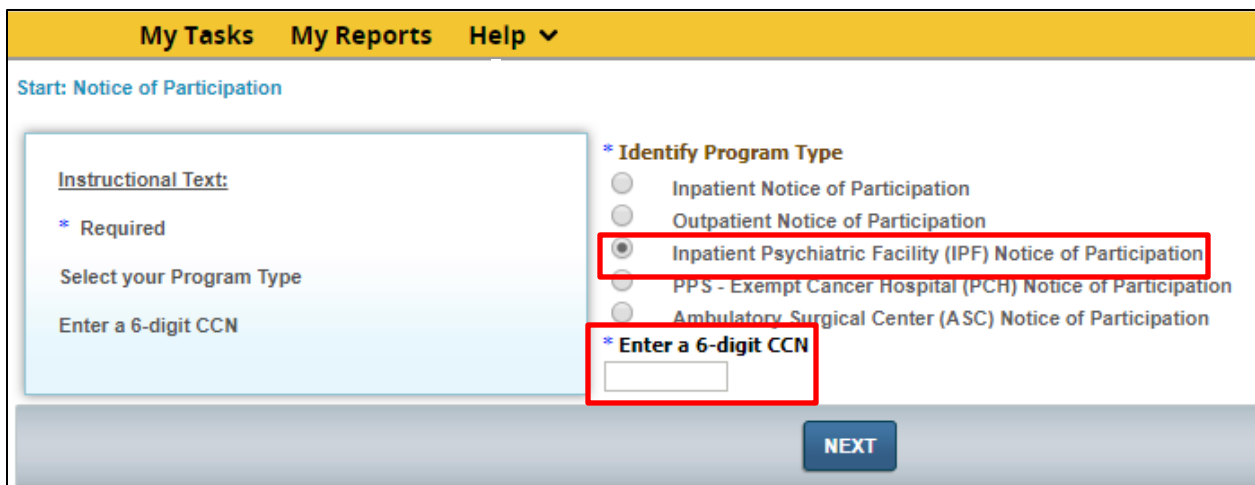
### Notice of Participation Application

To access the online NOP application:

1. Ensure the IPFQR NOP Read or IPFQR NOP Update (to add or edit) role has been assigned by the Security Administrator/Security Official.
2. Log in to the *QualityNet Secure Portal* and from the “Hospital Quality Reporting: My Tasks” page, select the *View/Edit Notice of Participation Contacts Campuses* link in the box labeled **Manage Notice of Participation**.



Users that are affiliated with only one facility will see their facility’s 6-digit CMS CCN after selecting the **Manage Notice of Participation** link under the *My Tasks* screen. Users that are affiliated with more than one program type will be prompted to select the radio button next to Inpatient Psychiatric Facility (IPF) Notice of Participation. Users that are affiliated with more than one facility will be prompted to enter the 6-digit CCN, as shown below.



3. Select the action to be completed.

**View, Add, or Update** the Notice of Participation, Contacts, or Additional Campuses information.

Additional campus information may not apply to all IPFs. It is applicable for facilities that have more than one physical location but are licensed and reimbursed under the same CCN.

Quality data are reported and published under the same CCN regardless of the number of physical locations associated with a CCN.

- If this is the first time the NOP is being added, enter the contact information. Do not enter a pledge before entering contact information. Notice no pledge exists for this provider.

- Select Contacts from the list.



6. Enter at least **two** facility contacts within the contact screen and ensure that the “Yes” box is checked to indicate that an email notification will be sent to the contact if there are any NOP, Contact, or Campus data changes.


E-mail if Notice of Participation, Contact or Campus data changes. Two contacts for e-mail notification are required.

Yes

7. Select the desired pledge option and the acknowledgement check box.

Upon initial completion of the NOP, two pledge options are available: **Participate** or **Do not agree to participate**.

IPFQR Notice of Participation

**Provider Name** 

**Provider ID**                      **Medicare Accept Date**                      **Facility Close Date**

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**Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Notice of Participation**

Please review the Notice of Participation below.

**Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Notice of Participation Agreement**

The Inpatient Psychiatric Facility (IPF) agrees to follow procedures for participating in the IPFQR Program as outlined in the federal regulations found in the Federal Register, or is indicating its decision to decline participation. The IPF understands that participation in the IPFQR Program is voluntary for the applicable fiscal year.

Each IPF must complete this "IPFQR Notice of Participation" (IPFQR Notice) as outlined in the IPFQR QualityNet and in the federal regulations found in the Federal Register. In an effort to alleviate the burden associated with submitting this form annually, effective with the IPFQR Notice submitted for participation in FY 2014 program year or later, an IPF that indicated its intent to participate will be considered an active IPFQR Program participant until CMS determines a need to resubmit the IPFQR Notice, or the IPF submits a request for withdrawal to CMS.

This information is in compliance with the CMS guidelines for IPFs submitting their quality performance data in accordance with section 1886(s)(4) of the Social Security Act. Pursuant to section 1886(s)(4)(E) of the Act, IPFs agreeing to participate in the IPFQR Program will have their data publicly displayed on the CMS website after being afforded the opportunity to review their data.

**We entities operating under the submitted Provider ID:**

[Agree to participate.](#)

[Do not agree to participate.](#)

This acknowledgement (to participate or not to participate or to withdraw) remains in effect until an electronically signed acknowledgement applying changes has been entered.

By entering my acknowledgement, I hereby issue this IPFQR Notice of Participation with the specified direction contained within:

**By entering this pledge, I agree to:**

- (1) Transmit or have data transmitted to CMS; and
- (2) Permit my hospital's performance information to be publicly reported.

<  >

8. Following the pledge selection select the **Save** button.  
A confirmation screen appears asking the user to confirm the selection to save the document.

Each IPF must complete this "IPFQR Notice of Participation" (IPFQR Notice) as outlined in the IPFQR QualityNet and in the federal regulations found in the Federal Register. In an effort to alleviate the burden associated with submitting this form annually, effective with the IPFQR Notice submitted for participation in FY 2014 program year or later, an IPF that indicated its intent to participate will be considered an active IPFQR Program participant until CMS determines a need to resubmit the IPFQR Notice, or the IPF submits a request for withdrawal to CMS.

This information is in compliance with the CMS guidelines for IPFs submitting their quality performance data in accordance with section 1886(s)(4) of the Social Security Act. Pursuant to section 1886(s)(4)(E) of the Act, IPFs agreeing to participate in the IPFQR Program will have their data publicly displayed on the CMS website after being afforded the opportunity to review their data.

\* We entities operating under the submitted Provider ID:521354

[Agree to participate.](#)  
 [Do not agree to participate.](#)  
 [Request to be withdrawn from participation.](#)

**Confirm SAVE?**

Select "YES" to confirm, save and submit your action(s), or select Cancel to return back to the pledging page.

This acknowledgement (to participate or not to participate or to withdraw) remains in effect until an electronically signed acknowledgement applying changes has been entered.

\*  By entering my acknowledgement, I hereby issue this IPFQR Notice of Participation with the specified direction contained within:

By entering this pledge, I agree to:

- (1) Transmit or have data transmitted to CMS; and
- (2) Permit my hospital's performance information to be publicly reported.

As a reminder, once a facility has agreed to participate, they remain a program participant until they log in and select the option to not participate or withdraw.

## Section 6: Data Accuracy and Completeness Acknowledgement

IPFQR Program participants enter NOP and measure data using the web-based applications on *QualityNet*. Following the submission of the measure data, each IPF must attest to the accuracy and completeness of the entered data via a Data Accuracy and Completeness Acknowledgement (DACA) statement. The DACA must be completed annually by the August 15 submission deadline, unless directed otherwise via the IPFQR Program Listserve.

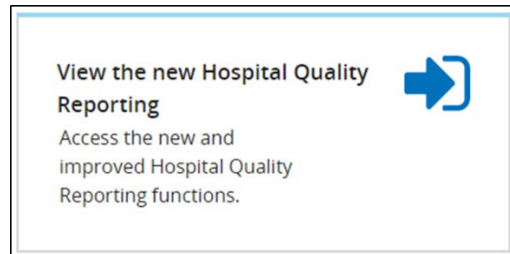
1. The IPFQR Program DACA is only accessible in the *QualityNet Secure Portal* from the Data Entry page by a representative of the IPF. After submitting data, a prompt to sign the DACA form will appear in a blue banner at the top of the simple data entry overview page. Click the “Sign” button to view and sign the DACA.



**i** IPFQR DACA - Signature Needed by Provider  
Provider must sign annual acknowledgement of submission accuracy. [Sign](#)

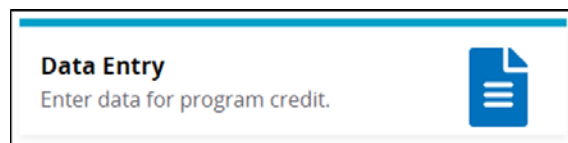
**✓** IPFQR Measures Successfully Submitted  
IPF measures for ABCDE Community Hospital have been successfully submitted.

- a. When a representative of the IPF is logged into the *QualityNet Secure Portal* the blue banner will appear immediately after all data are successfully submitted
- b. If not currently logged in when ready to sign the DACA, a representative of the IPF must complete the following steps to access the DACA form.
  - i. Log in to the *QualityNet Secure Portal*
  - ii. Click on the “**View the new Hospital Quality Reporting**” box on the upper right side of the My Tasks page.



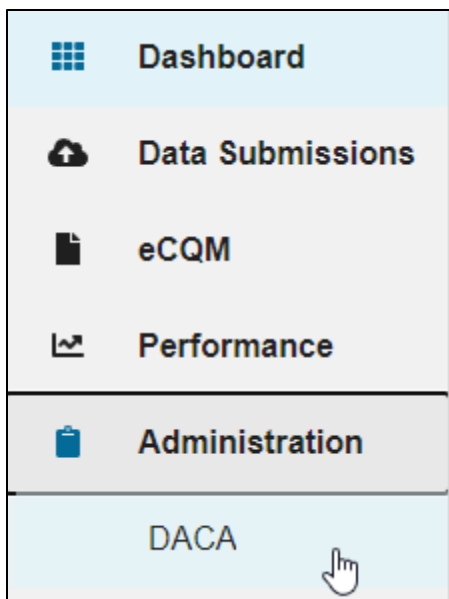
View the new Hospital Quality Reporting  
Access the new and improved Hospital Quality Reporting functions.

- iii. Select the “**Data Entry**” button.



**Data Entry**  
Enter data for program credit.

2. Click the “Sign” button to view and sign the DACA.
3. Enter your job title in the field below “Position.”
4. Click the button next to the statement “I confirm that the information I have submitted is accurate and complete to the best of my knowledge.”
5. Click the “Sign” button at the bottom of the page. Once the DACA is submitted successfully, a confirmation message will appear above the signature line.
  - At the bottom of the page will be a “Re-Sign” button, which will provide the option to sign the DACA Form again should you need to edit and re-save any measure and/or non-measure data on the data entry pages
  - Also, at the bottom of the page is the option to export the signed DACA as a PDF form.



6. To view a signed DACA, hover your mouse on the left side of the screen
7. Select the “Administration” button at the bottom of the list. Click on “DACA.” You will be able to view, and, if needed, re-sign the DACA form.
  - **NOTE:** The DACA form is updated annually to address the payment determination year impacted by the current data submission period. The updated form is accessible only during the annual data submission period.

## Section 7: Accessing and Reviewing Reports

Reports described in this section are helpful in monitoring IPF status as it relates to the IPFQR Program. The reports should be used as reference tools and do not guarantee a facility will receive its full APU. Updated versions of the Facility, State and National Report and the Provider Participation Report are in development. IPFs will be notified via the IPFQR Program Listserve once the reports are available in the *QualityNet Secure Portal*.

The Facility, State and National Report provides information about the data that are submitted to CMS. The facility rate is specific to the facility accessing the report. The state and national rates are calculated approximately 30 days following the end of the submission period. This information is used for an individual facility to compare its facility-specific rates with state and national averages for each measure.

The Provider Participation Report provides the facility with a summary of the requirements for participation in the IPFQR Program. The report assists IPFs in determining their facility's status towards meeting the program requirements. However, the information provided does not guarantee the hospital will receive the full APU. Follow the steps below to check whether your facility has met all IPFQR Program requirements.

1. Check *QualityNet* SA status.
  - Ensure that the SA at your IPF logs in to the *QualityNet Secure Portal* at least once during the data submission period
  - If SA status has lapsed, call the *QualityNet* Help Desk at (866) 288-8912 for assistance.
2. Check NOP.
  - Go to the HQR My Tasks page to ensure the IPFQR Program NOP status is "Participating." Refer to instructions provided in Section 6 of this manual.
3. Check accuracy of data.
  - Review the exported PDF data report against facility data.
4. Check DACA.
  - Ensure that DACA status is complete in *QualityNet Secure Portal* based on instructions provided in Section 6 of this manual.

## Section 8: Public Reporting of IPFQR Program Data

### **Background**

Section 1886(s)(4)(E) of the Social Security Act requires the Secretary of Health and Human Services to establish procedures for making the data submitted under the IPFQR Program available to the public.

CMS has made that data available to the public on [Hospital Compare](#) and [data.Medicare.gov](#). CMS is replacing these two websites with successor websites, [Medicare Care Compare](#) and [Provider Data Catalogue](#), respectively. This IPFQR program manual will therefore refer to the new [Medicare Care Compare](#) and [Provider Data Catalogue](#) websites rather than the older legacy websites.

### **Public Display Timeline**

The IPFQR Program will have quality of care data publicly displayed on an annual basis.

### **Preview**

Prior to the public release of data on CMS websites, facilities are given the opportunity to preview data for 30 days. Preview reports will be accessible for download by the facility via the Hospital Quality Reporting Public Reporting User Interface, and Claims-based measure (CBM) IPF-Specific Reports (ISRs) will be accessible for download by the facility via the Secure File Transfer function in the *QualityNet Secure Portal*. Providers will be notified via Listserve and on the [QualityNet](#) home page when the reports are available.

Preview Reports and ISRs are delivered separately although generally during the same timeframe. CBM results will be displayed in the same locations on the [Medicare Care Compare](#) and [Provider Data Catalogue](#) websites as the results for the remainder of the IPFQR program's measure data. Non-measure data are not publicly displayed on the [Medicare Care Compare](#) and [Provider Data Catalogue](#) websites.

### ***Preview Report Content***

The [Compare tool on Medicare.gov Preview Help Guide: Inpatient Psychiatric Facility Quality Reporting Program](#) is a tool that provides detailed information about the Preview Report. Some of the highlights include:

- An overview of public reporting for the IPFQR Program
- Instructions on how to access preview reports
- Details about the IPFQR preview report

In addition, a one-page quick reference guide is also available to provide an overview of how to access the Preview User Interface by logging into the Hospital Quality Reporting system as well as the content of the Preview Report content.

These are optional, informal tools that are currently available online on the following websites:

- [QualityNet](#) on the [IPF Public Reporting](#) page
- [Quality Reporting Center](#) on the [IPFQR Program Resources and Tools](#) page

### ***IPF-Specific Reports (ISRs) for Claims-Based Measures***

The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program provides inpatient psychiatric facilities (IPFs) with IPF-Specific Reports (ISRs) for claims-based measures.

ISRs allow IPFs to review the information that will be publicly reported annually for the Follow-Up After Hospitalization for Mental Illness and Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF measures which are calculated by Centers for Medicare & Medicaid Services (CMS) using administrative claims data. ISRs also contain confidential information that is not available to the public, like the beneficiary level claims data and risk factors used to calculate the measures, to help inform quality improvement activities.

Registered users who have been assigned the Hospital Reporting Feedback - IPFQR role and the File Exchange and Search role will receive an Auto Route File Delivery Notification email indicating that the ISRs are available. The files will be available for download for 60 days. New users can create an account by visiting <https://QualityNet.cms.gov/>.

Resources with instructions on how to download and interpret your data are available on the IPFQR Program Resources and Tools page on <https://www.QualityReportingCenter.com>.

The ISR user guides for the three claims-based measures provide detailed information about the ISR for each measure. Some of the highlights include:

- Instructions on how to access ISRs
- Details about the ISRs

A one-page quick reference guide is also available to provide an overview of the Claims-Based Measure Confidential Review Period. The *Quick Reference Guide for Claims-Based Measure Confidential Review Period* contains detailed instructions on how to download your ISRs and the Claims-Based Measure Specifications document contains information on how each measure was calculated.

## Medicare.gov Care Compare Website

**Direct Link:** <https://www.medicare.gov/care-compare/>

The following instructions describe how to navigate the *Care Compare* website to view, download, sort, and filter IPFQR Program data.

### **Access and Compare IPFQR Program Data from up to Three Facilities in the *Care Compare* Pages**

1. Access the [Medicare Care Compare Search](http://medicare.gov/care-compare/) webpage (<http://medicare.gov/care-compare/>).
2. There are two ways to search for a list of facilities.
  - a. Use the search function by:
    - i. Entering a ZIP code, or city (state options will auto-populate), or select “Use my current location” in the My Location field
    - ii. Selecting a provider type from the drop-down menu
    - iii. Entering keywords (optional), and
    - iv. Clicking the Search button.

Medicare.gov Login About Glossary Español

## Find & compare doctors, hospitals & other providers near you.

[Learn more about the types of providers listed here](#)

MY LOCATION PROVIDER TYPE KEYWORDS (OPTIONAL)

ZIP code or city  Select one

Use my current location



b. Select a provider type by clicking on one of the icons below the main search tool.

Or, select a provider type to learn more:

The image shows a grid of eight icons representing different provider types. Each icon is accompanied by a text label below it. The icons are: a doctor with a stethoscope, a blue square with a white 'H', a house with 'NH' inside, a house with a heart on top, hands holding a heart, a person sitting at a table, a multi-story building with a cross, and two kidneys.

- Doctors & clinicians
- Hospitals
- Nursing homes including rehab services
- Home health services
- Hospice care
- Inpatient rehabilitation facilities
- Long-term care hospitals
- Dialysis facilities

- i. Click “Hospitals” to search for inpatient psychiatric facilities.
- ii. Enter a ZIP code or city (state options will auto-populate) or select “Use my current location” in the My Location field.

The screenshot shows the 'Hospitals' search page. On the left, there is a large blue 'H' icon and the heading 'Hospitals'. Below the heading, there is a paragraph of text: 'Find and compare information about the quality of care at over 4,000 Medicare-certified hospitals, including over 130 Veterans Administration (VA) medical centers and over 50 military hospitals, across the country'. On the right, there is a search section titled 'Search for hospitals near you' with a 'MY LOCATION' dropdown menu. The dropdown menu has two options: 'ZIP code or city' and 'Use my current location', both with a green arrow icon to the right.

iii. Click the Search button.

3. On the next page, select up to three hospitals to compare by clicking on the “Compare” button. As each hospital is selected, it will appear in the blue bar near the top of the page.



4. Once selections are complete, click the “Compare” button to the right of the selections in the blue bar near the top of the page.

The screenshot shows a blue bar at the top of the page. It contains three hospital names in white text, each followed by a small 'x' icon: 'ABCDE University Medical Center', 'ABCDE Oaks Hospital', and 'ABCDE Medical Center'. To the right of these names are two buttons: 'Cancel' and 'Compare'. The 'Compare' button is highlighted with a red border.

- The next page will display the selected hospitals in a row at the top and default to the Overview tab. Click on the “Psychiatric unit services” tab to compare IPFQR Program measure results between the selected facilities.

HOSPITALS	
Overview	▼
Overall rating details	▼
Patient survey rating	▼
Timely & effective care	▼
Complications & deaths	▼
Unplanned hospital visits	▼
<b>Psychiatric unit services</b>	▼
Payment & value of care	▼

- In the “Psychiatric unit services” tab you will find 1) a brief introduction and 2) a table containing measure information. Scroll down the page to view measure descriptions and results for the selected providers in the “Psychiatric unit services” tab.

### Psychiatric unit services ^

1

These quality measures show how often or how quickly inpatient psychiatric facilities give recommended treatments and services known to get the best results for people with mental health conditions, substance abuse, and other health conditions. Some measures also describe whether these facilities have certain processes and procedures in place. This information can help you compare the quality of care inpatient psychiatric facilities provide to patients. Note that an N/A will be displayed where a hospital doesn't have an inpatient psychiatric unit. An N/A is also used to indicate the hospital doesn't have psychiatric measure data to report. [Read less](#)

#### Preventive care & screening

2

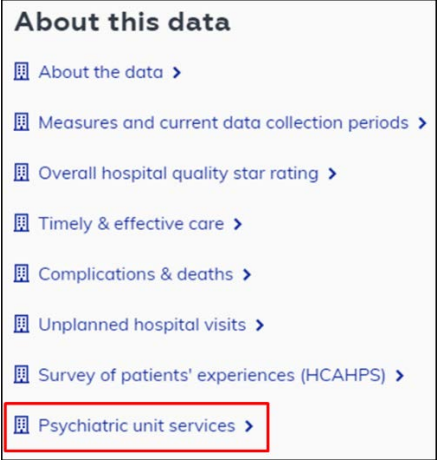
Patients discharged on antipsychotic medications who had body mass index, blood pressure, blood sugar, and cholesterol level screenings in the past year <small>↑ Higher percentages are better</small>	Not available <small>ⓘ</small>	98%	Not available <small>ⓘ</small>
National average: 74% TX average: 72%			

- The left column of the table includes the measure description, indicator of whether higher or lower values are better, the national average for the measure, and the state average for the measure
  - The columns to the right show the results specific to the facilities selected for comparison
  - The statement “Not available <sup>5</sup>” indicates that the facility did not have results to report for this reporting period.
- To learn more about and download hospital data click the link at the bottom of the page to access the data catalog on CMS.gov.

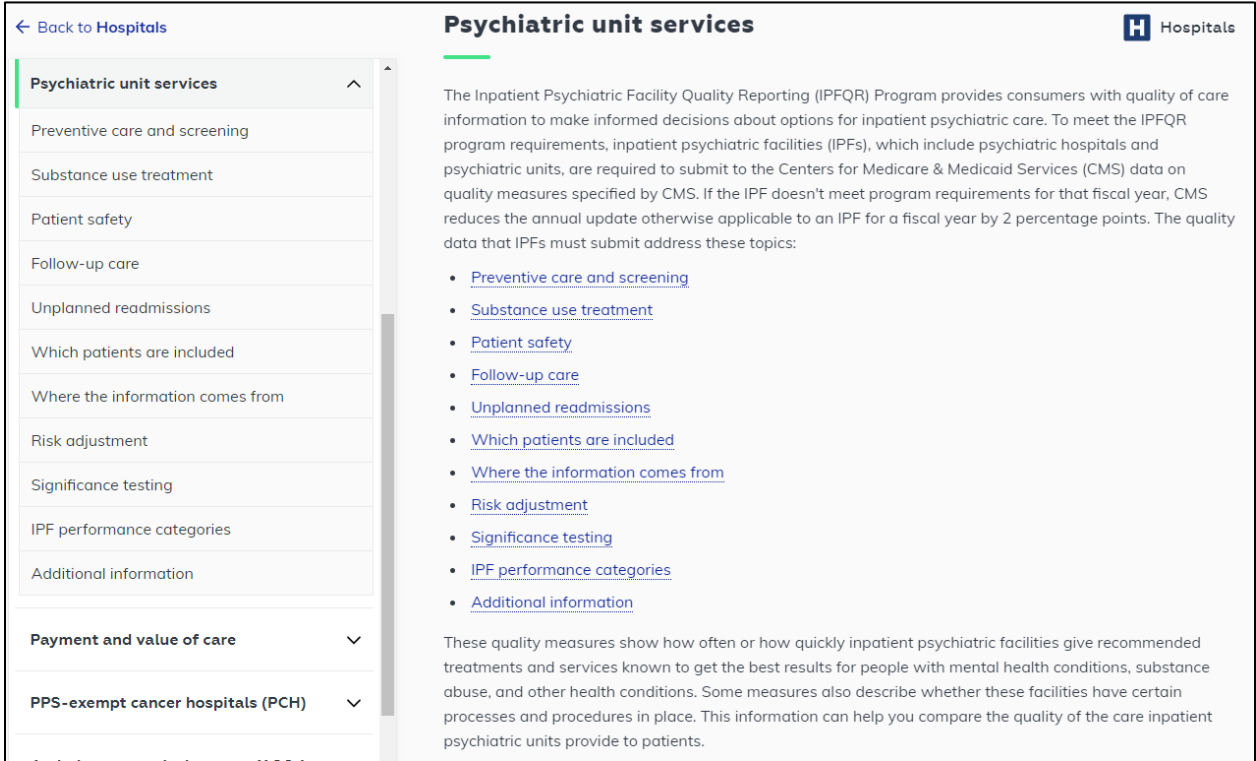
To explore and download hospital data, [visit the data catalog on CMS.gov](https://data.cms.gov)

### Find More Details About the IPFQR Program Measures in the Provider Data Catalogue

1. Go to <https://data.cms.gov/provider-data/topics/hospitals> to access the Provider Data Catalogue webpage for hospitals.
2. Scroll down to the “About this data” header and select “Psychiatric unit services.”



3. The next page includes a menu of topics on the left side. On the right side, you will find a brief description of the IPFQR Program, a list of hyperlinks that align with the menu items on the left side of the page, a series of tables listing each quality measure, a description of what it is, and why it is important.



## Access the Most Recently Reported IPFQR Program Data in the Provider Data Catalogue

1. Go to <https://data.cms.gov/provider-data/search>.
2. Type Inpatient Psychiatric Facility in the search field, and links to the facility, state, and national-level data will appear. Note that text highlighted in green indicates key words identified in the search field.

The screenshot shows a search interface with the following elements:

- Search** header.
- A search input field containing "Inpatient Psychiatric Facility" with a red border and a clear button (X).
- Results summary: "3 datasets found for 'Inpatient Psychiatric Facility'" and a "Clear all filters" link.
- Three result cards, each with a yellow "Hospitals" tag:

  - Card 1:** "Inpatient Psychiatric Facility Quality Measure Data - by State". Description: "Psychiatric facilities that are eligible for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program are required to meet all program requirements, otherwise their Medicare payments may be reduced." Last updated Jun 16, 2020. Includes a "Download CSV" link.
  - Card 2:** "Inpatient Psychiatric Facility Quality Measure Data - by Facility". Description: "Psychiatric facilities that are eligible for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program are required to meet all program requirements, otherwise their Medicare payments may be reduced." Last updated Jun 16, 2020. Includes a "Download CSV" link.
  - Card 3:** "Inpatient Psychiatric Facility Quality Measure Data - National". Description: "Psychiatric facilities that are eligible for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program are required to meet all program requirements, otherwise their Medicare payments may be reduced." Last updated Jun 16, 2020. Includes a "Download CSV" link.

3. Select the hyperlink ending in “by Facility” to view facility-level data.
4. On the next page, you will see the following:
  - Overview
  - Dataset explorer
  - View topic details
  - The option to “Download this dataset” as a CSV file
  - The Hospital Compare Data Dictionary in PDF format

5. Click the “Download this dataset” link to download the facility-level data for further analysis. This process is also applicable for the State and National level data tables.

### View Facility-Level IPFQR Program Data

Listed below are instructions on how to view the numerator, denominator, and rate or percentage values of a measure(s) reported to the IPFQR Program by a specific IPF by CCN. The following instructions describe ways to review the data set in Microsoft Excel by Facility; however, these instructions are also applicable for the State and National level data tables.

1. Follow instructions listed above on how to download the dataset as a CSV or CSV for Excel file.
2. Open the file from Microsoft Excel. At this point, you may choose to save the file as a Microsoft Excel file using the naming convention of your choice.
3. Add filters to columns.
  - a. Select columns all the way across from column A through the last column of data that you wish to review.
  - b. Click the **Sort & Filter** button in the top Home menu.
  - c. Select **Filter**.
4. View data for one or more specific IPFs, preserving all original data in the file.
  - a. Click on the filter down arrow for Column A. A list of all CCNs will appear.
  - b. Deselect the checkbox next to **Select All**.
  - c. Click on the checkbox next to the CCN(s) of the IPF(s) you wish to view.
  - d. Click **OK** and only data for the selected CCN(s) will appear. To view all data for all CCNs, go back to the filter for Column A and select the checkbox next to **Select All**.
5. View data for one or more specific IPFs, removing data for other facilities from the file.
  - a. Right-click on the tab of the original data file.
  - b. Select **Move** or **Copy**.
  - c. Click on the checkbox next to “Create a copy” and click **OK**.
  - d. Click on the filter down arrow for Column A in the copy version of the spreadsheet. A list of all CCNs will appear.
  - e. Deselect the checkbox next to the CCN(s) of the IPF(s) you wish to keep

- f. Click **OK**.
  - g. Highlight from Row 2 down to the last CCN listed in the file.
  - h. Right click and select **Delete Row**.
  - i. Click on the filter for Column and select the checkbox next to **Select All** to review the data for the remaining IPF(s) selected in step 5e.
6. View data for only one measure for providers in State X.
    - a. Click on the filter in column E.
    - b. Deselect **State X**.
    - c. Highlight rows 2 through last row of data.
    - d. Right click and select **Delete Row**.
    - e. Click on the filter in column E.
    - f. Select **State X**.

### Access the Previously Reported IPFQR Program Data in the *Provider Data Catalogue Hospitals Data Archive*

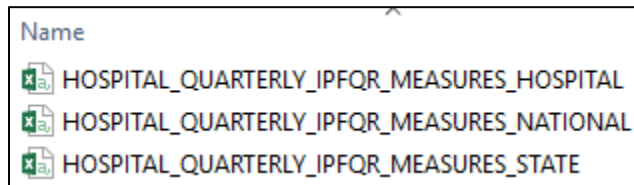
1. Go to <https://data.cms.gov/provider-data/archived-data/hospitals> to access the *Provider Data Catalogue Hospitals data archive* webpage.

The screenshot displays the CMS.gov website's 'Hospitals data archive' page. The header includes the CMS.gov logo and navigation links for 'About Us', 'Newsroom', and 'Data & Research'. The main navigation bar contains 'Home', 'Datasets', 'Topics', and 'About'. The page content is organized into a sidebar with 'Back to Topics' and a list of 'Annual Files' from 2013 to 2020. The main area shows a detailed view for the '2020 Annual Files' and '2019 Annual Files', each with a 'Download all' link. The 2020 files list includes: hospitals\_archive\_10\_2020.zip (10/2020, 13 MB), hospitals\_archive\_08\_2020.zip (08/2020, 13 MB), hos\_revised\_flatfiles\_archive\_04\_2020.zip (04/2020, 16 MB), and hos\_revised\_flatfiles\_archive\_01\_2020.zip (01/2020, 16 MB). The 2019 files list includes: hos\_revised\_flatfiles\_archive\_10\_2019.zip (10/2019, 17 MB), hos\_revised\_flatfiles\_archive\_07\_2019.zip (07/2019, 22 MB), hos\_revised\_flatfiles\_archive\_04\_2019.zip (04/2019, 18 MB), and hos\_revised\_flatfiles\_archive\_03\_2019.zip (03/2019, 19 MB).

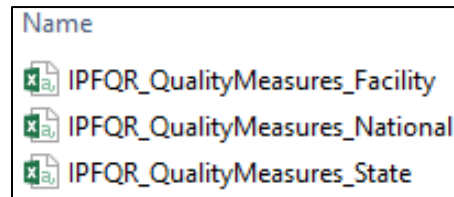
2. A new window or tab will open, listing annual files by year. Each zip file contains Microsoft Excel Comma Separated Values (CSV) files for all data reported to CMS.

Notes:

- The most current zip file for a given year will include “revised\_flatfiles” in the file name.
- In the 2017 and prior annual files, the Excel file name for facility-level data will be listed as “HOSPITAL\_QUARTERLY\_IPFQR\_MEASURES\_HOSPITAL”.



- In the 2018 and subsequent annual files, the Excel file name for facility-level data will be listed as “IPFQR\_QualityMeasures\_Facility”.



## Section 9: Resources

This section contains additional resources available to IPFs participating in the CMS IPFQR Program.

### IPFQR Program Webinars

CMS and the IPFQR Support Contractor provide National Provider Webinars on a routine basis. The slides from each of the education sessions are published to the *QualityNet* website and are available for review from the [Inpatient Psychiatric Facility Quality Reporting \(IPFQR\) Program](#) landing page by selecting the [Webinars](#) link from the top menu. These materials are also available on the *Quality Reporting Center* website on the [Archived Events](#) webpage.

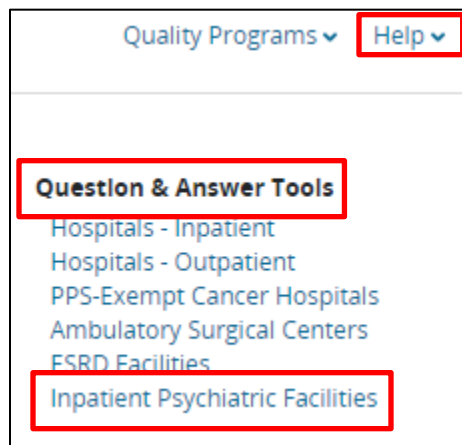
### IPFQR Program Listserve

To receive important IPFQR Program updates and notifications, please subscribe to the IPFQR Program Listserve on the *QualityNet* website. On the *QualityNet* home page, select the “Subscribe to Email Updates” box, enter your User Information, check the box next to Inpatient Psychiatric Facility Quality Reporting Program, and click **Submit**.

### Questions & Answers

The CMS Q&A tool is also a good resource for program information. The tool is intended to help users quickly find program answers.

1. Users can access the Q&A tool from *QualityNet* by hovering over the “Help” link at the top right of the screen and selecting the **Inpatient Psychiatric Facilities** link under Question & Answer Tool section. The direct link is [https://cmsqualitysupport.servicenowservices.com/qnet\\_qa](https://cmsqualitysupport.servicenowservices.com/qnet_qa).

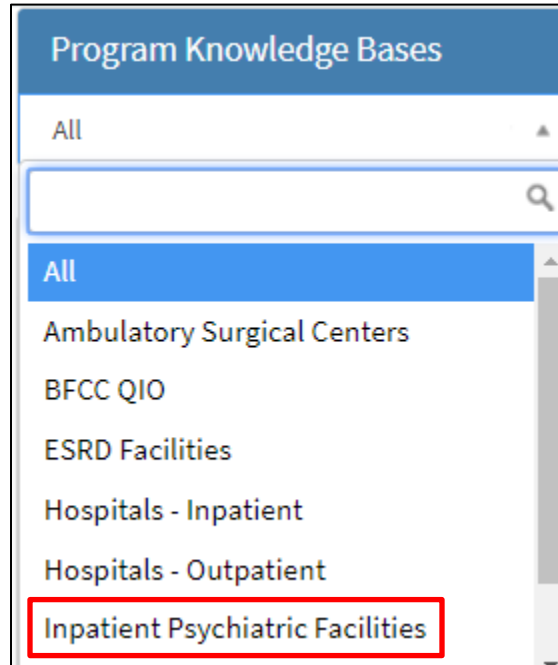


2. From the landing page, click the **Browse** button.

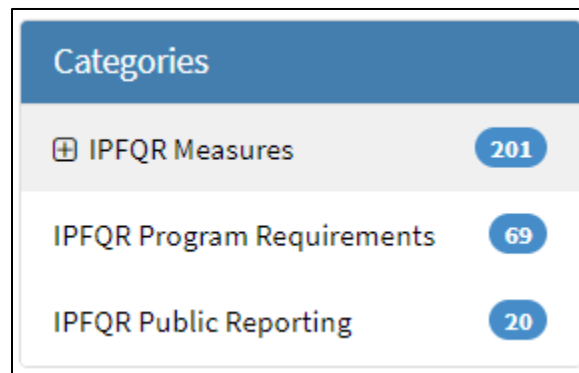




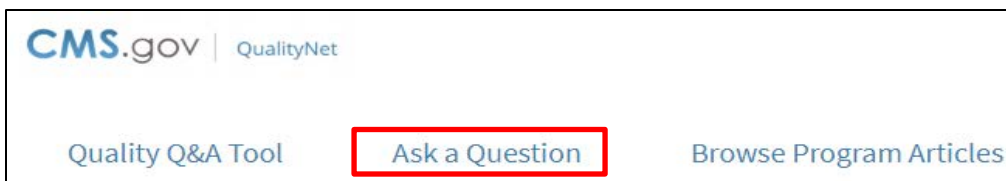
3. On the left side of the screen select Inpatient Psychiatric Facilities from the drop-down menu under Program Knowledge Bases.



4. Under Categories, select the applicable category. Click the plus sign next to the IPFQR Measures category to see additional options. You can browse the Top-Rated Articles, Most View Articles, or enter your question in the search field.



5. If you do not find an answer to your question via the **Browse** function, select the **Ask a Question** link to submit a question to the IPFQR Support Contractor.



6. You may also reach the IPFQR Support Contractor in the following ways:

- Toll-Free Telephone: (844) 472-4477 or (866) 800-8765  
Hours of Operation: 8:00 a.m.–8:00 p.m. Eastern Time
- Email: [IPFQualityReporting@hsag.com](mailto:IPFQualityReporting@hsag.com)

## **Help Desk - QualityNet**

For technical issues, you may reach the *QualityNet* Help Desk in the following ways.

- Toll-Free Telephone: (866) 288-8912  
Hours of Operation: 7:00 a.m.–7:00 p.m. Central Time
- Email: [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org)

## **QualityNet Website**

The IPFQR Program uses *QualityNet* to publish information including requirements, announcements about educational offerings, and news stories. The IPFQR Program home page is located at the following link: <https://qualitynet.cms.gov/ipf>

## **Paper Tools**

Measure abstraction and non-measure data collection paper tools have been developed for IPFs to use as an **optional** mechanism to aid in the collection of measure data for the CMS IPFQR Program. The paper tools are available at the following websites:

- *QualityNet*: [IPFQR Measures Resources](#)
- *Quality Reporting Center*: [IPFQR Program Resources and Tools](#)

## **Specifications Manuals for Chart-Based Measures**

### ***Specifications Manual for Joint Commission National Quality Measures***

To access this manual for specific detailed information for the HBIPS, SUB, TOB, and IMM measures, use the following link:

<http://manual.jointcommission.org/bin/view/Manual/WebHome>.

### ***Care Transitions – Performance Measurement Set***

To access this document for specific detailed information for the Transition Record measures, use the following link:

[http://cdn.ymaws.com/www.thecpci.org/resource/resmgr/Care\\_Transitions\\_updated\\_mea.pdf](http://cdn.ymaws.com/www.thecpci.org/resource/resmgr/Care_Transitions_updated_mea.pdf)

## **Claims-Based Measures Specifications**

Specifications concerning the Follow-Up After Hospitalization for Mental Illness, the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF), and the Medication Continuation Following Inpatient Psychiatric Discharge measures are available at the following websites:

- *QualityNet*: [IPFQR Program Resources](#)
- *Quality Reporting Center*: [IPFQR Program Resources and Tools](#)

## **National Committee for Quality Assurance (NCQA)**

NCQA is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality (<http://www.ncqa.org/>).

## **Other Resources**

### *National Institute on Alcohol Abuse and Alcoholism (NIAAA)*

NIAAA is one of the 27 institutes and centers that comprise the National Institutes of Health (NIH). NIAAA supports and conducts research on the impact of alcohol use on human health and well-being. It is the largest funder of alcohol research in the world. The NIAAA has published a list of validated screening tools that may be used by facilities in conducting their alcohol screening for the SUB measures (<http://www.niaaa.nih.gov/>).

## Appendix A: Psychiatric Advance Directives (PAD)

### General Information

The Patient Self Determination Act of 1990 amends titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act to require hospitals, skilled nursing facilities, home health agencies, hospice programs, and health maintenance organizations to: (1) inform patients of their rights under State law to make decisions concerning their medical care; (2) periodically inquire as to whether a patient executed an advanced directive and document the patient's wishes regarding their medical care; (3) not discriminate against persons who have executed an advance directive; (4) ensure that legally valid advance directives and documented medical care wishes are implemented to the extent permitted by State law; and (5) provide educational programs for staff, patients, and the community on ethical issues concerning patient self-determination and advance directives. More information can be found at this link <https://www.congress.gov/bill/101st-congress/house-bill/4449>.

Medical facilities that receive Medicaid and Medicare funds must have procedures in place for handling patients' advance directives, and to tell patients upon admission about their rights under state law to use advance directives. The PSDA does not set standards for what advance directives must say; it does not require facilities to provide advance directive forms; and it does not require people to have advance directives. Rather, the PSDA's purpose is to make people aware of their rights.

**For the purposes of the Transition measures, details regarding advance directives (including those for mental health purposes) should be included in the transition record. Review Section 4 for additional information and definitions. Listed below are common components of a Psychiatric Advance Directive, followed by a sample PAD that can be used by IPFs in creating documents used in the facility.**

### Common Components of a Psychiatric Advance Directive

- **Part 1:** A statement of one's intent in creating an advance directive for behavioral health care decision-making
- **Part 2:** The designation of another person to make decisions for an individual, if he or she is determined to be legally incompetent to make choices. Generally, this designation also includes provisions for who should be appointed as guardian, if a court decides to name one.
- **Part 3:** Specific instructions about preferences for hospitalization and alternatives to hospitalization, medications, electroconvulsive therapy, and emergency interventions, including seclusion, restraint, medication, and participation in experimental studies or drug trials
- **Part 4:** Instructions about who should be notified immediately if and when the person is admitted to a psychiatric facility. Instructions should also include who should be prohibited from visiting and who should have temporary custody of minor children or pets.
- **Part 5:** Personal rights to suspend or terminate an advance directive while incapacitated, if allowed by the law in the state
- **Part 6:** A signature page with two witnesses and a notary who sign the advance directive

## Example: Psychiatric Advance Directive

**DISCLAIMER: THE FOLLOWING DOCUMENT IS AN EXAMPLE FOR INFORMATIONAL USE ONLY AND SHOULD NOT BE USED UNLESS MODIFIED BY THE IPF. THIS DOCUMENT IS NOT MEANT TO SUBSTITUTE FOR AN EXISTING ADVANCE DIRECTIVE.**

### **PART 1: Statement of Intent to Appoint an Agent**

I, \_\_\_\_\_, being of sound mind, authorize a health care agent to make certain decisions on my behalf regarding my mental health treatment when I am determined to be legally incompetent to do so. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

### **PART 2: Designation of Mental Health Care Agent**

I hereby designate and appoint the following person as my agent to make mental health care decisions for me as authorized in this document. This person is to be notified immediately of my admission to a psychiatric facility.

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number \_\_\_\_\_

If the person named above is unavailable or unable to serve as my agent, I hereby appoint and desire immediate notification of my **alternate agent** as follows:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number \_\_\_\_\_

**1. Authority Granted to My Agent** (Initial if you agree with a statement; leave blank if you do not.)

A. \_\_\_\_\_ If I become incapable of giving consent to mental health care treatment, I hereby grant to my agent full power and authority to make mental health care decisions for me, including the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service or procedure, consistent with any instructions and/or limitations I have set forth in this advance directive. If I have not expressed a choice in this advance directive, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

B. \_\_\_\_\_ Having named an agent to act on my behalf, I do, however, wish to be able to discharge or change the person who is to be my agent if that agent is instrumental in the process of initiating or extending any period of psychiatric treatment against my will. My ability to revoke or change agents in this circumstance shall be in effect even while I am incompetent or

incapacitated, if allowed by law. Even if I choose to discharge or replace my agent, all other provisions of this advance directive shall remain in effect and shall only be revocable or changeable by me at a time when I am considered competent and capable of making informed health care decisions.

**2. My Preference as to a Court-Appointed Guardian** In the event a court decides to appoint a guardian who will make decisions regarding my mental health treatment, I desire the following person to be appointed:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address:  
\_\_\_\_\_

City, State, Zip Code:  
\_\_\_\_\_

Day phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

**PART 3: Specific Instructions, Special Provisions and Limitations Regarding My Mental Health Treatment and Care**

**1. My preferences regarding alternatives to hospitalization and choice of treatment facilities in the event 24-Hour Care is deemed medically necessary**

A. \_\_\_\_\_ In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care in programs/facilities designed as **alternatives to psychiatric hospitalizations**.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. \_\_\_\_\_ In the event I am to be **admitted to a hospital** for 24-hour care, I would **prefer** to receive care at **the following hospitals**:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. \_\_\_\_\_ I **do not wish to be committed to the following hospitals or programs/facilities** for psychiatric care for the reasons I have listed:

Facility's Name:  
\_\_\_\_\_

Reason:  
\_\_\_\_\_

Facility's Name:

---

Reason:

---

Facility's Name:

---

Reason:

---

## 2. My preferences regarding emergency interventions

If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency interventions should be made are as follows in order of preference:

Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If an intervention you prefer is not listed, write it in after "other" and give it a number as well.

\_\_\_\_\_ Seclusion

\_\_\_\_\_ Physical restraints

\_\_\_\_\_ Seclusion and physical restraint (combined)

\_\_\_\_\_ Medication by injection

\_\_\_\_\_ Medication in pill form

\_\_\_\_\_ Liquid medication

\_\_\_\_\_ Other: \_\_\_\_\_

Initial the paragraph below if you agree; leave blank if you do not agree.

\_\_\_\_\_ In the event that my attending physician decides to use medication for rapid tranquilization in response to an emergency situation after due consideration of my preferences for emergency treatments stated above, I expect the choice of medication to reflect any preferences I have expressed in this section and in Section 4. The preferences I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.

## 3. My preferences for physicians who will treat me if I am hospitalized

Put your initials after the letter and complete if you wish either or both paragraphs to apply.

A. My choice of treating physician is:

Dr. \_\_\_\_\_ Phone number

\_\_\_\_\_

**OR**

Dr. \_\_\_\_\_ Phone number

OR

Dr. \_\_\_\_\_ Phone number

B. \_\_\_\_\_ I do not wish to be treated by the following, for the reasons stated:

Dr. \_\_\_\_\_

Reason:

\_\_\_\_\_

Dr. \_\_\_\_\_

Reason:

\_\_\_\_\_

**4. My preferences regarding medications for psychiatric treatment**

In this section, you may choose any of the paragraphs A-G that you wish to apply. Be sure to initial those you choose.

If it is determined that I am not legally competent to consent to or to refuse medications relating to my mental health treatment, my wishes are as follows:

A. \_\_\_\_\_ I consent to the medications agreed to by my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, with the reservations, if any, described in (D) below.

B. \_\_\_\_\_ I consent to and authorize my agent to consent to the administration of:

Medication Name                      Not to exceed the following dosage:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OR

In such dosage(s) as determined by

Dr. \_\_\_\_\_

Dr. \_\_\_\_\_

Dr. \_\_\_\_\_



C. \_\_\_\_\_ I consent to the medications deemed appropriate by

Dr. \_\_\_\_\_, whose address and phone number are:

---

---

---

D. \_\_\_\_\_ I specifically do not consent and I do not authorize my agent to consent to the administration of the following medications or their respective brand-name, trade-name, or generic equivalents:

Name of Drug                      Reason for Refusal

Name of Drug	Reason for Refusal
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

E. \_\_\_\_\_ I am willing to take the medications excluded in (D) above, if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.

F. \_\_\_\_\_ I am concerned about the side effects of medications and do not consent or authorize my agent to consent to any medication that has any of the side effects I have checked below at a 1% or greater level of incidence (check all that apply).

- \_\_\_\_\_ Tardive dyskinesia
- \_\_\_\_\_ Tremors
- \_\_\_\_\_ Loss of sensation
- \_\_\_\_\_ Nausea/vomiting
- \_\_\_\_\_ Motor restlessness
- \_\_\_\_\_ Neuroleptic Malignant Syndrome
- \_\_\_\_\_ Seizures
- \_\_\_\_\_ Other \_\_\_\_\_
- \_\_\_\_\_ Muscle/skeletal rigidity

G. \_\_\_\_\_ I have the following other preferences about psychiatric medications:

---

---

---

### 5. My preferences regarding electroconvulsive therapy (ECT or Shock Treatment)

If it is determined that I am not legally capable of consenting to or refusing electroconvulsive therapy, my wishes regarding electroconvulsive therapy are as follows:

Initial A or B. If you check B, you must also initial B1, B2 or B3:

A. \_\_\_\_\_ I do not consent to administration of electroconvulsive therapy.

B. \_\_\_\_\_ I consent, and authorize my agent to consent, to the administration of electroconvulsive therapy, but only:

B1. \_\_\_\_\_ with the number of treatments that the attending psychiatrist deems appropriate;

**OR**

B2. \_\_\_\_\_ with the number of treatments that Dr. \_\_\_\_\_ deems appropriate. Phone number and address of doctor: \_\_\_\_\_  
\_\_\_\_\_

**OR**

B3. \_\_\_\_\_ for no more than the following number of ECT treatments: \_\_\_\_\_

C. \_\_\_\_\_ Other instructions and wishes regarding the administration of electroconvulsive therapy:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### **6. Consent for experimental studies or drug trials**

Initial one of the following paragraphs:

A. \_\_\_\_\_ I do not wish to participate in experimental drug studies or drug trials.

B. \_\_\_\_\_ I hereby consent to my participation in experimental drug studies or drug trials.

C. \_\_\_\_\_ I authorize my agent to consent to my participation in experimental drug studies if my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, determines that the potential benefits to me outweigh the possible risks of my participation and that other, non-experimental interventions are not likely to provide effective treatment.

#### **PART 4: Statement of My Preferences Regarding Notification of Others, Visitors, and Custody of My Child(ren)**

##### **1. The following individuals should be notified immediately of my admission to a psychiatric facility**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (Day): \_\_\_\_\_ Phone (Eve.): \_\_\_\_\_

Mobile phone: \_\_\_\_\_

It is also my desire that this person be permitted to visit me: Yes \_\_\_\_\_ No \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (Day): \_\_\_\_\_ Phone (Eve.): \_\_\_\_\_

Mobile phone: \_\_\_\_\_

It is also my desire that this person be permitted to visit me: Yes \_\_\_\_\_ No \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (Day): \_\_\_\_\_ Phone (Eve.): \_\_\_\_\_

Mobile phone: \_\_\_\_\_

It is also my desire that this person be permitted to visit me: Yes \_\_\_\_\_ No \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (Day): \_\_\_\_\_ Phone (Eve.): \_\_\_\_\_

Mobile phone: \_\_\_\_\_

It is also my desire that this person be permitted to visit me: Yes \_\_\_\_\_ No \_\_\_\_\_

**2. The following individuals are prohibited from visiting me:**

Name	Relationship
_____	_____
_____	_____

**3. My preferences for care and temporary custody of my children**

In the event that I am unable to care for my child(ren), I want the following person as my first choice to care for and have temporary custody of my child(ren):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: (Day) \_\_\_\_\_ Phone (Eve.) \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

In the event that the person named above is unable to care for and have temporary custody of my child(ren), I desire one of the following people to serve in that capacity.

My Second Choice

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (Day): \_\_\_\_\_ Phone (Eve.): \_\_\_\_\_

Mobile phone: \_\_\_\_\_

My Third Choice

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (Day): \_\_\_\_\_ Phone (Eve.): \_\_\_\_\_

Mobile phone: \_\_\_\_\_

**PART 5: Statement of My Preferences Regarding Revocation or Termination of This Advance Directive**

Initial all paragraphs that you wish to apply to you.

**1. Revocation of My Psychiatric Advance Directive**

\_\_\_\_\_ My wish is that this mental health directive may be revoked, suspended, or terminated by me at any time, **if state law so permits.**

**2. Revocation of My Psychiatric Advance Directive During a Period of Incapacity**

\_\_\_\_\_ My wish is that this mental health care directive may be revoked, suspended, or terminated by me only at times that I have the capacity and competence to do so. I understand that I may be choosing to give up the right to change my mind at any time. I expressly give up this right to ensure compliance with my advance directive. My decision not to be able to change this advance directive while I am incompetent or incapacitated is made to ensure that my previous, carefully considered thoughts about how I want to be treated will remain in effect during the time I am incompetent or incapacitated.

2A. \_\_\_\_\_ Notwithstanding the above, it is my wish that my agent or other decision maker specifically ask me about my preferences before making a decision regarding mental health care and take the preferences I express here into account when making such a decision, even while I am incompetent or incapacitated.

**3. Other Instructions about Mental Health Care**

(Use this space to add any other instructions that you wish to have followed. If you need to, add pages, numbering them as part of this section.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Go to the notary form if your state requires it.

(for use by the notary): State of \_\_\_\_\_, County of \_\_\_\_\_

Subscribed and sworn to or affirmed before me by the Declarant,

\_\_\_\_\_,

and (names of witnesses) \_\_\_\_\_ and

\_\_\_\_\_,

witnesses, as the voluntary act and deed of the Declarant,

this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

My commission expires:

\_\_\_\_\_

\_\_\_\_\_

Notary Public Seal:

## Appendix B: Screening for Metabolic Disorders

### Measure Information Form

**Performance Measure Name:** Screening for Metabolic Disorders

**Description:** Percentage of patients discharged from an Inpatient Psychiatric Facility (IPF) with a prescription for one or more routinely scheduled antipsychotic medications for which a structured metabolic screening for four elements was completed in the 12 months prior to discharge – either prior to or during the index IPF stay.

**Rationale:** Studies show that antipsychotics increase the risk of metabolic syndrome.<sup>1</sup> Metabolic syndrome is a cluster of conditions that occur together, including excess body fat around the waist, high blood sugar, high cholesterol, high blood pressure, all of which increase the risk of coronary artery disease, stroke, and type 2 diabetes.

In 2004, a consensus statement was released by the ADA, the APA, the AACE, and the NAASO regarding an association between the use of specific SGAs and diabetes and obesity.<sup>1</sup> This group 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.

The Screening for Metabolic Disorders measure was developed to assess the percentage of patients discharged with antipsychotics from an IPF for which a structured metabolic screening for four elements was completed in the past year.

**Type of Measure:** Process

**Improvement Noted As:** Increase in the rate

**Numerator Statement:** 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

**Data Elements:**

- Body Mass Index (BMI)
- Blood Pressure
- Blood Glucose
- Discharge Disposition
- Lipid Panel
- Reason for Incomplete Metabolic Screening

**Denominator Statement:** Discharges from an IPF during the measurement period with a prescription for one or more routinely scheduled antipsychotic medications

**Included Populations:** All patients discharged from IPFs with one or more routinely scheduled antipsychotic medications during the measurement period

**Excluded Populations:**

- Patients for whom a screening could not be completed due to the patient's enduring unstable medical condition or enduring unstable psychological condition

- Patients with a LOS equal to or greater than 365 days, or equal to or less than three days
- Patients who expired during the admission (Discharge Disposition = 6)

**Data Elements:**

- Admission Date
- Discharge Date
- Number of Antipsychotic Medications Prescribed at Discharge

**Risk Adjustment:** No

**Data Collection Approach:** Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service.

**Screening Elements:**

- The medical record must provide documentation of the completion of all four of the following tests/measurements:
  - BMI
  - Blood Pressure
  - Blood Glucose
  - Lipid Panel

**Criteria for the Screening:**

- Screenings can be conducted either at the reporting facility or another facility for which records are available to the reporting facility.
- The completion of each screening element is determined by identifying the documentation of at least one numeric result in the medical record reviewed.
- The report date for the screening must be within the 12 months prior to the patient's date of discharge.

**Data Accuracy:** Data accuracy is enhanced when all definitions are used without modification. The data dictionary should be referenced for definitions and abstraction notes when questions arise during data collection.

**Sampling:** For reporting to the IPFQR Program, two options are available for sampling, as described on pages 18–19 of this program manual.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion

**Selected Reference:**

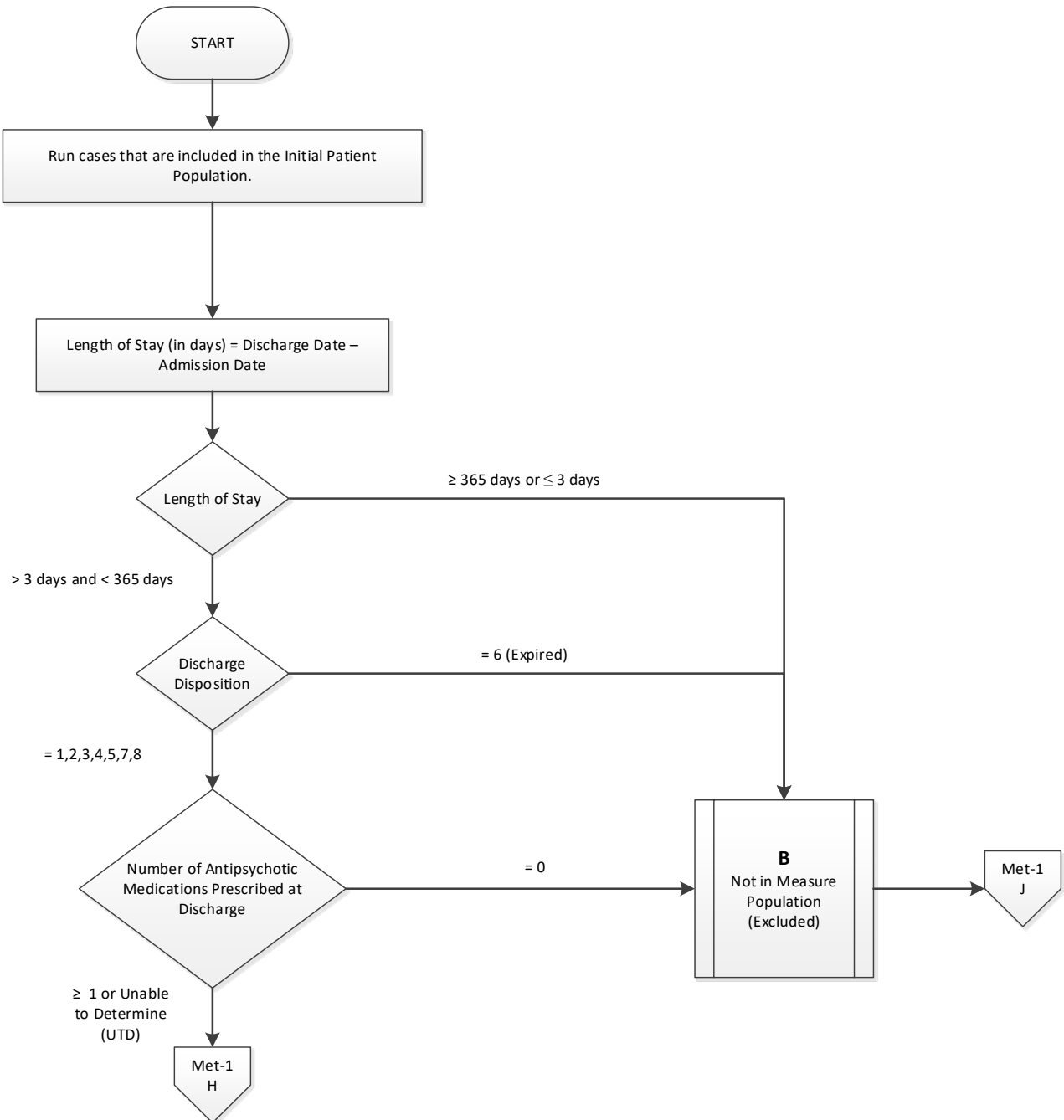
1. The American Diabetes Association, American Psychological Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. *Diabetes Care*. 2004;27(596–601).

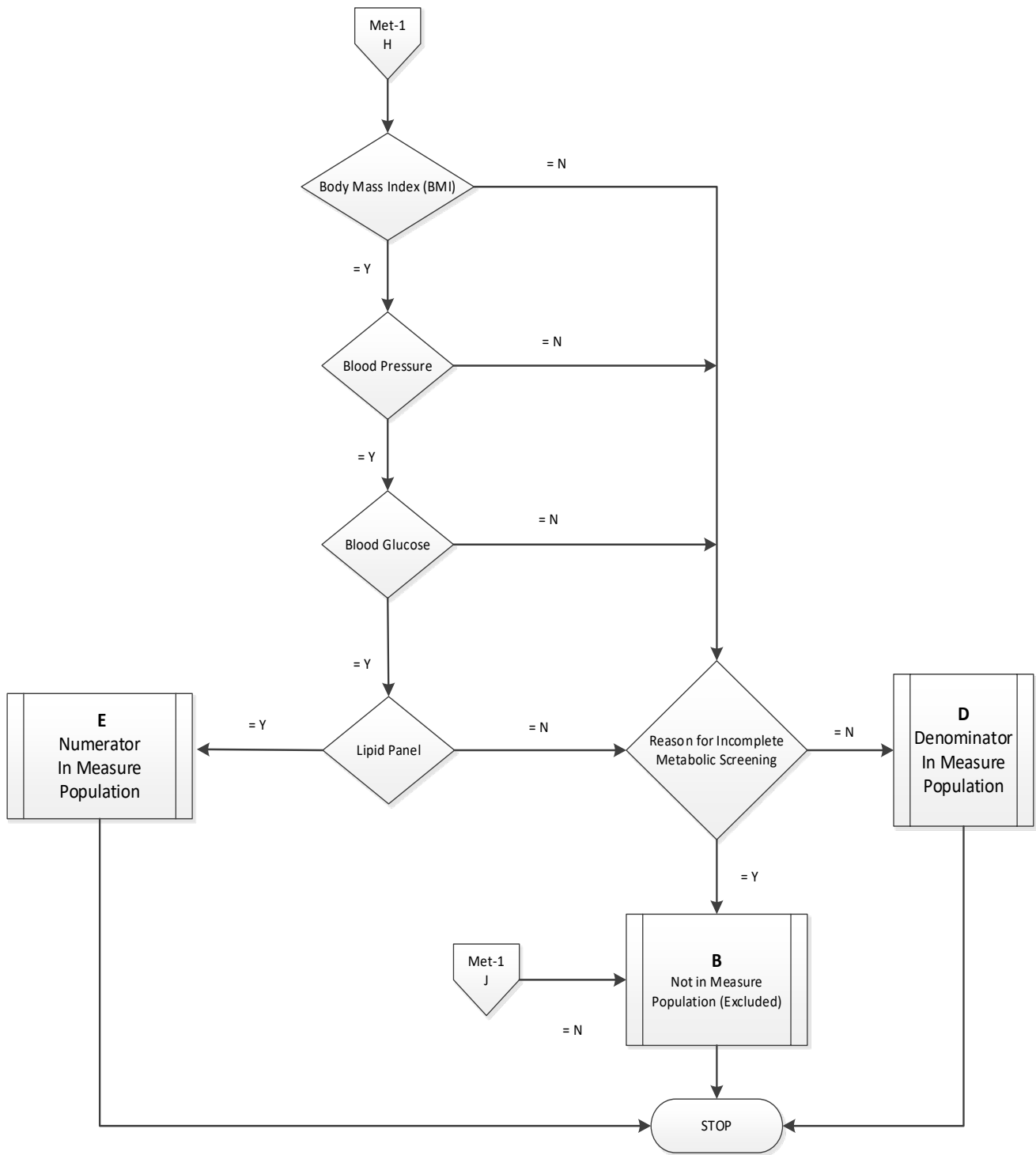


## Screening for Metabolic Disorders

**Numerator:** 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

**Denominator:** Discharges from an IPF during the measurement period with a prescription for one or more routinely scheduled antipsychotic medications





## Screening for Metabolic Disorders Narrative

**Numerator:** 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

**Denominator:** Discharges from an IPF during the measurement period with a prescription for one or more routinely scheduled antipsychotic medications

1. Start processing. Run cases that are included in the Initial Patient Population.
2. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date.
3. Check Length of Stay.
  - a. If Length of Stay is equal to or greater than 365 days or equal to or less than 3 days, the record will proceed to Measure Category Assignment of B and will not be in the Measure Population (excluded). Stop processing.
  - b. If Length of Stay is less than 365 days and greater than 3 days, proceed to Discharge Disposition.
4. Check Discharge Disposition.
  - a. If Discharge Disposition equals 6, the record will proceed to Measure Category Assignment of B and will not be in the Measure Population (excluded). Stop processing.
  - b. If Discharge Disposition equals 1, 2, 3, 4, 5, 7, or 8, proceed to Number of Antipsychotic Medications Prescribed at Discharge.
5. Check Number of Antipsychotic Medications Prescribed at Discharge.
  - a. If Number of Antipsychotic Medications Prescribed at Discharge is equal to zero, the record will proceed to Measure Category Assignment of B and will not be in the Measure Population (excluded). Stop processing.
  - b. If Number of Antipsychotic Medications Prescribed at Discharge is equal to or greater than 1 or unable to determine, proceed to Body Mass Index.
6. Check Body Mass Index.
  - a. If Body Mass Index equals No, proceed to Reason for Incomplete Metabolic Screening.
  - b. If Body Mass Index equals Yes, proceed to Blood Pressure.
7. Check Blood Pressure.
  - a. If Blood Pressure equals No, proceed to Reason for Incomplete Metabolic Screening.
  - b. If Blood Pressure equals Yes, proceed to Blood Glucose.
8. Check Blood Glucose.
  - a. If Blood Glucose equals No, proceed to Reason for Incomplete Metabolic Screening.
  - b. If Blood Glucose equals Yes, proceed to Lipid Panel.
9. Check Lipid Panel.
  - a. If Lipid Panel equals No, proceed to Reason for Incomplete Metabolic Screening.
  - b. If Lipid Panel equals Yes, the record will proceed to Measure Category Assignment of E and will be in the Numerator Measure Population. Stop processing.
10. Check Reason for Incomplete Metabolic Screening
  - a. If Reason for Incomplete Metabolic Screening equals No, the record will proceed to Measure Category Assignment of D and will be in the Denominator Measure Population. Stop processing.
  - b. If Reason for Incomplete Metabolic Screening equals Yes, the record will proceed to Measure Category Assignment of B and will not be in the Measure Population (excluded). Stop processing.

## Alphabetical Data Dictionary

(Select an element name to navigate to respective data element)

### Index

<b>Element Name</b>	<b>Page #</b>
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Discharge Disposition	109
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**Data Element Name:** *Admission Date*

**Definition:** The month, day, and year of admission to an inpatient psychiatric facility

**Suggested Data Collection Question:** What is the date the patient was admitted to the inpatient psychiatric facility?

**Format:**

**Length:** 10 – MM-DD-YYYY (includes dashes)

**Type:** Date

**Occurs:** 1

**Allowable Values:**

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (20xx)

**Notes for Abstraction:**

- The intent of this data element is to determine the date that the patient was actually admitted to an IPF. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date from billing is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.
- If using claim information, “Statement Covers Period” is not synonymous with “Admission Date” and should not be used to abstract this data element. These are two distinctly different identifiers:
  - The Admission Date is purely the date the patient was admitted as an inpatient to the facility.
  - The Statement Covers Period (“From” and “Through” dates) identifies the span of service dates included in a particular claim. The “From” Date is the earliest date of service on the claim.
- For patients who are admitted to observation status and subsequently admitted to inpatient psychiatric care, abstract the date that the determination was made to admit to inpatient psychiatric care and the order was written. Do not abstract the date that the patient was admitted to observation.

**Example:**

Medical record documentation reflects that the patient was admitted to observation on 04/05/2019. On 04/06/2019, the physician writes an order to admit to inpatient psychiatric care, effective 04/05/2019. The Admission Date would be abstracted as 04/06/2019–; the date the determination was made to admit to inpatient psychiatric care and the order was written.

- The Admission Date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient psychiatric care, this date should not be used.
- If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.

**Suggested Data Sources:**

**Note:** The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other Only Allowable Sources to determine the *Admission Date*.

**ONLY ALLOWABLE SOURCES:**

1. Physician orders
2. Face sheet
3. UB-04

**Excluded Data Sources:** UB-04 “From” and “Through” dates

**Inclusion Guidelines for Abstraction:** None

**Exclusion Guidelines for Abstraction:**

- Admit to observation
- Arrival date

**Data Element Name:** *Blood Glucose*

**Definition:** A lab test of glucose levels in the blood

**Suggested Data Collection Question:** Is there documentation of a numerical value of blood glucose in the patient’s medical record during this stay or at any time during the 12 months prior to discharge?

**Format:**

**Length:** 1

**Type:** Character

**Occurs:** 1

**Allowable Values:**

Y (Yes) Documentation in the medical record of the numerical value of blood glucose tested during the stay or at any time during the 12 months prior to discharge.

N (No) Documentation in the medical record does not include the numerical value of blood glucose tested during the stay or at any time during the 12 months prior to discharge or unable to determine from medical record documentation.

**Notes for Abstraction:**

- To meet the screening element for Blood Glucose, the abstractor must identify at least one documented result of HbA1c, fasting blood glucose, or two-hour post blood glucose value during a 75 g Oral Glucose Tolerance Test (OGTT).
- Blood glucose results can be derived from either plasma or serum and can be obtained as an independent test or as part of a Comprehensive Metabolic Panel or Basic Metabolic Panel. However, there must be explicit documentation associated with the glucose test that the patient fasted prior to the test. If there is no documentation that the patient fasted prior to performing the glucose test, that test cannot be used for this data element.
- Review only the medical record of the current patient stay. The record must contain at least one documented result for a qualifying test listed above with a result date within 12 months prior to the date of discharge. If the clinician accessed the medical record/EMR and obtained blood glucose results from a previous stay or visit within the 12 months prior to the date of discharge, documentation in the current record must also include the source of the result (e.g., medical record of prior hospital stay, EMR, or the name of the provider who ordered the test).
- If the patient refuses during this admission and no other documentation regarding a previous blood glucose result is found, select “No.”

**Suggested Data Sources:**

- Emergency department record
- Consultation notes
- History and physical
- Initial (admission) assessment form
- Laboratory reports
- Nursing graphic sheets

- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form

**Inclusion Guidelines for Abstraction:**

- Fasting blood glucose from plasma or serum
- Fasting sugar
- HbA1c
- Two-hour post blood glucose value during a 75g OGTT

**Exclusion Guidelines for Abstraction:**

- Non-quantitative assessment of glucose test (i.e., normal, abnormal, etc.)
- Finger-stick blood sugar (FSBS)



**Data Element Name:** *Blood Pressure*

**Definition:** A reading of diastolic and systolic blood pressure

**Suggested Data Collection Question:** Was there a blood pressure (numerical systolic and diastolic values in mmHg) documented in the patient’s medical record during this stay or at any time during the 12 months prior to discharge?

**Format:**

**Length:** 1

**Type:** Character

**Occurs:** 1

**Allowable Values:**

Y (Yes) Documentation in the medical record of the numerical value of blood pressure tested during the stay or at any time during the 12 months prior to discharge.

N (No) Documentation in the medical record does not include the numerical value of blood pressure tested during the stay or at any time during the 12 months prior to discharge or unable to determine from medical record documentation.

**Notes for Abstraction:**

- To meet the screening element for Blood Pressure, the abstractor must identify at least one documented value.
- Review only the medical record of the current patient stay. The record must contain at least one documented result with a result date within 12 months prior to the date of discharge. If the clinician accessed the medical record/EMR and obtained blood pressure results from a previous stay or visit within the 12 months prior to the date of discharge, documentation in the current record must also include the source of the result (e.g., medical record of prior hospital stay, EMR, or name of provider who ordered the test).
- If the patient refuses during this admission and no other documentation regarding a previous blood pressure result is found, select “No.”

**Suggested Data Sources:**

- Biopsychosocial assessment
- Emergency department record
- History and physical
- Initial (admission) assessment form
- Laboratory Report
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form
- Vital record/flow sheet

**Inclusion Guidelines for Abstraction:**

- None

**Exclusion Guidelines for Abstraction:**

- Self-reported blood pressure
- Non-quantitative assessment of blood pressure (i.e. normal, abnormal, etc.)

**Data Element Name:** *Body Mass Index (BMI)*

**Definition:** A weight-to-height ratio calculated by dividing weight in kilograms (kg) by the square of height in meters (m). If the weight is in pounds (lb) and height is in feet (ft) or inches (in), conversion to the metric unit is needed prior to the BMI calculation.

**Suggested Data Collection Question:** Was there a numerical value of Body Mass Index (BMI) documented in the patient’s medical record during this stay or at any time during the 12 months prior to discharge?

**Format:**

**Length:** 1  
**Type:** Character  
**Occurs:** 1

**Allowable Values:**

- Y (Yes) Documentation in the medical record of the numerical value of BMI tested during the stay or at any time during the 12 months prior to discharge.
- N (No) Documentation in the medical record does not include the numerical value of BMI tested during the stay or at any time during the 12 months prior to discharge or unable to determine from medical record documentation.

**Notes for Abstraction:**

- To meet the screening element for BMI, the abstractor must identify at least one documented value. Documentation of height and weight only is NOT an acceptable substitute for BMI.
- Review only the medical record of the current patient stay. The record must contain at least one documented result with a result date within 12 months prior to the date of discharge. If the clinician accessed the medical record/EMR and obtained BMI from a previous stay or visit within the 12 months prior to the date of discharge, documentation in the current record must also include the source of the result (e.g., medical record of prior hospital stay, EMR or the name of the provider who ordered the test).
- If the patient refuses during this admission and no other documentation regarding a previous BMI is found, select “No.”

**Suggested Data Sources:**

- Biopsychosocial assessment
- Emergency department record
- History and physical
- Initial (admission) assessment form
- Nursing graphic sheets
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form

**Inclusion Guidelines for Abstraction:**

- None

**Exclusion Guidelines for Abstraction:**

- Documentation of height and weight only
- Non-quantitative assessment of BMI (i.e., normal, abnormal, etc.)

**Data Element Name:** *Discharge Date*

**Definition:** The month, day, and year the patient was discharged from inpatient psychiatric care, left against medical advice, or expired during this stay

**Suggested Data Collection Question:** What is the date the patient was discharged from inpatient psychiatric care, left against medical advice (AMA), or expired?

**Format:**

**Length:** 10 – MM-DD-YYYY (includes dashes)

**Type:** Date

**Occurs:** 1

**Allowable Values:**

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (20xx)

**Notes for Abstraction:**

Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

**Suggested Data Sources:**

- Face sheet
- Progress notes
- Physician orders
- Discharge summary
- Nursing discharge notes
- Transfer note
- UB-04

**Inclusion Guidelines for Abstraction:** None

**Exclusion Guidelines for Abstraction:** None

**Data Element Name:** *Discharge Disposition*

**Definition:** The final place or setting to which the patient was discharged on the day of discharge

**Suggested Data Collection Question:** What was the patient’s discharge disposition on the day of discharge?

**Format:**

**Length:** 1

**Type:** Alphanumeric

**Occurs:** 1

**Allowable Values:**

- 1 – Home
- 2 – Hospice: Home
- 3 – Hospice: Health Care Facility
- 4 – Acute Care Facility
- 5 – Other Health Care Facility
- 6 – Expired
- 7 – Left Against Medical Advice/AMA
- 8 – Not Documented or Unable to Determine (UTD)

**Notes for Abstraction:**

- Only use documentation written on the day prior to discharge through 30 days after discharge when abstracting this data element.

Example:

Documentation in the Discharge Planning notes on 04/01/2019 state that the patient will be discharged back home. On 04/06/2019, the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04/06/2019 would be used to select value “5” (Other Health Care Facility).

- The medical record must be abstracted as documented (taken at “face value”). Inferences should not be made based on internal knowledge.
- If there is documentation that further clarifies the level of care, that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.

Examples:

- Discharge summary dictated two days after discharge states patient went home. Physician note on day of discharge further clarifies that the patient will be going home with hospice. Select value “2” (Hospice: Home).
- Discharge planner note from day before discharge states XYZ Nursing Home. Discharge order from day of discharge states discharge home. With contradictory documentation, use latest. Select value “1” (Home).
- Physician order on discharge states Discharge to assisted living facility (ALF). Discharge instruction sheet completed after the physician order states patient discharged to SNF. With contradictory documentation, use latest. Select value “5” (Other Health Care Facility).

- If documentation is contradictory and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. (See Inclusion lists for examples.)
  - Acute Care Facility
  - Hospice: Health Care Facility
  - Hospice: Home
  - Other Health Care Facility
  - Home
- Hospice (values “2” and “3”) includes discharges with hospice referrals and evaluations.
- If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select value “4” (Acute Care Facility).
- If the medical record states the patient is being discharged to assisted living care or an assisted living facility (ALF) and the documentation also includes nursing home, intermediate care, or skilled nursing facility, select Value “1” (“Home”).
- If the medical record states the patient is being discharged to nursing home, intermediate care, or skilled nursing facility without mention of assisted living care or assisted living facility (ALF), select Value “5” (“Other Health Care Facility”).
- If the medical record identifies the facility the patient is being discharged to by name only (e.g., Park Meadows) and does not reflect the type of facility or level of care, select value “5” (Other Health Care Facility).
- If the medical record states only that the patient is being discharged and does not address the place or setting to which the patient was discharged, select value “1” (Home).
- When determining whether to select value “7” (Left Against Medical Advice/AMA):
  - Explicit “left against medical advice” documentation is not required (e.g., Patient is refusing to stay for continued care.). Select value “7”.
  - Documentation suggesting that the patient left before discharge instructions could be given does not count.
  - A signed AMA form is not required for the purposes of this data element.
  - Do not consider AMA documentation and other disposition documentation as contradictory. If any source states the patient left against medical advice, select value “7,” regardless of whether the AMA documentation was written last (e.g., AMA form signed, and discharge instruction sheet states, “Discharged home with belongings.”). Select “7”.

**Suggested Data Sources:**

- Progress notes
- Physician orders
- Discharge summary
- Discharge instruction sheet
- Discharge planning notes
- Nursing discharge notes
- Social services notes
- Transfer record

**Excluded Data Sources:**

- Any documentation prior to the last two days of hospitalization
- Coding documents
- UB-04

**Inclusion Guidelines for Abstraction:**

## Home (Value 1):

- Assisted Living Facilities (ALFs) – Includes ALFs and assisted living care at nursing home, intermediate care, and skilled nursing facilities
- Court/Law Enforcement – Includes detention facilities, jails, and prison
- Home – Includes board and care, foster or residential care, group or personal care homes, retirement communities, and homeless shelters
- Home with Home Health Services
- Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization

## Hospice – Home (Value 2):

- Hospice in the home (or other Home setting as above in Value 1)

## Hospice Health Care Facility (Value 3):

- Hospice – General Inpatient and Respite
- Hospice – Residential and Skilled Facilities
- Hospice – Other Health Care Facilities

## Acute Care Facility (Value 4):

- Acute Short Term General and Critical Access Hospitals
- Cancer and Children’s Hospitals
- Department of Defense and Veteran’s Administration Hospitals

## Other Health Care Facility (Value 5):

- Extended or Intermediate Care Facility (ECF/ICF)
- Long Term Acute Care Hospital (LTACH)
- Nursing Home or Facility including Veteran’s Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
- Transitional Care Unit (TCU)
- Veterans Home

**Exclusion Guidelines for Abstraction: None**

**Data Element Name:** *Lipid Panel*

**Definition:** A lab test including at least the following four components: total cholesterol, triglycerides, high-density lipoprotein cholesterol, and low-density lipoprotein cholesterol

**Suggested Data Collection Question:** Is there documentation of numerical values of all the components of a lipid panel (total cholesterol, triglycerides, high-density lipoprotein cholesterol, and low-density lipoprotein cholesterol) in the patient’s medical record during this stay or at any time during the 12 months prior to discharge?

**Format:**

**Length:** 1

**Type:** Character

**Occurs:** 1

**Allowable Values:**

Y (Yes) Documentation in the medical record of the numerical values for all four components of the lipid panel tested during the stay or at any time during the 12 months prior to discharge.

N (No) Documentation in the medical record does not include the numerical values for all four components of the lipid panel tested during the stay or at any time during the 12 months prior to discharge or unable to determine from medical record documentation.

**Notes for Abstraction:**

- To meet the screening element for Lipid Panel, the abstractor must identify at least one documented value for all four parts of the lipid panel: total cholesterol, triglycerides, high-density lipoprotein (HDL), and low-density lipoprotein (LDL). If any one of the parts is missing, select “No.”
- If the lab report states a value was unable to be calculated, select “Yes.”
- Review only the medical record of the current patient stay. The record must contain at least one documented result with a result date within 12 months prior to the date of discharge. If the clinician accessed the medical record/EMR and obtained a lipid panel from a previous stay or visit within the 12 months prior to the date of discharge, documentation in the current record must also include the source of the result (e.g., medical record of prior hospital stay, EMR, or the name of the provider who ordered the test).
- If the patient refuses during this admission and no other documentation regarding a previous lipid panel value is found, select “No.”

**Suggested Data Sources:**

- Consultation notes
- History and physical
- Initial (admission) assessment form
- Laboratory reports
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form

**Inclusion Guidelines for Abstraction:**

There must be numerical values for all four lipid panel components documented in the medical record. This list is all inclusive:

- TC: total cholesterol
- TG: triglycerides
- HDL
- LDL
- HDL-C: high-density lipoprotein cholesterol
- LDL-C: low-density lipoprotein cholesterol

**Exclusion Guidelines for Abstraction:**

- Non-quantitative assessment of lipid panel (e.g., normal, abnormal)
- Results from point-of-care tests for any of the four lipid panel components



**Data Element Name:** *Number of Antipsychotic Medications Prescribed at Discharge*

**Definition:** The number of routinely scheduled antipsychotic medications prescribed to the patient at discharge as documented in the medical record

**Suggested Data Collection Question:** What is the documented number of antipsychotic medications prescribed for the patient at discharge?

**Format:**

**Length:** 2 or UTD  
**Type:** Alphanumeric  
**Occurs:** 1

**Allowable Values:**

- 0–99
- UTD (Unable to Determine)

**Notes for Abstraction:**

- An antipsychotic medication is defined as any of a group of drugs (such as phenothiazines, butyrophenones, or serotonin-dopamine antagonists) which are used to treat psychosis. An antipsychotic medication is also called neuroleptic.
  - To access the list of routinely scheduled antipsychotic medications, identify the *Specifications Manual for Joint Commission National Quality Measures* associated with the discharge time frame of the case being abstracted. The manuals are available at: <https://manual.jointcommission.org/Manual/WebHome>. Refer to Appendix C: Medication Tables, Table Number 10.0 Antipsychotic Medications for a list of medications. Please note that The Joint Commission may update the medications tables up to two times per year to ensure that they align with current clinical guidelines.
- Only use “Antipsychotic Not Otherwise Specified (NOS)” for new antipsychotics that are not listed in Table Number 10.0 Antipsychotic Medications.
  - Include “Antipsychotic Not Otherwise Specified (NOS)” in the count of the “Number of Antipsychotic Medications Prescribed at Discharge.”
- All routinely scheduled antipsychotic medications should be counted regardless of the indication for use or the reason documented for prescribing the antipsychotic medication.
- PRN (as needed) antipsychotic medications or short-acting intramuscular antipsychotic medications should not be included in the count of the “Number of Antipsychotic Medications Prescribed at Discharge.”
  - To access the list of short-acting intramuscular antipsychotic medications, identify the *Specifications Manual for Joint Commission National Quality Measures* associated with the discharge time frame of the case being abstracted. The manuals are available at: <https://manual.jointcommission.org/Manual/WebHome>. Refer to Appendix C: Medication Tables, Table Number 10.1 Short-acting Intramuscular Antipsychotic Medications for a list of medications. Please note that The Joint Commission may update the medications tables up to two times per year to ensure that they align with current clinical guidelines.
- If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.

- If the patient is on two forms of the same medication (i.e., po and IM), this would be counted as one antipsychotic medication.

It is acceptable to use data derived from pharmacy reports or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the suggested data sources listed below.

**Suggested Data Sources:**

- Aftercare discharge plan
- Discharge plan
- Final discharge summary
- Interim discharge summary
- Medication reconciliation form
- Physician discharge orders
- Physician progress notes
- Referral form

**Inclusion Guidelines for Abstraction:**

Antipsychotic medications found on Table Number 10.0 - Antipsychotic Medications in the *Specifications Manual for Joint Commission National Quality Measures* associated with the discharge date of the case being abstracted are included in the count of the Number of Antipsychotic Medications Prescribed at Discharge.

**Exclusion Guidelines for Abstraction:**

- PRN antipsychotic medications
- Short-acting intramuscular antipsychotic medications found on Table Number 10.1 Short-acting Intramuscular Antipsychotic Medications in the *Specifications Manual for Joint Commission National Quality Measures* associated with the discharge date of the case being abstracted are excluded from the count of the Number of Antipsychotic Medications Prescribed at Discharge.

**Data Element Name:** *Reason for Incomplete Metabolic Screening*

**Definition:** A written statement by the physician/APN/PA in the current medical record indicating that the screening elements could not be completed due to patient’s enduring unstable medical condition or enduring unstable psychological condition

**Suggested Data Collection Question:** Is there documentation in the medical record noting that the metabolic screening cannot be completed due to patient’s enduring unstable medical or psychological condition?

**Format:**

**Length:** 1

**Type:** Character

**Occurs:** 1

**Allowable Values:**

Y (Yes) Documentation in the medical record for this stay specifies that the metabolic screening cannot be completed due to patient’s enduring unstable medical condition or enduring unstable psychological condition.

N (No) Documentation in the medical record for this stay does not specify that the patient’s enduring unstable medical or psychological condition was the reason that the metabolic screening cannot be completed or unable to be determined from medical record documentation.

**Notes for Abstraction:**

- There must be specific documentation by the physician/APN/PA in the medical record for this stay that contains the exact wording that the patient has an “enduring unstable medical condition” or an “enduring unstable psychological condition” that prevents completion of a metabolic screening.
- Documentation stating that the patient has an “enduring unstable medical or psychological condition” is not acceptable as it is not specific to the individual patient and does not indicate which of the two conditions is relevant for the patient.
- If both conditions apply to a patient, then there must be specific documentation by the physician/APN/PA in the medical record for this stay that contains the exact wording that the patient has an “enduring unstable medical condition and enduring unstable psychological condition.”

**Suggested Data Sources:**

- Biopsychosocial assessment
- Functional skills assessment
- History and physical
- Individual plan of service
- Initial (admission) assessment form
- Physician progress notes
- Psychiatrist assessment/admission form

**Inclusion Guidelines for Abstraction:**

This list is **all inclusive** and documentation must contain exact wording of:

- “Enduring unstable medical condition”  
OR
- “Enduring unstable psychological condition”  
OR
- “Enduring unstable medical condition and enduring unstable psychological condition”

**Exclusion Guidelines for Abstraction:** None