



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 (CMS).

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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.

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. This would be a contact at the discharging IPF, not a health care professional or site designated for follow-up care. 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 Hospital Quality Reporting system (formerly the *QualityNet Secure Portal*), including accounts needed to access the Hospital Quality Reporting system.

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 Hospital Quality Reporting system (formerly 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), 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 IPF PPS 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 IPF 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. Register for a HCQIS Access Roles and Profile (HARP) Security Administrator/Official (SA/O) account on the [Getting Started with QualityNet](#) webpage.
 - This step must be accomplished for each SA/O who will access the [Hospital Quality Reporting \(HQR\)](#) system.
 - Once registered, it is important that the SAs/SOs 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 in the 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 Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Project Lead by emailing 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.
 - 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.

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
Specifications Manual for Joint Commission National Quality Measures	HBIPS-2, -3, -5, TOB, SUB, and IMM-2 measure sets
Care Transitions - Performance Measurement Set	Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record
IPFQR Program Claims-Based Measure Specifications	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
IPFQR Program Manual - Appendix B	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

Measure ID	Measure Description
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 percent 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 Hospital Quality Reporting system. 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 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 the SUB-2 measure is the number of hospital inpatients 18 years of age and older who screen positive for unhealthy alcohol use or an alcohol use disorder (alcohol abuse or alcohol dependence). The SUB-2a denominator is the same as that of the SUB-2 measure but excludes those who were screened with a non-validated tool within the first day of admission (by end of Day 1) and those not screened for alcohol use within the first day of admission (by end of Day 1) or unable to determine from medical record documentation. Both measures exclude 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 percent of general hospital inpatients and 40–60 percent 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 percent 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 following website: https://qualitynet.cms.gov/files/602d8a8b6bb42a002559574e?filename=AMA_PCPI_Care_Transitions_2016.pdf.

Screening for Metabolic Disorders

Studies show that antipsychotics increase the risk of metabolic syndrome.¹ 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.¹

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.

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).

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 patient discharges from an IPF 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 2023 and FY 2024 payment determinations.

Table 4: IPFQR Program Measures for FY 2023 Payment Determination

Measure	Reporting Period	Submission Period	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
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 ¹	October 1, 2021–March 31, 2022	July 1–August 15, 2022	Chart-Abstracted	Yes

Measure	Reporting Period	Submission Period	Measure Type	Sampling Allowed
FUH: Follow-Up After Hospitalization for Mental Illness	July 1, 2020–June 30, 2021	Calculated by CMS	Claims-Based	N/A
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF ²	July 1, 2019–June 30, 2021	Calculated by CMS	Claims-Based	N/A
Medication Continuation Following Inpatient Psychiatric Discharge ²	July 1, 2019–June 30, 2021	Calculated by CMS	Claims-Based	N/A

¹ 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.

² Q1 and Q2 2020 data for 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>).

Table 5: IPFQR Program Measures for FY 2024 Payment Determination³

Measure	Reporting Period	Submission Period	Measure Type	Sampling Allowed
HBIPS-2: Hours of Physical Restraint Use	January 1–December 31, 2022	July 1–August 15, 2023	Chart-Abstracted	No
HBIPS-3: Hours of Seclusion Use	January 1–December 31, 2022	July 1–August 15, 2023	Chart-Abstracted	No
HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	January 1–December 31, 2022	July 1–August 15, 2023	Chart-Abstracted	Yes
Transition Record with Specified Elements Received by Discharged Patients	January 1–December 31, 2022	July 1–August 15, 2023	Chart-Abstracted	Yes
Timely Transmission of Transition Record	January 1–December 31, 2022	July 1–August 15, 2023	Chart-Abstracted	Yes
Screening for Metabolic Disorders	January 1–December 31, 2022	July 1–August 15, 2023	Chart-Abstracted	Yes
SUB-2: Alcohol Use Brief Intervention Provided or Offered and SUB-2a: Alcohol Use Brief Intervention	January 1–December 31, 2022	July 1–August 15, 2023	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, 2022	July 1–August 15, 2023	Chart-Abstracted	Yes

Measure	Reporting Period	Submission Period	Measure Type	Sampling Allowed
TOB-2: Tobacco Use Treatment Provided or Offered and TOB-2a Tobacco Use Treatment	January 1–December 31, 2022	July 1–August 15, 2023	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, 2022	July 1–August 15, 2023	Chart-Abstracted	Yes
IMM-2: Influenza Immunization ⁴	October 1, 2022–March 31, 2023	July 1–August 15, 2023	Chart-Abstracted	Yes
FUH: Follow-Up After Hospitalization for Mental Illness	July 1, 2021–June 30, 2022	Calculated by CMS	Claims-Based	N/A
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF	July 1, 2020–June 30, 2022	Calculated by CMS	Claims-Based	N/A
Medication Continuation Following Inpatient Psychiatric Discharge	July 1, 2020–June 30, 2022	Calculated by CMS	Claims-Based	N/A

³ Measures for FY 2024 payment determination are subject to change. Information in this table is current as of the publication date for this manual.

⁴ The IMM-2 measure is the only chart-abstracted measure in which the reporting period crosses over two calendar years, from October 1, 2022, through March 31, 2023, for the FY 2024 payment determination.

Submission of Non-Measure Data/Population Counts

CMS requires IPFs to report 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 no longer required 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 starting with calendar year 2022 discharges, which will be reported to CMS during the summer 2023 data submission period.

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.

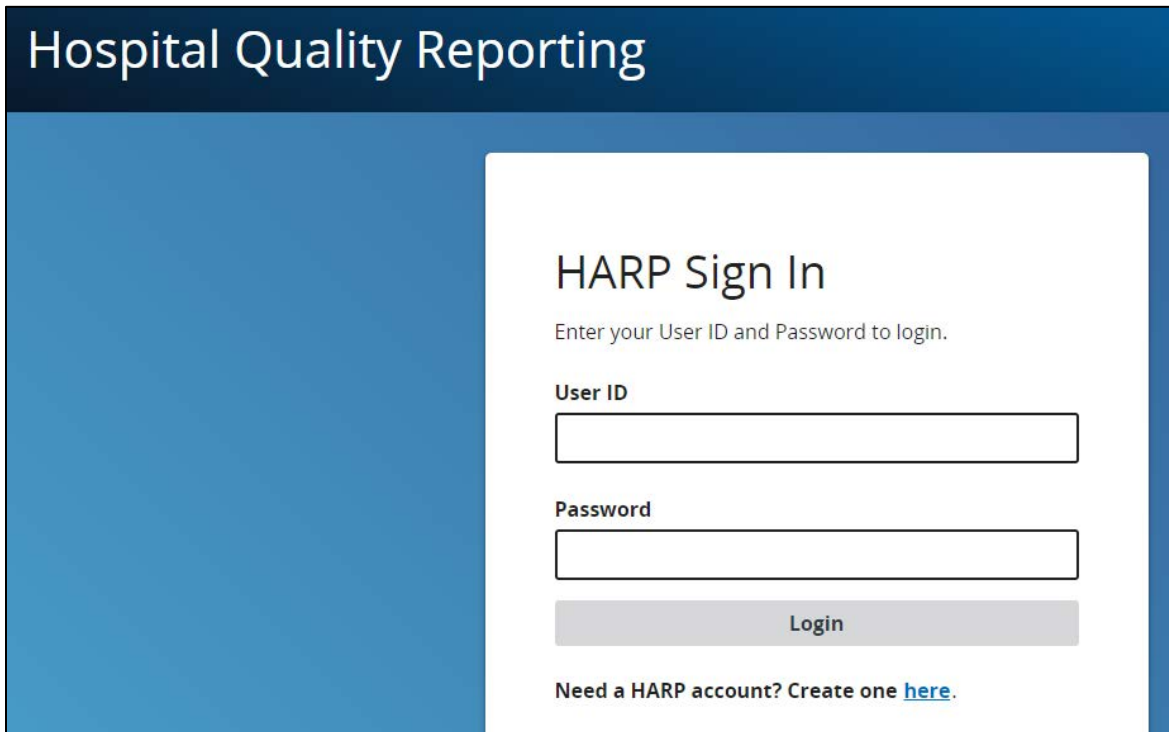
Submission Information

IPFs submit measure and non-measure data via the Simple Data Entry (SDE) tool located in the Hospital Quality Reporting system. IPFs will also complete and submit the DACA form but in a separate location in the Hospital Quality Reporting system. 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 Hospital Quality Reporting system, 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 Hospital Quality Reporting system.
 - 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' login interface. At the top, there is a dark blue header with the text 'Hospital Quality Reporting' in white. Below this is a white login box with a blue border. The box contains the title 'HARP Sign In' and the instruction 'Enter your User ID and Password to login.' There are two input fields: 'User ID' and 'Password'. Below the 'Password' field is a grey 'Login' button. At the bottom of the box, there is a link: 'Need a HARP account? Create one [here](#).'

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

Hospital Quality Reporting

Two-Factor Authentication

Select a device to verify your account



SMS Text for number ending in 3551



Email

Cancel

Next

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

Hospital Quality Reporting

Two-Factor Authentication

For your security, we need to authenticate your request. We've sent a verification code via:

SMS Text

Please enter it below.

Enter Code

740477

Continue

[Resend Code](#)

[Change two factor authentication](#)

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

Hospital Quality Reporting

Terms & Conditions

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.

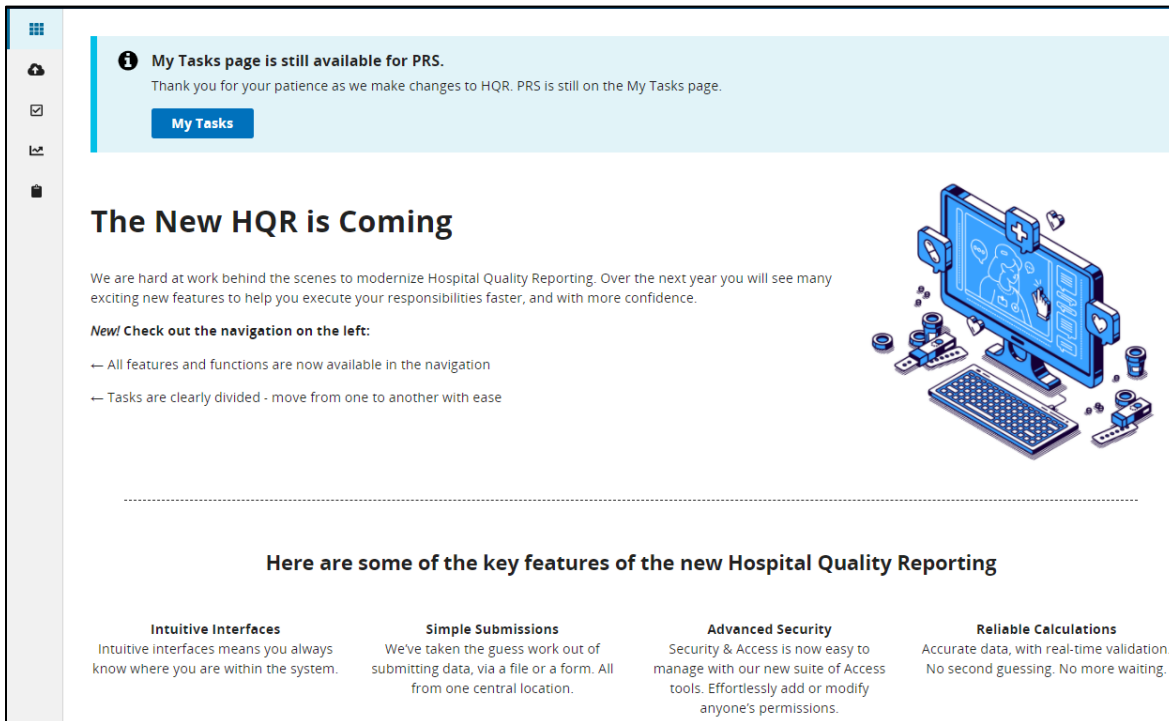
Any communication or data transiting or stored on this system may be disclosed or used for any lawful Government purpose.

I accept the above Terms and Conditions

Cancel

Accept

Once logged in, you will see the HQR landing page.



My Tasks page is still available for PRS.
Thank you for your patience as we make changes to HQR. PRS is still on the My Tasks page.
[My Tasks](#)

The New HQR is Coming

We are hard at work behind the scenes to modernize Hospital Quality Reporting. Over the next year you will see many exciting new features to help you execute your responsibilities faster, and with more confidence.

New! Check out the navigation on the left:

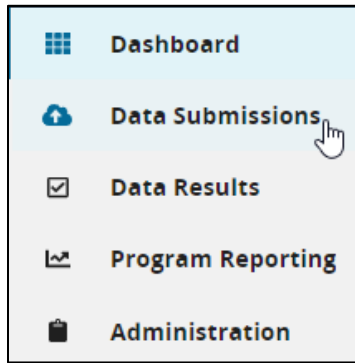
- All features and functions are now available in the navigation
- Tasks are clearly divided - move from one to another with ease

.....

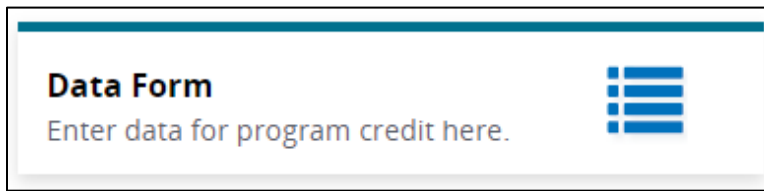
Here are some of the key features of the new Hospital Quality Reporting

Intuitive Interfaces Intuitive interfaces means you always know where you are within the system.	Simple Submissions We've taken the guess work out of submitting data, via a file or a form. All from one central location.	Advanced Security Security & Access is now easy to manage with our new suite of Access tools. Effortlessly add or modify anyone's permissions.	Reliable Calculations Accurate data, with real-time validation. No second guessing. No more waiting.
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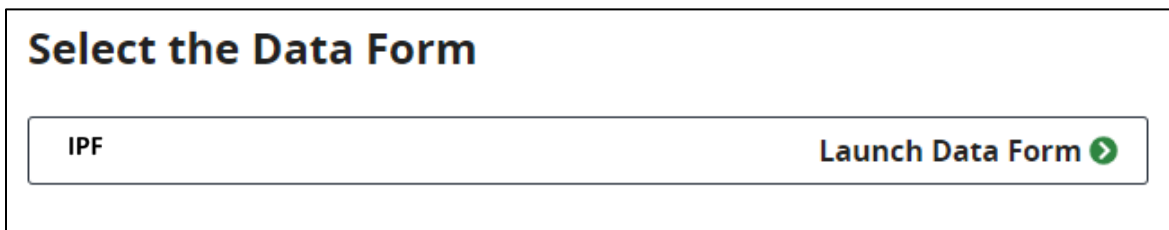
2. Hover your mouse on the left side of the screen to expand the menu options and select **“Data Submissions”**.



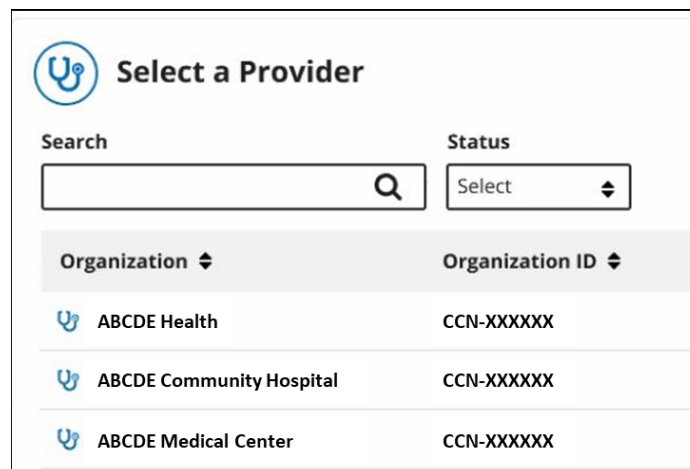
3. Click the “**Data Form**” button.



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



5. 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 measures in the SDE tool. Each measure entry includes a title, a brief description, and a green 'Start Measure' button. The measures listed are:

- 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
- Screening 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 page, there is a large green 'Start Measure' button with a play icon, and a smaller grey button labeled 'I'm ready to submit' with a checkmark icon. A red arrow points from the 'Start Measure' button to the 'I'm ready to submit' button.

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

The image shows two buttons side-by-side. The first button is white with a blue border and the text 'Cancel' in blue. The second button is green with a white border and the text 'Save & Return' in white.

- 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.

+ HBIPS-2 and HBIPS-3 ✓ Complete [Edit Measure](#)
HBIPS-2: Hours of Physical Restraint Use and HBIPS-3: Hours of Seclusion Use

7. 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.



8. 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.

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

✓ Enter ————— ✓ Preview ————— ✓ Submit

- 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

Total Annual Discharges

* Please enter an aggregate, yearly count of your facility's annual discharges.

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

Age Strata

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

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

* Children (1 - 12 years)

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

* Adolescent (13 - 17 years)

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

* Adult (18 - 64 years)

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

* Older Adult (65 and over)

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

Diagnostic Categories

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

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

* Anxiety disorders (651)

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

* Delirium, dementia, and amnestic and other cognitive disorders (653)

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

* Mood disorders (657)

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

* Schizophrenia and other psychotic disorders (659)

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

* Substance-related disorders (661)

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

* Other diagnosis - Not included in one of the above categories

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

* Non-Medicare

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:

HBIPS-3 Numerator

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

HBIPS-2 and HBIPS-3 Denominator

* Number of psychiatric inpatient days:

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:

Denominator

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

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: <input type="text" value="Ex. 0,1,2,3,...,99999"/>
Denominator * Number of patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period: <input type="text" value="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: <input type="text" value="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): <input type="text" value="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: <input type="text" value="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): <input type="text" value="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>SUB-2 and SUB-2a</p> <p>SUB-2 and SUB-2a: Alcohol Use Brief Intervention Provided or Offered/ Alcohol Use Brief Intervention</p>
<p>SUB-2 Numerator</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>SUB-2a Numerator</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>SUB-2 and SUB-2a Denominator</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>SUB-3 and SUB-3a</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>SUB-3 Numerator</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>SUB-3a Numerator</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>SUB-3 and SUB-3a Denominator</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

TOB-2 and TOB-2a
TOB-2 and TOB-2a: Tobacco Use Treatment Provided or Offered
TOB-2 Numerator
* 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:
<input type="text" value="Ex. 0,1,2,3,...,99999"/>
TOB-2a Numerator
* 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:
<input type="text" value="Ex. 0,1,2,3,...,99999"/>
TOB-2 and TOB-2a Denominator
* Number of hospitalized patients 18 years of age and older identified as current tobacco users:
<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

TOB-3 and TOB-3a
TOB-3 and TOB-3a: Tobacco Use Treatment Provided or Offered at Discharge/Tobacco Use Treatment at Discharge
TOB-3 Numerator
* 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:
<input type="text" value="Ex. 0,1,2,3,...,99999"/>
TOB-3a Numerator
* 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:
<input type="text" value="Ex. 0,1,2,3,...,99999"/>
TOB-3 and TOB-3a Denominator
* Number of hospitalized patients 18 years of age and older identified as current tobacco users:
<input type="text" value="Ex. 0,1,2,3,...,99999"/>

IMM-2: Influenza Immunization Information

IMM-2 IMM-2: Influenza Immunization Information
Numerator * 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"/>
Denominator * 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: HCQIS Access Roles and Profile (HARP) Registration

To participate and submit data for reporting in the IPFQR Program, facilities must obtain a HCQIS Access Roles and Profile (HARP) user account and register with the *QualityNet* Hospital Quality Reporting system. All users requesting access to the Hospital Quality Reporting system 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 Hospital Quality Reporting system. These are CMS-approved sites for secure health care quality data exchange for facility reporting.

To register for a HARP account as a Security Administrator/ Official:

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*/Registering for HARP page appears.

The Registering for HARP page contains a table of resources, including a user guide, frequently asked questions document, and training videos.

The screenshot shows the QualityNet 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 main content area features a large blue banner with the text 'Welcome to QualityNet! Your one-stop shop for CMS Quality Programs.' Below this banner are 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 articles: 'Q3 2020 HCAHPS and CY 2020 eCQM Submission Deadline Extensions' and 'FY 2021 Results for Three Value-Based Purchasing Programs Now on Provider Data Catalog'. Below the news section is a search bar with the text 'I am looking for quality information associated with...'. Underneath the search bar are six category tiles: 'Hospitals - Inpatient', 'Hospitals - Outpatient', 'Ambulatory Surgical Centers', 'PPS-Exempt Cancer Hospitals', 'ESRD Facilities', and 'Inpatient Psychiatric Facilities'.

3. Click on the “I am an HQR user” link on the left side of the page.

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

Home / Getting Started with QualityNet

Getting Started Training & Guides Known Issues & Maintenance QualityNet Support

Registration

I am an HQR user

I am an EQRS User

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

Registering for HARP

QualityNet Secure Portal (QSP) has officially been retired and replaced with hqr.cms.gov and eqrs.cms.gov for Hospital Quality Reporting (HQR) and End Stage Renal Disease (ESRD) Quality Reporting, respectively.

To log into HQR or EQRS, you must create a HCQIS Access Roles and Profile (HARP) account. HARP is a secure identity management portal provided by the Centers for Medicare and Medicaid Services (CMS). Creating a HARP account provides you with a user ID and password that can be used to sign in to many CMS applications, including HQR and EQRS.

For information on registering for HARP, please view the following resources:

Resource Name	
HARP User Guide	View
HARP Frequently Asked Questions (FAQ)	View
HARP Registration Training Video	View
HARP Manual Proofing Training Video	View

4. Scroll down the page and complete the steps to register for access to the HQR system as a Security Administrator/Official.

To register as a Basic User or Security Administrator/Official in the new Hospital Quality Reporting (HQR) System:

****NEW USERS TO HQR:** New users (those with no current affiliation to any organization) must contact their Security Administrator/Official to request access. If there is no current SA/O at their Organization, they will need to contact the QualityNet Help Desk for all access requests.**

Effective November 13, 2020, the new **Access Management** feature makes requesting and assigning access for current users much quicker.

All current users should follow these steps to request access:

1. Log onto hqr.cms.gov with your HARP User ID and Password
 - o (No **HARP** account? Create one [here](#).)
2. Go to **My Profile** (Under your **User Name** in the upper right)
 - o From this page, you can [Request Access](#) or [View Current Access](#)
3. Select either **Basic User** or **Security Administrator/Official** when prompted to **Choose Your User Type**
4. **Select** your required permissions, **Review** them, and click **Submit** when ready
5. You will be notified by email when your request has been approved

PLEASE NOTE: If you are new user to HQR and requesting to be the first SA/O for your organization, you can submit requests using the Electronic Access Request (EAR) [here](#). (Ambulatory Surgery Center's must continue to submit via the EAR. Future HQR enhancements may enable the ASC community to utilize Access Management resources.

New Vendor? Call the QualityNet Help Desk to get your Vendor ID.

Security Administrator/Official

The IPFQR Program requires the facility to have at least one active Security Administrator/Official in the HQR system.

Best Practice: We recommend facilities designate a minimum of two Security Administrators/Officials (SA/Os) in the HQR system, one to serve as the primary SA/O and the other to serve as the alternate SA/O. To keep the facility's account active, your SA/O 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/Official Responsibilities

The Security Administrator/Official has the following responsibilities:

- Approve, edit, deny, suspend, and/or remove Basic User permissions
- Monitor HQR system usage at the IPF to ensure security and confidentiality is maintained
- Serve as a point of contact for information regarding the HQR system

Security Administrator/Official Tasks

The Security Administrator/Official has all the permissions necessary to complete these tasks:

- Access reports
- Authorize vendors to submit data
- Manage measures
- Manage security
- Submit and make changes to the Notice of Participation
- View/edit online forms

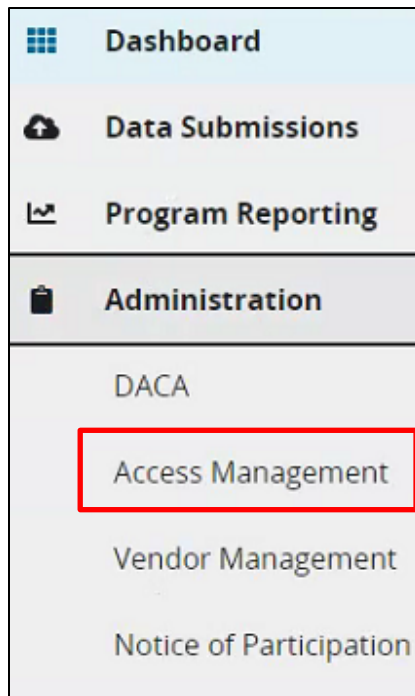
Basic User

Any user not designated as a Security Administrator/Official in the HQR system is considered a Basic User. If assigned the appropriate permissions, the user may perform one or more of the SA/O tasks listed above.

Basic User Permissions

For the IPFQR Program, there are two types of user permissions that may be assigned. Those permissions are “View” or “Upload/Edit.” The “Upload/Edit” role allows the user to edit information within the application, whereas the “View” role allows the user to read the information only. Below is a list of permissions that a Security Administrator/Official may assign to a Basic User account, via the Access Management option under **Administration** in the navigation menu.

- **Data Submissions** – DACA; Web-Based Measures
- **Submission Results** – Web-Based Measures
- **Program Results** – Public Reporting
- **Authorizations** – Auto-Route (IPFQR); Managed File Transfer (MFT); Notice of Participation and Vendor Management



Logging in to the Hospital Quality Reporting System

After completing all necessary paperwork and the New User Enrollment, the user will have access to the Hospital Quality Reporting system. While the registration and login steps noted earlier in this section will allow you to access the Hospital Quality Reporting system, 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>.

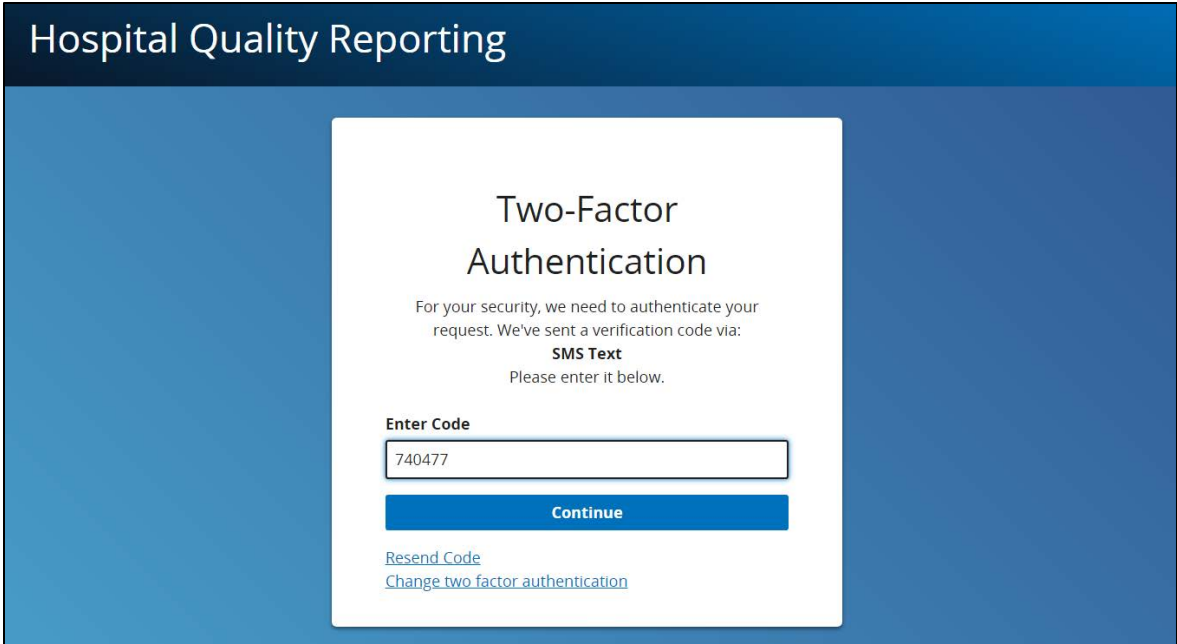
1. Access and log into the Hospital Quality Reporting system by going to <https://hqr.cms.gov/hqrng/login>.
2. Enter your Healthcare Quality Information System (HCQIS) Access, Roles, and Profile (HARP) user ID and password and click “Login.”
 - a. If you do not have a HARP account, sign into the Hospital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



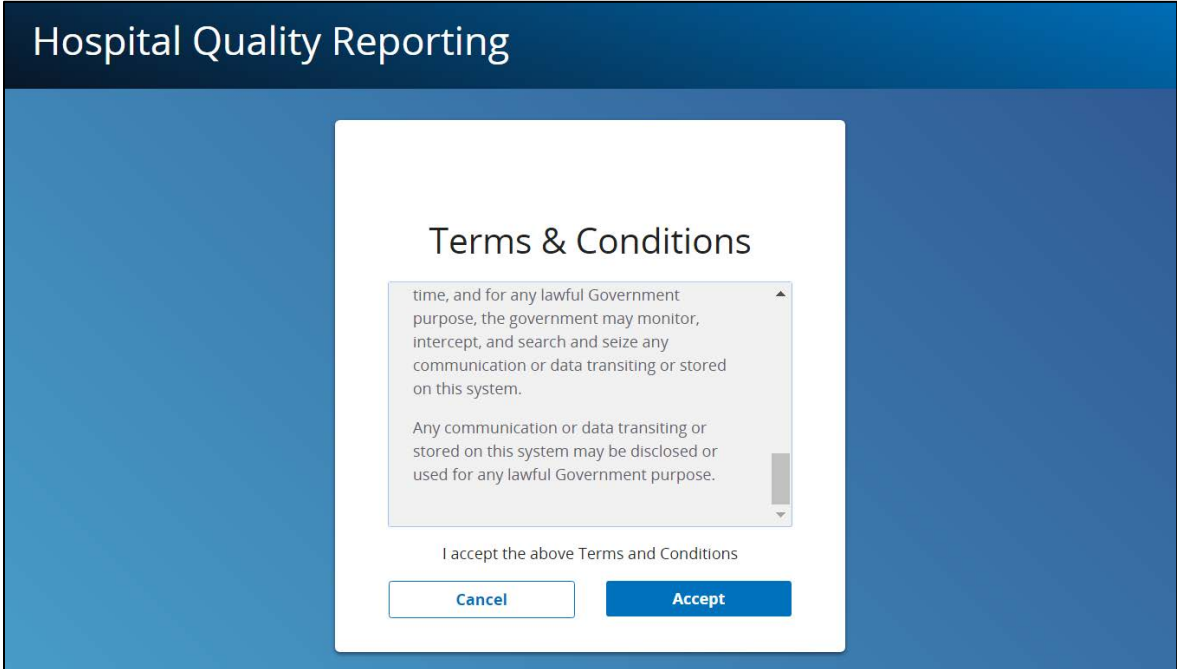
- 3. Select an option for two-factor authentication to be sent to verify your account and click “Next”. The device option(s) was setup when you registered for your HARP account (e.g., email, SMS text number, voice) .



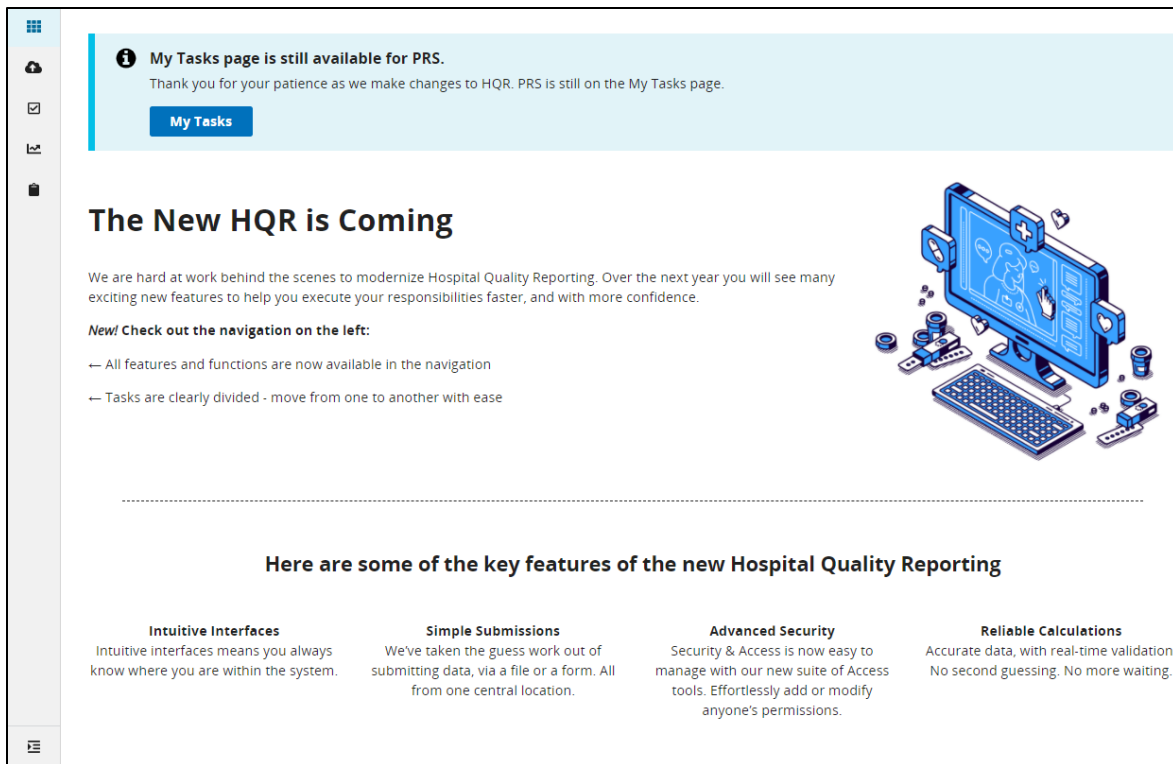
- 4. Enter the code received and click “Continue.”



5. Read and scroll to the bottom of the Terms & Conditions then click on “Accept.”

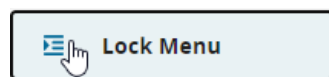


Once logged in, you will be taken to the dashboard of the Hospital Quality Reporting system.



The content of the dashboard page includes helpful general information and announcements about the HQR system.

6. Use the navigation options on the left side of the screen to access any of the tasks assigned to your account. Hover over the icon in the lower left corner of the page to lock the navigation menu.



If you have a Security Administrator/Official account, then you have access to all of the tasks listed below:

- Data Submissions – DACA, Web-Based Measures
- Submission Results – Web-Based Measures
- Program Results – Public Reporting
- Authorizations – Auto-Route, Managed File Transfer (MFT), Notice of Participation, Vendor Management

If you have a Basic User account, then you have access to the tasks that were assigned to you by your facility's Security Administrator/Official.

Section 4: 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, 2022, to meet the NOP requirement for the FY 2023 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 Agreement

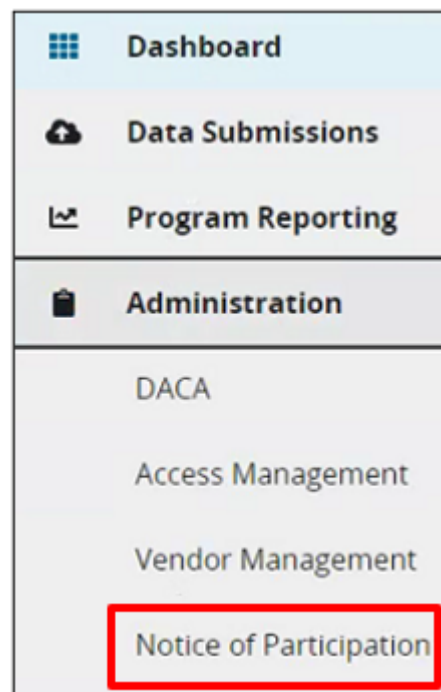
To access the online NOP agreement:

1. Ensure that you have the appropriate permissions to access the IPFQR Program NOP.

If you have a Security Administrator/Official account for your IPF, then you will have access to the IPFQR NOP agreement.

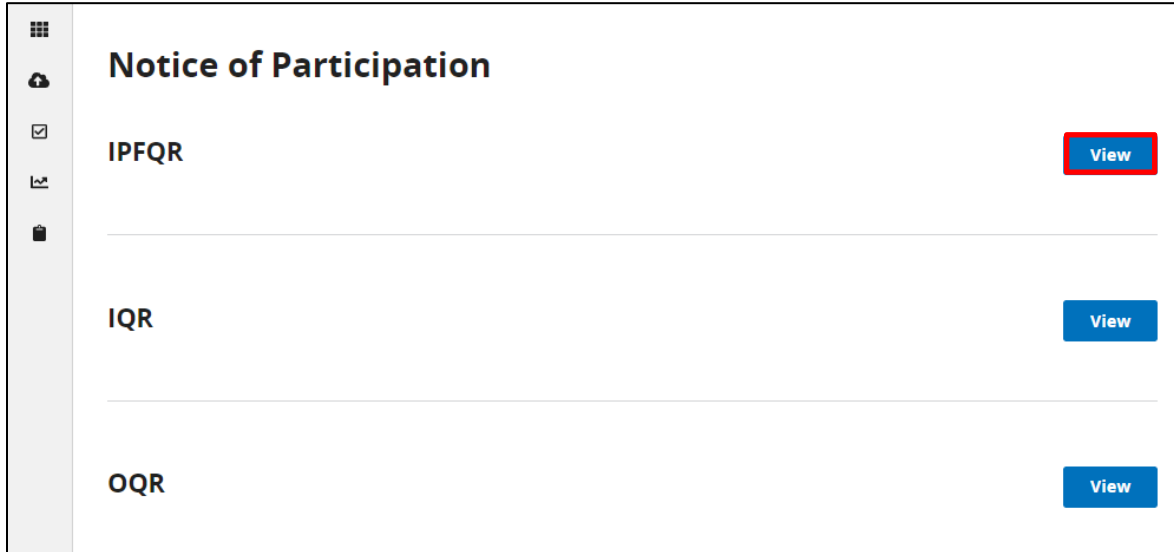
If you have a Basic User account for your IPF, then you must request Upload/Edit permissions from the Security Administrator/Official at your facility.

2. Log in to the Hospital Quality Reporting system (see instructions on pages 50–53).
3. Select **Administration** then Notice of Participation from the menu.



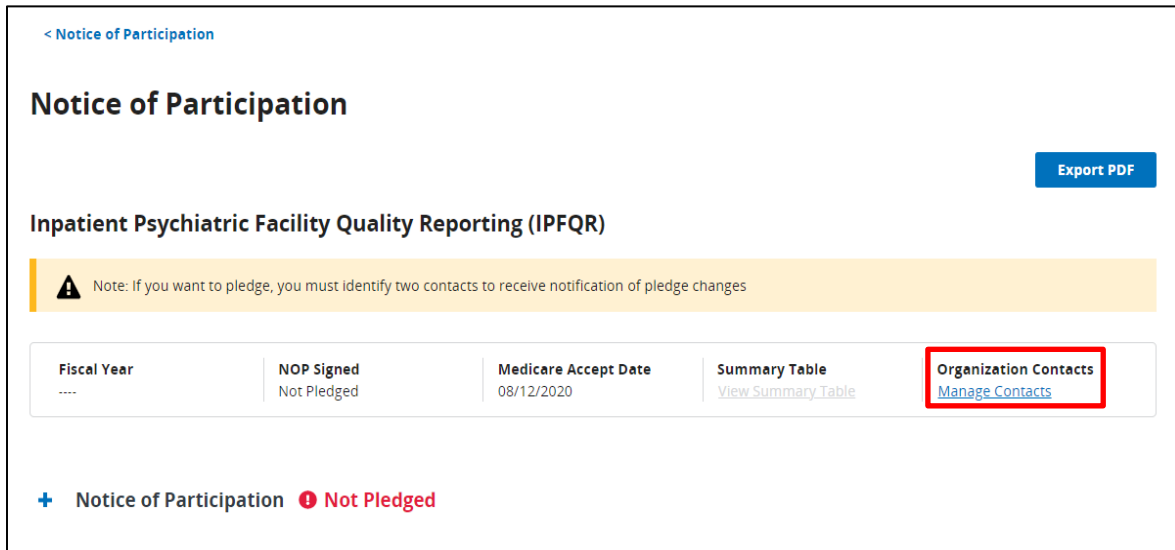
If your facility participates in more than one quality reporting program, as shown in the example below, then you will have the option to view each program’s Notice of Participation.

4. Click the “View” button on the IPFQR row.



If you choose to participate in the IPFQR Program, you will first have to enter the name and contact information for at least two contacts at your facility who will be notified of any updates that occur with the IPFQR Program NOP.

5. On the next webpage, click on the “Manage Contacts” link in the last column of the table.



6. Click on the blue “Add Contact” button and a new window will appear.

< IPFQR Notice of Participation

Notice of Participation

Export PDF

Inpatient Psychiatric Facility Quality Reporting (IPFQR)

Notice of Participation Contact Table

Add Contact

Contact Type	Contact Name	Phone	Address	Email
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7. Enter and submit information in the required fields for at least two contacts who will receive notifications of any pledge changes.

View/Edit/Delete Contact

* Indicates required field

* Contact Type

Select One

* Contact Name

Job Title

* Email * Re-enter Email

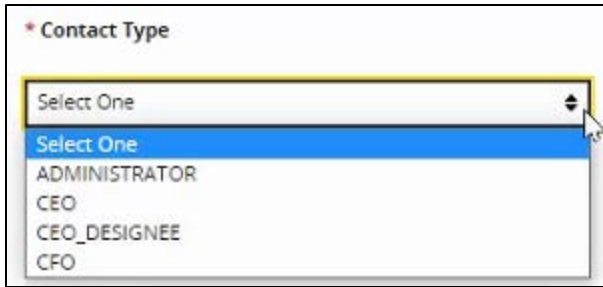
* Address 1

Address 2

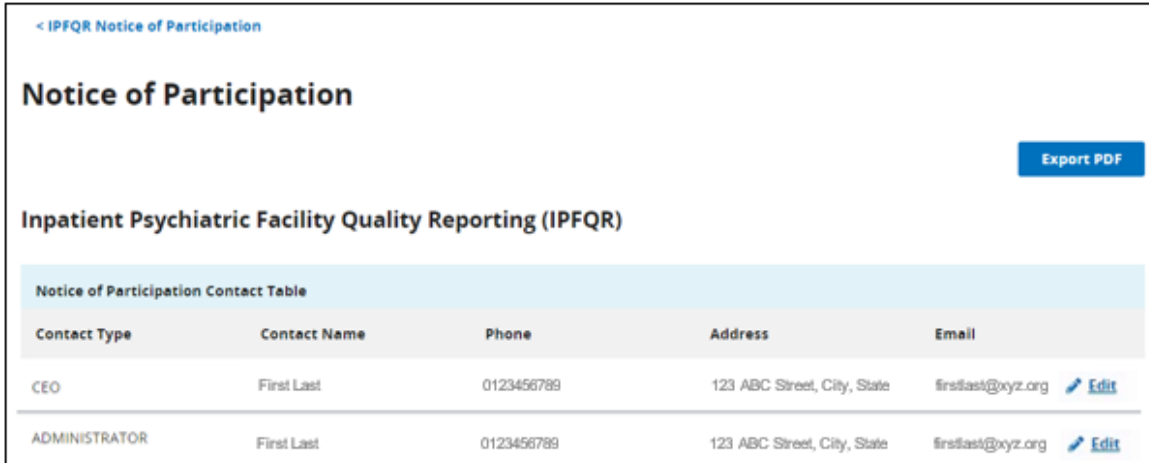
* City * State * Zip +4

* Telephone Extension Fax

Save and Close Cancel



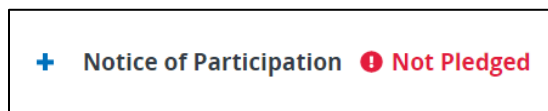
8. Click Edit to revise or delete an existing contact.



9. Return to the previous page by clicking the blue “< IPFQR Notice of Participation” link at the top left of the page.



10. Next, click on the plus sign next to “Notice of Participation Not Pledged” and the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Notice of Participation Agreement will appear.



11. Review the NOP agreement.

- Your facility's CCN will auto-populate.
- You will have three pledge options from which to choose:
 - Agree to participate
 - Do not agree to participate
 - Request to be withdrawn from participation

— Notice of Participation ❗ Not Pledged

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.

Each IPF must complete this "IPFQR Notice of Participation" (IPFQR Notice) as outlined 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 a CMS' website after being afforded the opportunity to review their data.

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

Agree to participate

Do not agree to participate

Request to be withdrawn from participation

This acknowledgement (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:

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

[Submit Notice of Participation](#)

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

— Notice of Participation ❗ Not Pledged

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.

Each IPF must complete this "IPFQR Notice of Participation" (IPFQR Notice) as outlined 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 a CMS' website after being afforded the opportunity to review their data.

We entities operating under the submitted Provider ID: **CCN - XXXXXX**

Agree to participate

Do not agree to participate

Request to be withdrawn from participation

This acknowledgement (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:

- Transmit or have data transmitted to CMS, and
- Permit my hospital's performance information to be publicly reported.

[Submit Notice of Participation](#)

A window will appear asking you to confirm that you wish to submit the NOP.

13. Click the "Submit" button to confirm, save, and submit the IPFQR Program NOP, or click "Cancel" to return back to the pledge page.

Submit Notice of Participation ✕ Close

Click "Submit" to confirm, save and submit your action(s), or click Cancel to return back to the pledge page.

[Submit](#) [Cancel](#)

Once your facility participates in the IPFQR Program, a summary table will be created to track and carry forward the facility’s participation status annually, until a change is made to the NOP (e.g., withdrawn or not participating).

< Notice of Participation

Notice of Participation

[Export Signed Pledge Statement](#)

Inpatient Psychiatric Facility Quality Reporting (IPFQR)

Fiscal Year 2022	NOP Signed 07/01/2020	Medicare Accept Date 07/01/1966	Summary Table View Summary Table	Organization Contacts Manage Contacts
----------------------------	---------------------------------	---	--	---

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.

< IPFQR Notice of Participation

Notice of Participation

[Export PDF](#)

Inpatient Psychiatric Facility Quality Reporting (IPFQR)

Notice of Participation Summary Table

Fiscal Year	NOP Status	NOP Date	Added By	Date Edited	Edited By
2022	PARTICIPATING	07/01/2020	CARRY_FORWARD		CARRY_FORWARD
2021	PARTICIPATING	07/01/2020	CARRY_FORWARD	08/23/2020	CARRY_FORWARD

Section 5: Vendor Management

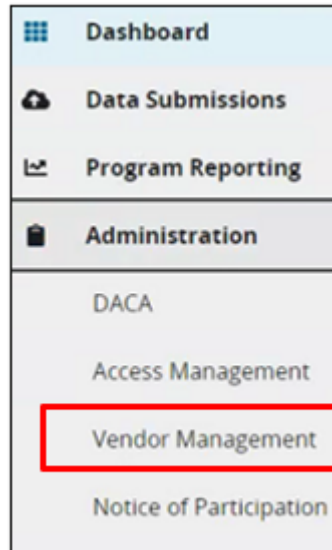
Facilities may elect to use a vendor to collect and submit data on their behalf. A vendor must have an assigned vendor ID before the IPF authorizes the vendor to submit data or to have access to the facility's data and/or reports.

To register as a new vendor, the vendor may submit an email request to the *QualityNet* Support Team at 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.**

A representative from the IPF must have the Vendor Management permission to access the **Vendor Management** link in the HQR system.

1. Log in to the Hospital Quality Reporting system (see instructions on pages 50–53).
2. Select **Administration** then Vendor Management from the menu.



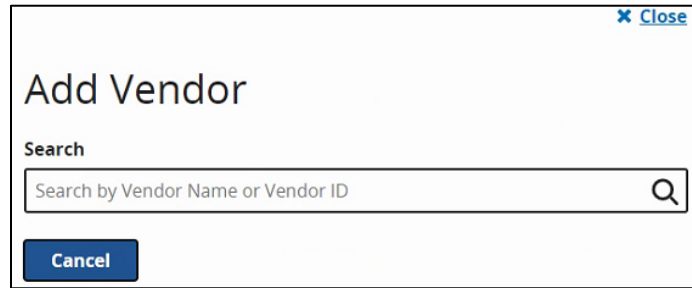
The Vendor Management page will display all the vendors associated with the IPF in the “Your Vendors” tab.

The screenshot shows the Vendor Management page with a search bar and a table of vendors. The table has columns for Name, Vendor ID, and Status. Two vendors are listed, both with the status 'Active'.

Name	Vendor ID	Status
VENDOR A	V123456	Active
VENDOR B	V123456	Active

Add a Vendor

1. Click the “Add Vendor” button and a search window will appear.



The screenshot shows a modal window titled "Add Vendor" with a close button in the top right corner. Below the title is a search field with the placeholder text "Search by Vendor Name or Vendor ID" and a magnifying glass icon. A "Cancel" button is located at the bottom left of the window.

2. Type the name of the vendor in the search field. As you type a word a list of vendors with that name will appear along with the associated vendor ID.

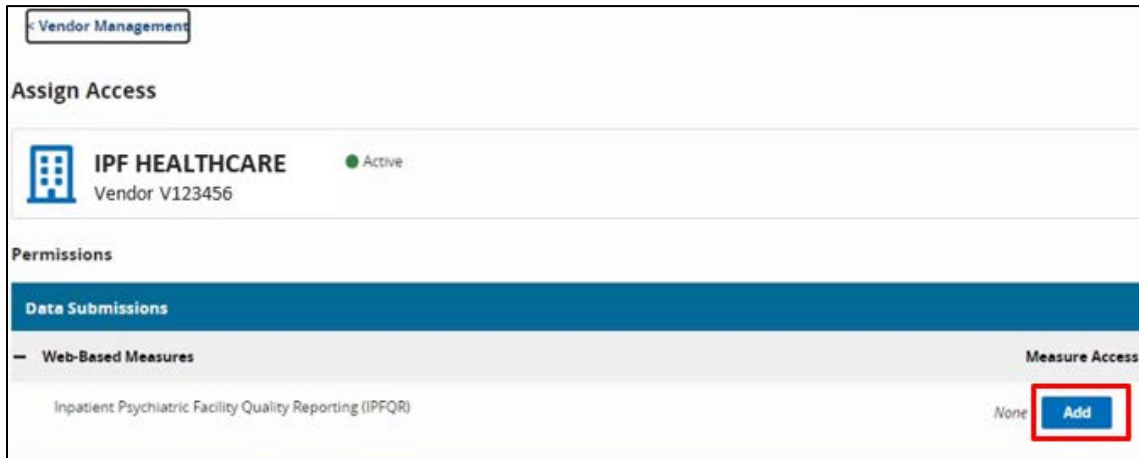
If the vendor does not appear on the list, contact the vendor to ensure that you have the correct name and vendor ID.

As stated above, to register as a new vendor, the vendor may submit an email request to the *QualityNet* Support Team at qnet-support@hcqis.org

3. Select the vendor from the list and the following window will appear listing options for you to assign permissions to the vendor.

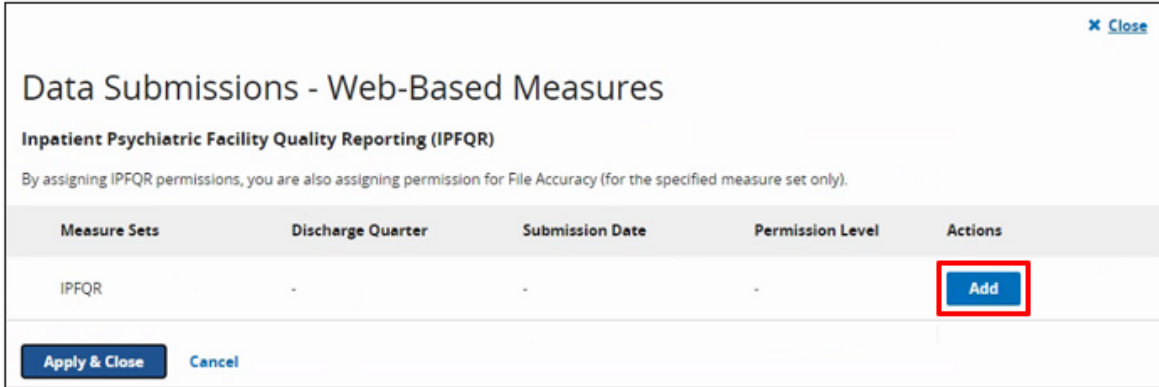
The remaining instructions are specific to the Data Submissions – Web-Based Measures permissions, which are also applicable for the Submission Results – Web-Based Measures permissions.

4. Click the “Add” button under Data Submissions – Web-Based Measures to update permissions and the following window will appear.

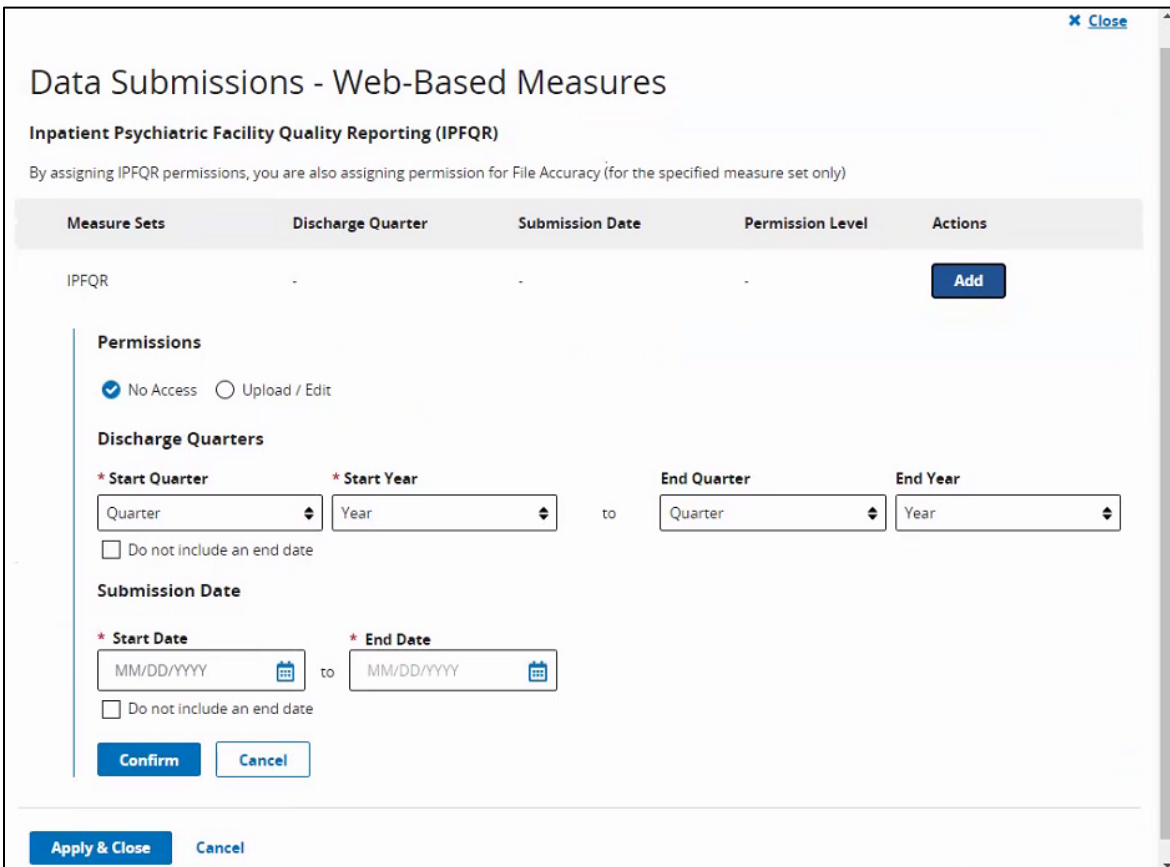


The screenshot shows a "Vendor Management" window with a tab for "Assign Access". It displays information for "IPF HEALTHCARE" (Vendor V123456) with an "Active" status. Under the "Permissions" section, "Data Submissions" is selected. Within "Data Submissions", "Web-Based Measures" is expanded, showing "Inpatient Psychiatric Facility Quality Reporting (IPFQR)" with a "Measure Access" dropdown set to "None". A red box highlights the "Add" button next to the dropdown.

5. Click the next “Add” button, as shown in the image below, to view/select options.



The following window appears showing that the vendor does not currently have permissions pertaining to data submission for the web-based measures.



6. Select “Upload / Edit” and then complete all required fields.

Permissions

No Access Upload / Edit

Discharge Quarters

* Start Quarter: Q1 * Start Year: 2020

Do not include an end date

Start Quarter overlaps with existing Vendor permissions

Submission Date

* Start Date: 3/8/2021

Do not include an end date

I acknowledge that multiple vendors have access to this program

Confirm Cancel

In the **Discharge Quarters** section, click the box next to “Do not include an end date” if you wish to grant the vendor authorization to submit data pertaining to all quarters and years after the selected start quarter and year.

In the **Submission Date** section, click the box next to “Do not include an end date” if you wish to grant the vendor authorization to submit data indefinitely.

If there is another vendor with permissions that overlap with the selected vendor’s discharge quarters, it will be stated in red text. You will be able to proceed but will need to verify that the dates entered are correct, per the acknowledgment statement that will appear above the greyed out “Confirm” button.

7. Click the box next to the acknowledgement statement and click the “Confirm” button.

Do not include an end date

I acknowledge that multiple vendors have access to this program

Confirm Cancel

8. Click the “Apply & Close” button in the new window that opens.

Data Submissions - Web-Based Measures

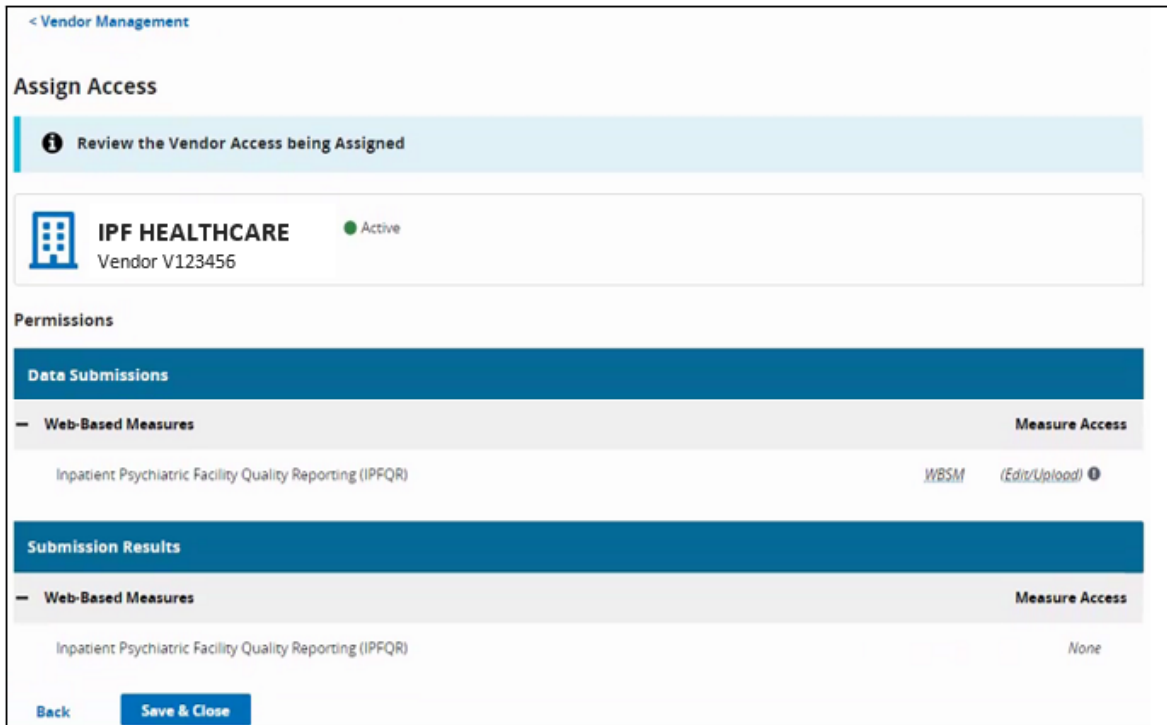
Inpatient Psychiatric Facility Quality Reporting (IPFQR)

By assigning IPFQR permissions, you are also assigning permission for File Accuracy (for the specified measure set only)

Measure Sets	Discharge Quarter	Submission Date	Permission Level	Actions
IPFQR	Q1:01-01-2020 - Ongoing	03-08-2021 - Ongoing	Upload / Edit	Edit

Apply & Close Cancel

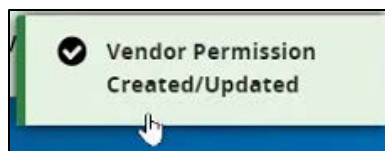
The image below shows the updated “Web-Based Measures” section under Data Submissions.



9. Hover over the WBSM in italics to view the selections.



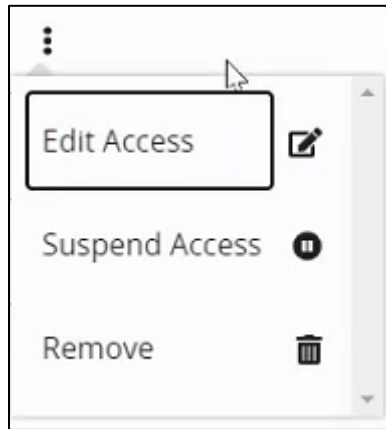
10. Click the “Save & Close” button to confirm and return to the Vendor Management landing page. A notification will appear at the top of the page to indicate that the vendor permission was created/update.



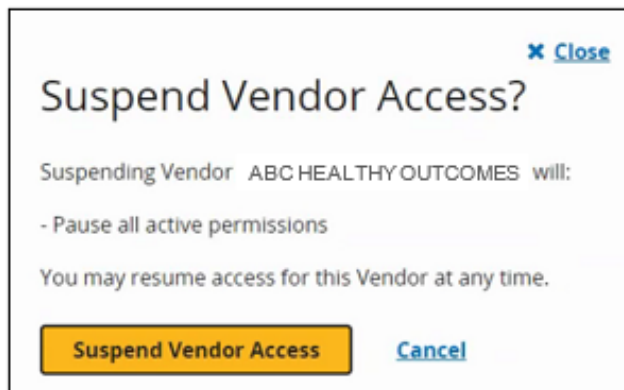
Change an Active Vendor's Access

If you need to make any changes to an active vendor's access, then you have a few options from which to choose.

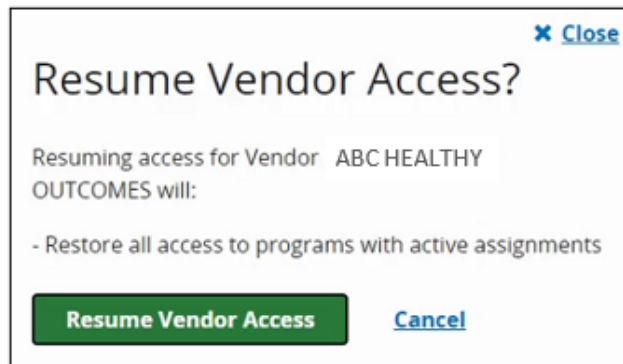
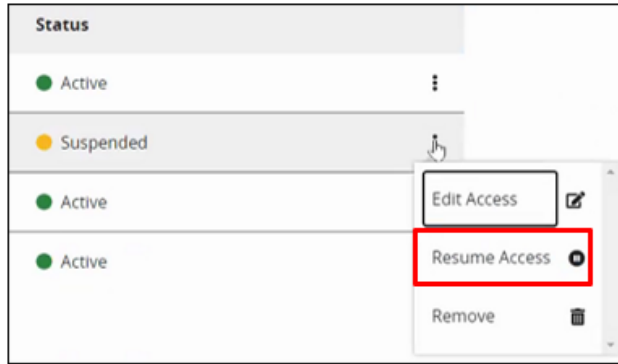
1. On the main Vendor Management page, click on the three vertical dots on the row of the vendor you wish to update.
2. Select one of the following options from the short menu that appears:
 - **Edit Access:** Choose this option to revise the vendor's access to the facility's data and reports.



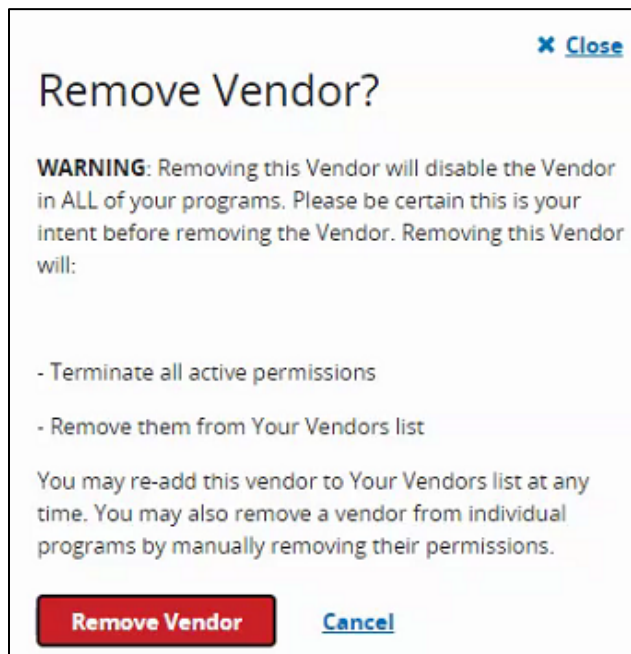
- **Suspend Access:** Choose this option to retain but pause the vendor's existing access until the IPF chooses to resume or remove the vendor's permissions.



If the IPF chooses to resume the vendor's access, after it has been suspended, then you must click on the three vertical dots on the row of the vendor you wish to update and select "Resume Access".



- Remove: Choose this option to eliminate a vendor's access. Note that the vendor's access can only be reinstated for the IPF if the vendor is added via the **Add a Vendor** instructions above.



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.

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 last date the vendor can submit data may precede the data submission deadline due to the possibility of a submission date extension. CMS recommends that you enter the Submission Date End Date when all data have been transmitted.

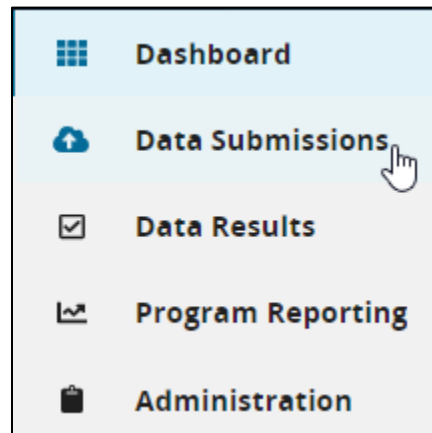
Section 6: Data Accuracy and Completeness Acknowledgement

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.

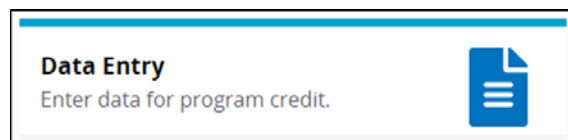
1. The IPFQR Program DACA is only accessible in the Hospital Quality Reporting system from the Data Entry page by a representative of the IPF. After submitting data, a prompt to sign the DACA form will appear in a blue banner at the top of the simple data entry overview page. Click the “Sign” button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



- a. When a representative of the IPF is logged into the Hospital Quality Reporting system 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 Hospital Quality Reporting system
 - ii. Hover your mouse on the left side of the screen to expand the menu options and click on **Data Submissions**.

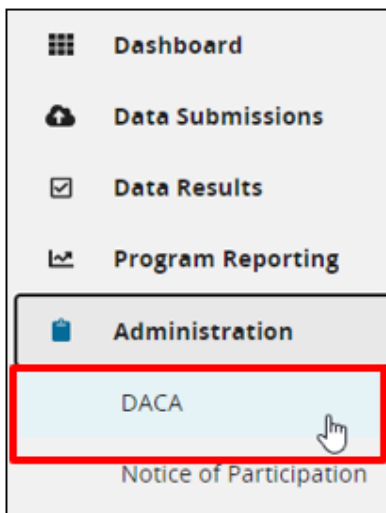


- iii. Select the “**Data Entry**” button.



At the top of the Data Submissions page, a blue banner indicates the DACA needs to be signed.

2. Review the data for accuracy and completeness and then 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.
8. 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 Hospital Quality Reporting system.

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/O status.
 - Ensure that the SA/O at your IPF logs in to the Hospital Quality Reporting system 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.
 - Refer to instructions provided in [Section 5 – Notice of Participation](#) of this manual to ensure the IPFQR Program NOP status is “Participating.”
3. Check accuracy of data.
 - Review the exported PDF data report against facility data.
4. Check DACA.
 - Ensure that DACA status is complete in Hospital Quality Reporting system based on instructions provided in [Section 6 –Data Accuracy and Completeness Acknowledgement](#) 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 Catalog](#), respectively. This IPFQR program manual will therefore refer to the new [Medicare Care Compare](#) and [Provider Data Catalog](#) 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. Claims-based measure (CBM) IPF-Specific Reports (ISRs) will be accessible for download by the facility via the Managed File Transfer function in the Hospital Quality Reporting system. 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 Catalog](#) 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 Catalog](#) websites.

Preview Report Content

The Inpatient Psychiatric Facility Public Reporting Preview Help Guide 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 via the Hospital Quality Reporting system as well as the content of the Preview Report.

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.

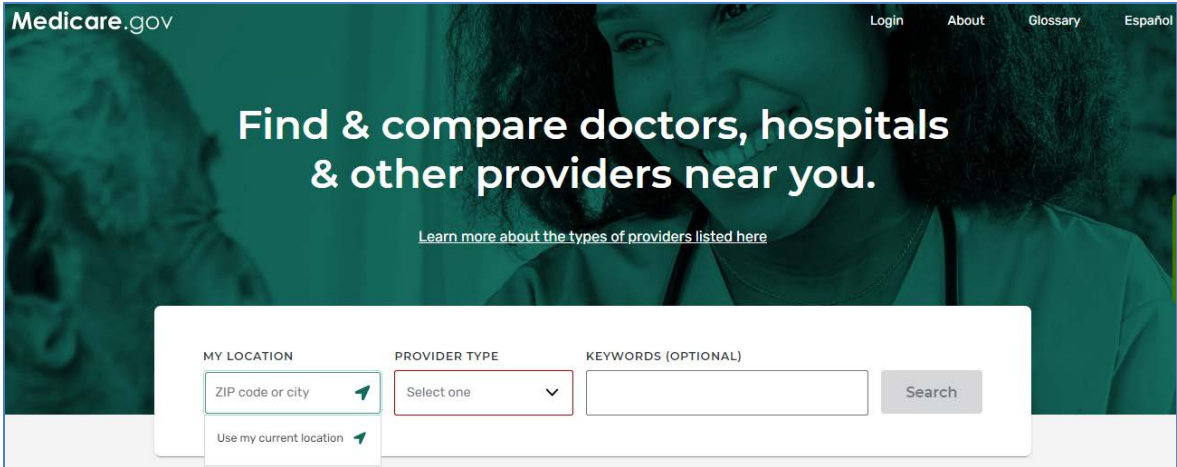
Medicare.gov Care Compare Website

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

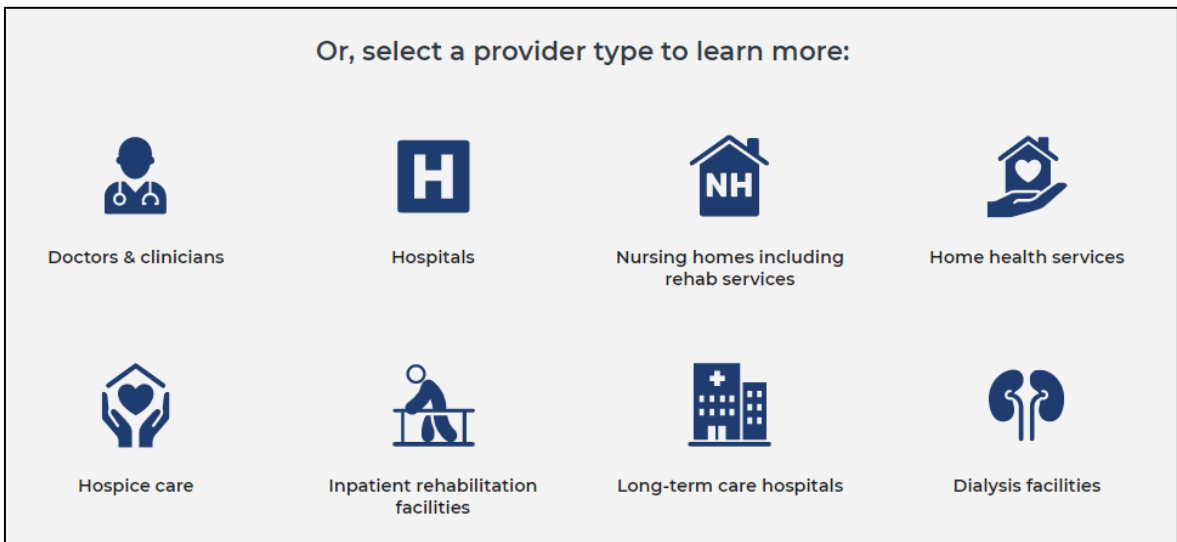
The following instructions describe how to navigate the *Care Compare* website to view, download, sort, and filter IPFQR Program data.

Access and Compare IPFQR Program Data for up to Three Facilities in *Care Compare*

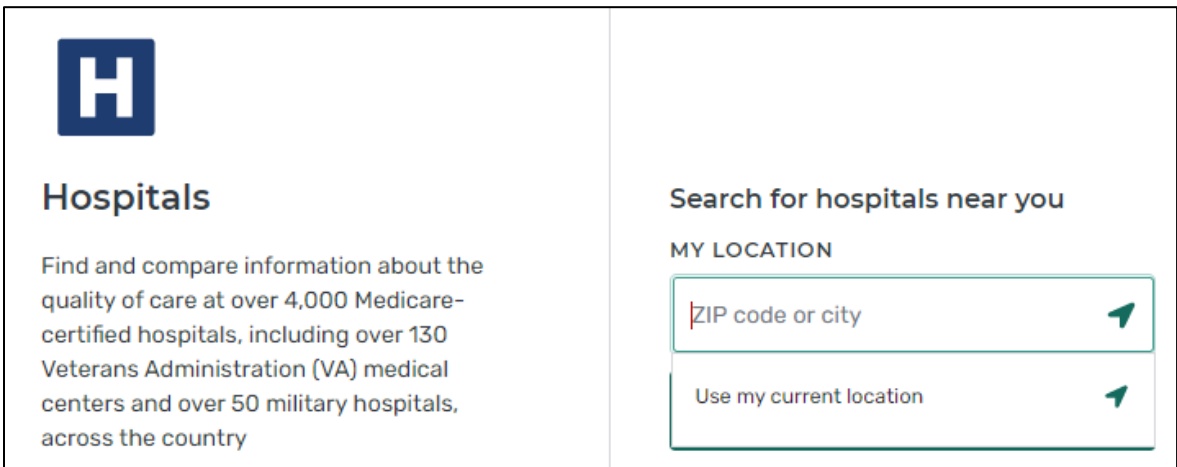
1. Access the [Medicare Care Compare Search](http://medicare.gov/care-compare/) webpage (<http://medicare.gov/care-compare/>).
2. There are two ways to search for a list of facilities.
 - a. Use the search function by:
 - i. Entering a ZIP code, or city (state options will auto-populate), or select “Use 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.



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



- 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.



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.



5. 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	▼
Psychiatric unit services	▼
Payment & value of care	▼

6. 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.

1

Psychiatric unit services

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](#)

2

Measure	Facility 1	Facility 2	Facility 3
Patients discharged on antipsychotic medications who had body mass index, blood pressure, blood sugar, and cholesterol level screenings in the past year ↑ Higher percentages are better National average: 74% TX average: 72%	Not available	98%	Not available

- 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 ⁵” indicates that the facility did not have results to report for this reporting period.
7. 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 Catalog

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

About this data

- About the data >
- Measures and current data collection periods >
- Overall hospital quality star rating >
- Timely & effective care >
- Complications & deaths >
- Unplanned hospital visits >
- Survey of patients' experiences (HCAHPS) >
- Psychiatric unit services >**

- 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.

[← Back to Hospitals](#) H Hospitals

Psychiatric unit services

The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program provides consumers with quality of care information to make informed decisions about options for inpatient psychiatric care. To meet the IPFQR program requirements, inpatient psychiatric facilities (IPFs), which include psychiatric hospitals and psychiatric units, are required to submit to the Centers for Medicare & Medicaid Services (CMS) data on quality measures specified by CMS. If the IPF doesn't meet program requirements for that fiscal year, CMS reduces the annual update otherwise applicable to an IPF for a fiscal year by 2 percentage points. The quality data that IPFs must submit address these topics:

- [Preventive care and screening](#)
- [Substance use treatment](#)
- [Patient safety](#)
- [Follow-up care](#)
- [Unplanned readmissions](#)
- [Which patients are included](#)
- [Where the information comes from](#)
- [Risk adjustment](#)
- [Significance testing](#)
- [IPF performance categories](#)
- [Additional information](#)

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 the care inpatient psychiatric units provide to patients.

Access the Most Recently Reported IPFQR Program Data in the Provider Data Catalog

- Go to <https://data.cms.gov/provider-data/search>.
- 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.

Search

Inpatient Psychiatric Facility ×

3 datasets found for "Inpatient Psychiatric Facility" [Clear all filters](#)

Hospitals

Inpatient Psychiatric Facility Quality Measure Data - by State

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 • [Download CSV](#)

Hospitals

Inpatient Psychiatric Facility Quality Measure Data - by Facility

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 • [Download CSV](#)

Hospitals

Inpatient Psychiatric Facility Quality Measure Data - National

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 • [Download CSV](#)

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 Catalog Hospitals Data Archive*

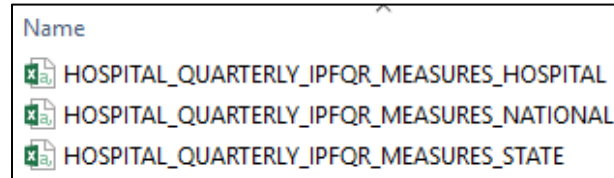
1. Go to <https://data.cms.gov/provider-data/archived-data/hospitals> to access the *Provider Data Catalog Hospitals* data archive webpage, which lists files grouped by year.

The screenshot shows the CMS.gov website's 'Hospitals data archive' page. The page has a blue header with the CMS.gov logo and navigation links: 'Home', 'Datasets', 'Topics', and 'About'. Below the header, there is a sidebar on the left with a 'Back to Topics' link and a list of 'Annual Files' from 2020 down to 2013. The main content area is titled 'Hospitals data archive' and features a 'View topic >' link. It displays two sections: '2020 Annual Files' and '2019 Annual Files'. Each section has a 'Download all' link. The 2020 section lists four files: '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 section lists four files: '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). A 'View archived data policy *' link is located at the bottom left of the main content area.

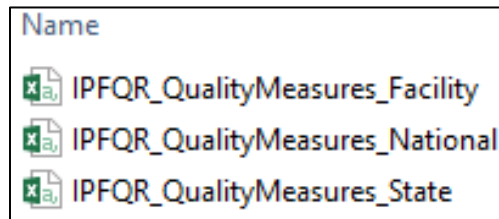
2. Select the zip file of choice to download it to your computer. Each zip file contains Microsoft Excel Comma Separated Values (CSV) files for all data reported to CMS.

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.

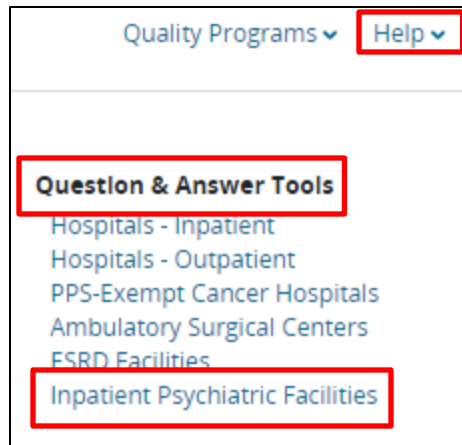
IPFQR Program Listserve

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.

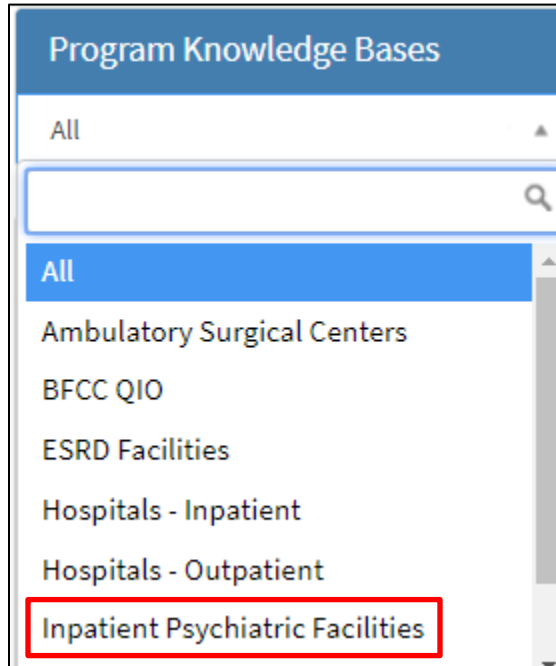
1. Users can access the Q&A tool from *QualityNet* by hovering over the “Help” link at the top right of the screen and selecting the **Inpatient Psychiatric Facilities** link under Question & Answer Tool section. The direct link is https://cmsqualitysupport.servicenowservices.com/qnet_qa.



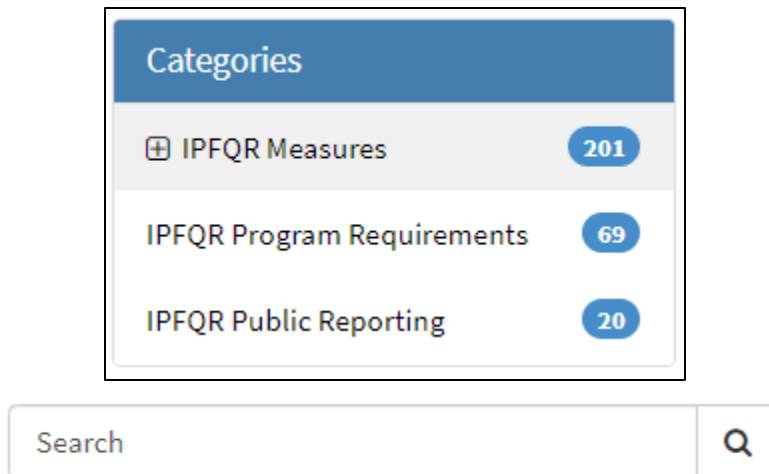
2. From the landing page, click the **Browse** button.



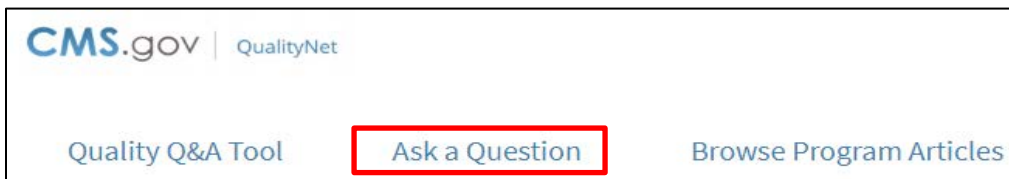
3. On the left side of the screen select Inpatient Psychiatric Facilities from the drop-down menu under Program Knowledge Bases.



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

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

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: https://qualitynet.cms.gov/files/602d8a8b6bb42a002559574e?filename=AMA_PCPI_Care_Transitions_2016.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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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.)

4. Duration of Mental Health Care Directive Initial A or B.

A. _____ It is my intention that this advance directive will remain in effect for an indefinite period of time.

OR

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.¹ 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.¹ 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

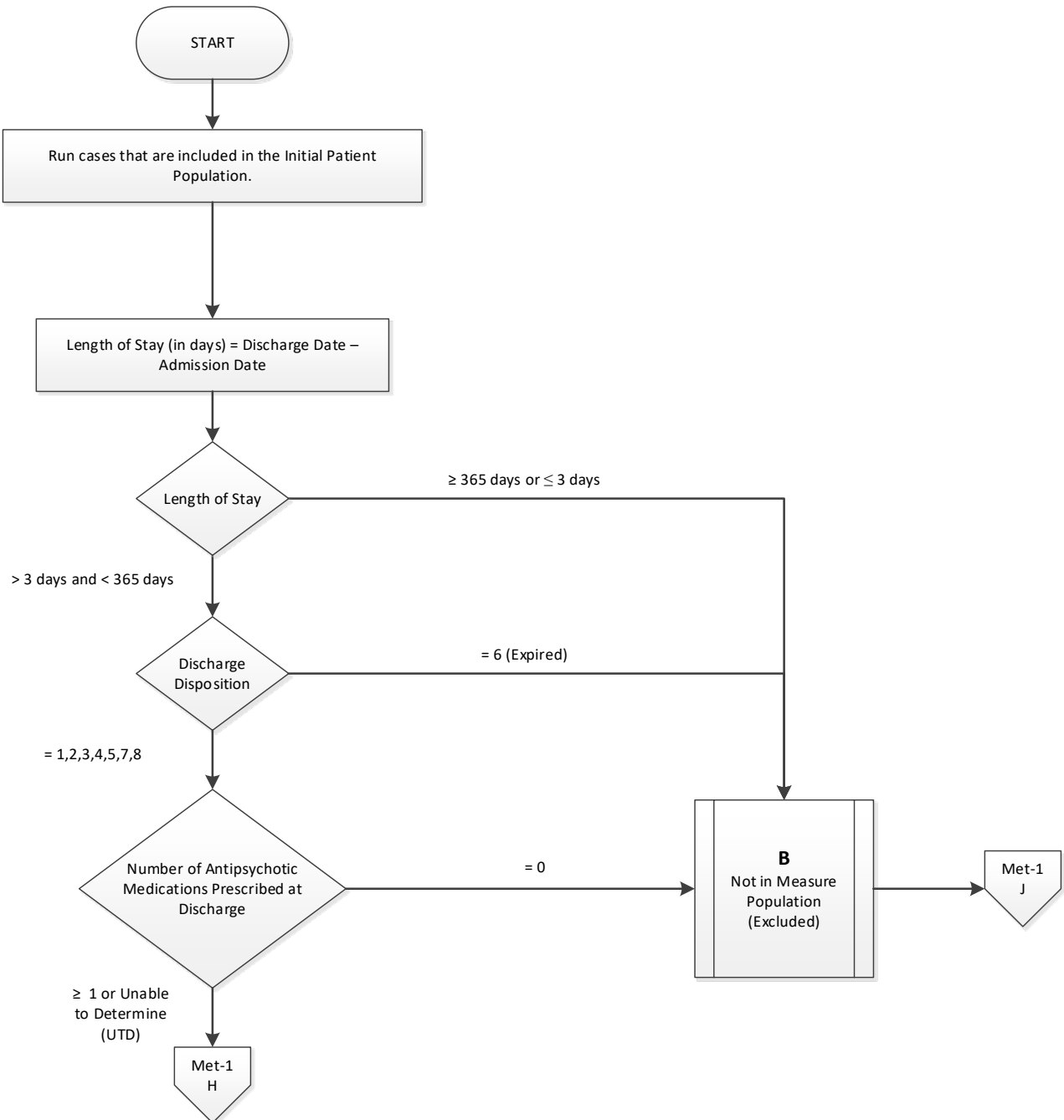
Selected Reference:

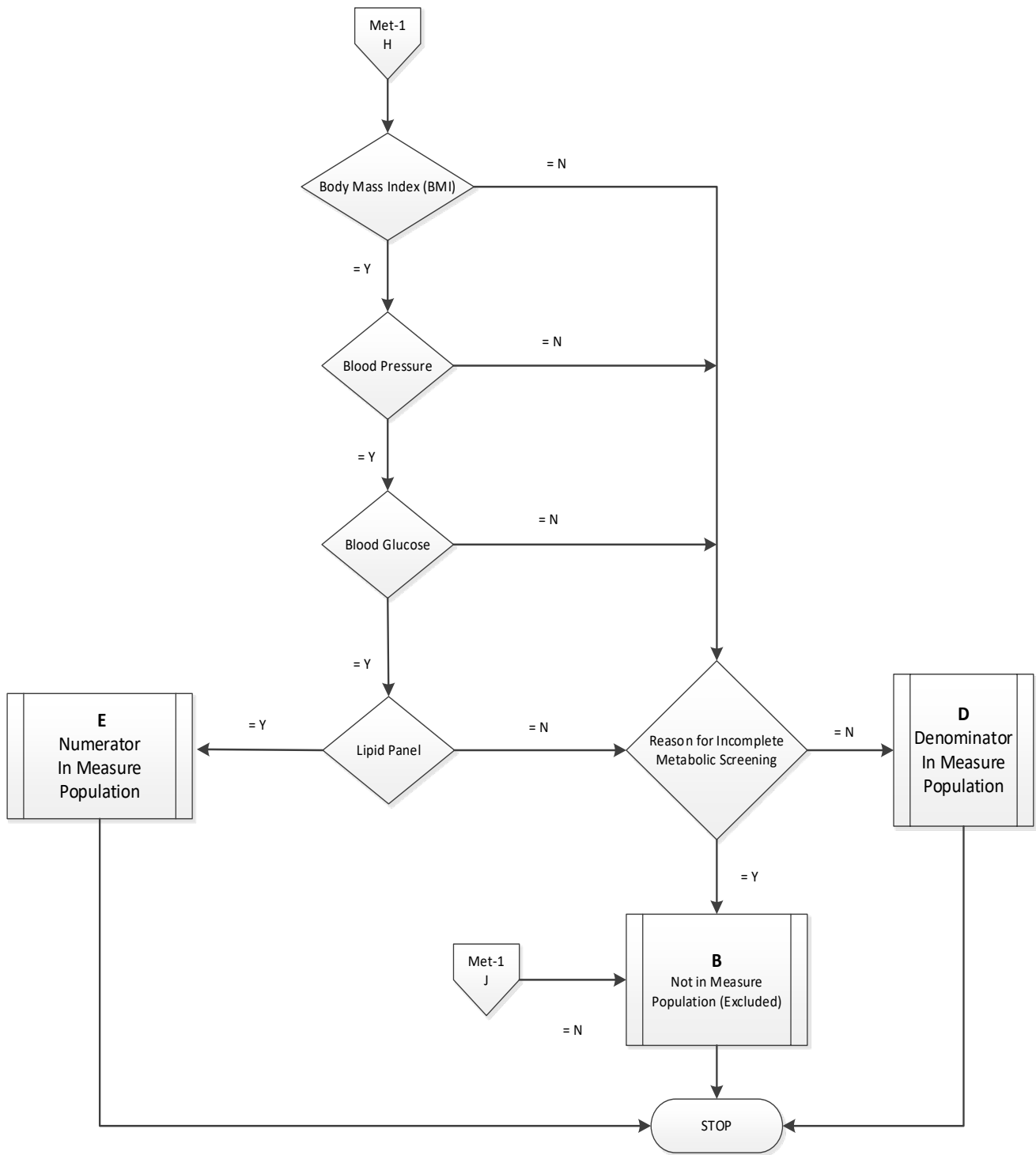
1. The American Diabetes Association, American Psychological Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. *Diabetes Care*. 2004;27(596–601).

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)

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Element Name	Page #
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Reason for Incomplete Metabolic Screening	112

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 04/05/2020. On 04/06/2020, the physician writes an order to admit to inpatient psychiatric care, effective 04/05/2020. The Admission Date would be abstracted as 04/06/2020; 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). Fasting is not required for an HbA1c.
- 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 04/01/2020 state that the patient will be discharged back home. On 04/06/2020, 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 04/06/2020 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