



Inpatient Psychiatric Facility Quality Reporting Program Manual

This program manual is a resource for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program for the Centers for Medicare & Medicaid Services (CMS).

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Section 1: CMS 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.

The IPFQR pay-for-reporting program is intended to equip consumers with quality of care information to make more informed decisions about healthcare 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, inpatient psychiatric facilities (IPFs) are required to collect and submit all quality measures in the form, manner, and time as specified by the Secretary, to CMS, which began with the Fiscal Year (FY) 2014 annual payment update (APU) and continues in subsequent fiscal years.

This program manual is intended for use as a quick reference to assist in the implementation of the program and is effective as of the date listed on the cover page of this document. Links to the websites that display the measure specifications are provided, as this manual does not contain the specifications for the individual measures. 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:

- *QualityNet* registration
- Vendor authorization;
- Notice of Participation completion
- Location of measure specifications
- Data Accuracy and Completeness Acknowledgement
- Report review and public reporting
- Additional resources

QualityNet

Established by CMS, *QualityNet* provides healthcare quality improvement news, resources, and data reporting tools and applications used by healthcare providers and others. *QualityNet* is the only CMS-approved website for secure communications and healthcare quality data exchange between: quality improvement organizations (QIOs), hospitals, physician offices, nursing homes, end-stage renal disease (ESRD) networks and facilities, and data vendors.

Eligibility

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 psychiatric units in acute care or critical access hospitals (CAHs). 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):

<http://www.QualityNet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier1&cid=1228772862944>.

National Provider Webinars are provided by CMS and by the IPFQR 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/Calls** link from the drop-down menu.

Glossary of Terms

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).

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).

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

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

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

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.”

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

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.

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.

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 (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the NASMHPD Research Institute, Inc. (NRI) collaborated on the development of performance measures specific to hospital-based inpatient psychiatric services.

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 Psychiatric Facility Prospective Payment System (IPF PPS) – A payment system for specialty hospitals and units established according to Section 1886(b) of the Social Security Act, as amended by Section 101 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Facilities are paid on the basis of Medicare reasonable costs per case, limited by a hospital specific target amount per discharge. The base year target amount is adjusted annually by an update factor and published in the IPF PPS Rule. Facilities paid under this system are required to report under the CMS IPFQR Program.

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.

Medical Record (Data Source) – Data obtained from the records or documentation maintained on a patient in any healthcare setting (for example, hospital, home care, long-term care, practitioner’s office); includes automated and paper medical record systems.

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.

Patient Level Data – Collection of data elements that depict the healthcare 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.

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

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

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

“Sampling Approaches” discussion in the Population and Sampling Specifications section of the respective manuals for further information.

Sampling Size – The number of individuals or patients included.

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 Core Measures – A manual that contains the specifications for The Joint Commission measures used in the IPFQR Program. This manual includes detailed information about the HBIPS measures, with a data dictionary and Measurement Information Forms.

Specifications Manual for National Hospital Inpatient Quality Measures – A manual that includes detailed information for the SUB, TOB, and IMM measures, with a data dictionary and Measurement Information Forms.

Strata – See stratified measure.

Stratified Measure – A measure that is classified into several categories to assist in analysis and interpretation. The overall or un-stratified measure evaluates all the strata together. A stratified measure, or each stratum, consists of a subset of the overall measure. For example, the HBIPS measures are stratified by age group.

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. Refer to the “Sampling Approaches” discussion in the Population and Sampling Specifications section of the respective manuals for further information.

Proposed Rule and Final Rule Publication Site

Every year, CMS publishes proposed program and policy changes to the IPFQR Program in April. 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 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 August.

The IPFQR Program was implemented with the FY 2013 IPPS/LTCH 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 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 (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 (direct download, 790 KB): <http://www.gpo.gov/fdsys/pkg/FR-2015-08-05/pdf/2015-18903.pdf>.

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

The FY 2018 IPPS/LTCH 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>.

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.

FY 2019

1. Complete the [QualityNet Registration](#).
 - This step must be accomplished for each [QualityNet Security Administrator \(SA\)](#) and user who will access the [QualityNet Secure Portal](#).
 - Once registered, it is important that the SA(s) and user(s) maintain an active account by periodically logging into the system. CMS recommends that each IPF have at least two SAs, so that 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 an NOP for the IPFQR Program.
 - An IPF NOP status of “Participating” must be on file in the [QualityNet Secure Portal](#) by the annual August 15 deadline to meet the NOP requirement, unless directed otherwise via the IPFQR Program ListServe. Once a participation status is selected, the status automatically carries over year after year.
 - Any eligible IPF that chooses not to participate in the program should contact the IPFQR Program Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Project Lead by emailing IPFQualityReporting@hcqis.org.
 3. Collect measure and non-measure data during the 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 reporting period is January 1, 2017, through December 31, 2017, (1Q 2017 through 4Q 2017) for all but one of the 13 chart-abstracted IPF quality measures and the non-measure data.
 - IPFs must collect data for the two structural measures based on the status of the facility as of December 31, 2017.
 - For the IMM-2 (a chart-abstracted measure) and the Influenza Vaccination Coverage Among Healthcare Personnel (HCP) measures, the reporting period is October 1, 2017, through March 31, 2018.
 4. Submit measure data before the annual data submission deadlines.
 - The Influenza Vaccination Coverage Among Healthcare Personnel measure data is due to the National Healthcare Safety Network (NHSN) by May 15, 2018, unless directed otherwise via the IPFQR Program ListServe.
 - The chart-abstracted IPF quality measure data, non-measure data and two structural measures are due July 1, 2018, through August 15, 2018, unless directed otherwise via the IPFQR Program ListServe.
- NOTE:** The claims-based measures will be calculated by CMS using Medicare fee-for-service Parts A and B claims data; therefore, no action is required by IPFs for these measures.
5. Complete the Data Accuracy and Completeness Acknowledgement (DACA) by the August 15, 2018 submission deadline, unless directed otherwise via the IPFQR Program ListServe.

FY 2020

1. Complete the [QualityNet Registration](#).
 - This step must be accomplished for each [QualityNet Security Administrator \(SA\)](#) and user who will access the [QualityNet Secure Portal](#).
 - Once registered, it is important that the SA(s) and user(s) maintain an active account by periodically logging into the system. CMS recommends that each IPF have at least two SAs, so that 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 an NOP for the IPFQR Program.
 - An IPF NOP status of “Participating” must be on file in the [QualityNet Secure Portal](#) by the annual August 15 deadline to meet the NOP requirement, unless directed otherwise via the IPFQR Program ListServe. Once a participation status is selected, the status automatically carries over year after year.
 - Any eligible IPF that chooses not to participate in the program should contact the IPFQR Program VIQR Outreach and Education Project Lead by emailing IPFQualityReporting@hcqis.org.
3. Collect measure data during the measure reporting period.
 - Newly participating facilities must start collecting measure data at the beginning of the first quarter following submission of the NOP.
 - The measure reporting period is January 1, 2018, through December 31, 2018, (1Q 2018 through 4Q 2018) for all but one of the 13 chart-abstracted IPF quality measures and the non-measure data.
 - IPFs must collect data for the two structural measures based on the status of the facility as of December 31, 2018.
 - For the IMM-2 (a chart-abstracted measure) and the Influenza Vaccination Coverage Among Healthcare Personnel measures, the reporting period is October 1, 2018, through March 31, 2019.
4. Submit measure data before the annual data submission deadlines.
 - The Influenza Vaccination Coverage Among Healthcare Personnel measure data is due to the National Healthcare Safety Network (NHSN) by May 15, 2019, unless directed otherwise via the IPFQR Program ListServe.
 - The chart-abstracted IPF quality measures data, non-measure data and two structural measures are due July 1, 2019, through August 15, 2019, unless directed otherwise via the IPFQR Program ListServe.

NOTE: The claims-based measures will be calculated by CMS using Medicare fee-for-service Parts A and B claims data; therefore, no action is required by IPFs for these measures.
5. Complete the Data Accuracy and Completeness Acknowledgement (DACA) by the August 15, 2019, 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, the National Committee for Quality Assurance (NCQA), or NHSN.**

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 2020 annual payment update, the data collected are for calendar year 2018 for most measures. This requires the facility to reference the *Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.3a*, for collection of the first two quarters of 2018 and the *Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.4*, for the third and fourth quarters of 2018. 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
<i>Specifications Manual for National Hospital Inpatient Quality Measures</i>	Tobacco Treatment (TOB), Substance Use (SUB), and Influenza Immunization (IMM-2) measure sets
<i>Specifications Manual for Joint Commission National Quality Measures</i>	HBIPS-2, -3, -5
<i>Healthcare Personnel Vaccination Module: Influenza Vaccination Summary Protocol July 2017 (NHSN)</i>	Influenza Vaccination Among Healthcare Personnel (HCP)
<i>Care Transitions - Performance Measurement Set (American Medical Association [AMA]-convened Physician Consortium for Performance Improvement® [PCPI])</i>	Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record

Specifications Resource as Defined by the Measure Steward	IPFQR Program Measures
<u>IPFQR Program Claims-Based Measure Specifications</u>	Follow-Up After Hospitalization (FUH) for Mental Illness and 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF
<u>IPFQR Program Manual - Appendix D</u>	Screening for Metabolic Disorders Measure

To view all updates made in this version of the IPFQR Program Manual compared to the previous version, review the Release Notes document associated with this version of the manual, which is available at the following websites:

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

CMS requires the submission of aggregate numerator and denominator data. There are no patient-level data reported to CMS for the IPFQR Program.

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 IPFQR/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.

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

- 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).
- The measure does not align with current clinical guidelines or practice.
- 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.
- Measure performance or improvement does not result in better patient outcomes.
- The measure can be replaced by a measure that is more strongly associated with desired patient outcomes for the topic.
- Measure collection or public reporting leads to negative unintended consequences other than patient harm.
- The measure is not feasible to implement as specified.

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, such as those delineated in the National Quality Strategy or CMS Quality Strategy.
- 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 take into account these removal and retention factors when considering 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 2019 and Subsequent Years

Effective for FY 2019 payment determination and subsequent years, CMS will collect data for five new measures for the IPFQR Program.

Four are chart-abstracted measures:

- Transition Record with Specified Elements Received by Discharged Patients
- Timely Transmission of Transition Record
- Screening for Metabolic Disorders
- Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge (SUB-3) and the subset measure Alcohol and Other Drug Use Disorder Treatment at Discharge (SUB-3a)

The fifth is a claims-based measure: 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF).

NOTE: Data collection for the new chart-abstracted measures begins with discharges in the first quarter of 2017. IPFs will not collect or report data for the new claims-based measure, as CMS will complete the calculation.

The following table lists all IPFQR Program measures for FY 2019 and subsequent years. New measures for FY 2017 are marked with an asterisk.

Table 2: IPFQR Program Measures for FY 2019 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-1	Alcohol Use Screening
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-1	Tobacco Use Screening
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 Discharge Patients	Transition Record with Specified Elements Received by Discharged Patients
Timely Transmission of Transition Record	Timely Transmission of Transition Record

Measure ID	Measure Description
Screening for Metabolic Disorders	Screening for Metabolic Disorders
N/A	Assessment of Patient Experience of Care
N/A	Use of an Electronic Health Record
IMM-2	Influenza Immunization
N/A	Influenza Vaccination Coverage Among Healthcare Personnel (HCP)
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)

Identifying the IPFQR Patient Population

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

- Hospital Based Inpatient Psychiatric Services (HBIPS) measure IPP details are found in the [Specifications Manual for Joint Commission National Quality Measures](#).
- Substance Use (SUB), Tobacco Use (TOB), and Immunization (IMM) measure IPP details are found in the [Specifications Manual for National Hospital Inpatient Quality Measures](#) (Section 2 – Measure Information, Section 2.10 Prevention).
- 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) and the IPP algorithm located in Appendix C of this program manual.
- The Screening for Metabolic Disorders measure will use the entire population (all IPF discharges) as the IPP.

HBIPS Population

The HBIPS measure set is unique in that there are two distinct Initial Patient Populations within the measure set, one for the event measures (HBIPS-2 and HBIPS-3) and one for the discharge measure (HBIPS-5).

Event Measures (HBIPS-2 and HBIPS-3)

All patients within an IPF or an acute care hospital/critical access hospital's psychiatric unit reimbursed under IPF PPS during the reporting quarter are included in the initial patient population for events.

Facilities must use the entire Initial Patient Population for reporting, including all payer sources (Medicare and non-Medicare). The Event Measures (HBIPS-2 and HBIPS-3) **are not eligible for sampling**.

Discharge Measure (HBIPS-5)

The discharge measure HBIPS-5 can be sampled. For specific details regarding the Initial Patient Population and sampling, refer to the guidelines published within the HBIPS-5 section of the [Specifications Manual for Joint Commission National Quality Measures](#).

SUB, TOB, IMM, Transition and Metabolic Screening Measures Population

Data for the following measures are collected from patients within freestanding IPFs or acute care hospital/critical access hospital psychiatric units that are reimbursed under IPF PPS during the reporting period: SUB-1, SUB-2/-2a, SUB-3/-3a, TOB-1, TOB-2/-2a, TOB-3/-3a, IMM-2, Transition Record, and Screening for Metabolic Disorders.

NOTE: The initial patient population for the SUB, TOB, IMM, Transition Record, and Screening for Metabolic Disorders measure sets differs for CMS IPFQR Program reporting as compared to The Joint Commission.

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 initial patient population size does not exceed the minimum number of cases per year for the measure set, the facility must submit 100% of the initial patient population.

NOTE: Sampling is not allowed for HBIPS-2, HBIPS-3, and the Influenza Vaccination Coverage Among Healthcare Personnel measures.

FY 2019 Payment Determination and Subsequent Years

Data collected by IPFs during the 2017 calendar year will be reported to CMS in 2018 and impact the FY 2019 payment determination. Data collected by IPFs during the 2018 calendar year will be reported to CMS in 2019 and impact the FY 2020 payment determination. IPFs will have two options for sampling measure data.

Option 1: IPFs may choose to continue referencing the sampling guidelines described in the following manuals:

- [*Specifications Manual for Joint Commission National Quality Measures*](#)
HBIPS-5 measure only
- [*Specifications Manual for National Hospital Inpatient Quality Measures*](#)
SUB and TOB measures, IMM-2, Transition Record measures; and Screening for Metabolic Disorders measures. **NOTE:** The sampling guidelines in the Specifications Manual for National Hospital Inpatient Quality Measures can be applied to the Transition Record and Screening for Metabolic Disorders measures *after* determining each measure's Initial Patient Population, even though the new 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 and TOB measures, IMM-2, Transition Record measures, and the Screening for Metabolic Disorders measure.

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

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

Chart Abstraction

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

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. Total leave days are excluded from the denominator.

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

This measure is collected on those patients discharged on multiple antipsychotics and is 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 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* at <https://manual.jointcommission.org/>. The measure information is contained in Section 1 under the Measure Information Forms Section. The HBIPS data elements are located under Section 3 – Data Dictionary.

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

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-1: Alcohol Use Screening

Individuals with mental health conditions experience substance use disorders (SUDs) at a much higher rate than the general population. Individuals with the most serious mental illnesses have the highest rates of such disorders. Co-occurring SUDs often go undiagnosed and, without treatment, contribute to a longer persistence of disorders, poorer treatment outcomes, lower rates of medication adherence, and greater impairments to functioning. This measure is intended to assess efforts by IPFs to screen for the most common type of such disorder, alcohol abuse.

The **numerator** is defined as the number of patients who were screened for alcohol use using a validated screening questionnaire within the first day of admission. The **denominator** is defined as the number of psychiatric inpatients 18 years of age and older. The measure excludes patients who are less than 18 years of age, are cognitively impaired, or have Comfort Measures Only documented. Exclusions based on length of stay (LOS) are determined using the current *Specifications Manual*.

SUB-2 (Alcohol Use Brief Intervention Provided or Offered) and the subset SUB-2a (Alcohol Use Brief Intervention)

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

The SUB-2 **numerator** is defined as the number of patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The SUB-2a **numerator** is defined as the number of patients who received a brief intervention. The **denominator** for both measures is the number of patients 18 years of age and older who screen positive for unhealthy alcohol use or an alcohol use disorder (alcohol abuse or alcohol dependence). The measure excludes patients who are less than 18 years of age, are cognitively impaired, patients who refused or were not screened for alcohol use during the hospital stay, or have Comfort Measures Only documented. Exclusions based on length of stay (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 twenty patients with an addiction are referred for treatment. Hospitalization provides a prime opportunity to address the entire spectrum of substance use problems within the health care system. Approximately 8% of general hospital inpatients and 40 to 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 length of stay (LOS) are determined using the current *Specifications Manual*.

For SUB-1, SUB-2/-2a and SUB-3/-3a measure information, please refer to the [Specifications Manual for National Hospital Inpatient Quality Measures](#).

TOB-1: Tobacco Use Screening

Tobacco use is currently the single greatest cause of disease in the U.S., accounting for more than 435,000 deaths annually. Smoking is a known cause of multiple cancers, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease, other respiratory problems, poorer wound healing, and many other diseases. This health issue is especially important for persons with mental illness and substance use disorders.

The TOB-1 chart-abstracted measure assesses hospitalized patients who are screened for tobacco use (cigarettes, smokeless tobacco, pipe, and cigar) within the previous 30 days. The **numerator** includes the number of patients who were screened for tobacco use within the first day of admission. The **denominator** includes the number of hospitalized patients 18 years of age and older. The measure excludes patients who are less than 18 years of age, are cognitively impaired or have Comfort Measures Only documented. Exclusions based on length of stay (LOS) are determined using the current *Specifications Manual*.

TOB-2 (Tobacco Use Treatment Provided or Offered) and 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 within the past 30 days 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 both TOB-2 and TOB-2a 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 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 TOB-3a (Tobacco Use Treatment at Discharge)

The overall rate, TOB-3, assesses patients identified as tobacco product users within the past 30 days 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 the [*Specifications Manual for National Hospital Inpatient 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 the [Specifications Manual for National Hospital Inpatient Quality Measures](#).

Transition Record with Specified Elements Received by Discharged Patients

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

The Transition Record with Specified Elements Received by Discharged Patients measure assesses the percentage of patients, regardless of age, discharged from an IPF to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements.

The **numerator** is comprised of patients 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 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 to satisfy the measure numerator. Please refer to the definitions following this section for additional guidance pertaining to the required elements for this measure.

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, or 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 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. All eleven elements must be captured and transmitted within 24 hours to satisfy the measure numerator.

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 following this section for additional guidance pertaining to the required elements for this measure.

Definitions for Transition Record Measures

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

24-hour/7-day contact information including physician for emergencies related to inpatient stay – 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.

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 an appendix of the IPFQR Program Manual at <http://www.qualityreportingcenter.com/inpatient/ipf/tools/>.

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 or patient confusion - 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.”

Contact information for obtaining results of studies pending at discharge – Healthcare professional or facility contact number at which patient can receive information on studies that were not concluded at discharge. Patient preference should be considered in sharing results of studies, including whether results should be provided on paper. If there is documentation in the transition record indicating that no tests are pending at discharge, then this will satisfy the element.

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

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

Current medication list – The current medication list should include prescription 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.

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

Elopement: The National Quality Forum (NQF) defines elopement as any situation in which an admitted patient leaves the healthcare facility without staff's knowledge. 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 advance directive or surrogate decision maker was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance directive; OR, documentation as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning or a surrogate decision maker, as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship.

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

Major procedures and tests performed during inpatient stay and summary of results – All procedures and tests noteworthy in supporting patients' diagnosis, treatment, or discharge plan as determined by provider or facility. Examples may include: complete blood count and metabolic panel, urinalysis, or radiological imaging. If there is documentation in the transition record indicating that no major procedures or tests were performed, then this will satisfy the element.

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.

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 (i.e., 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 in the physician's final progress note may be used.

Reason for IPF Admission – The events the patient experienced prior to this hospitalization; the reason for hospitalization may be a short synopsis describing or listing the triggering or precipitating event. A diagnosis alone is not sufficient.

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

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. A surrogate decision maker must be designated by the patient in a way that complies with the state’s laws for the state in which the patient receives care.

Transition record – A core, standardized set of data elements related to patient’s demographics, diagnosis, treatment, and care plan that is discussed with and provided to the patient in a printed or electronic format at each transition of care and transmitted to the facility/physician/other health care professional providing follow-up care. The transition record may only be provided in electronic format if acceptable to the patient and only after all components have been discussed with the patient.

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 healthcare 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.

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.

For measure information, please refer to the measure specifications for NQF #0647 (Transition Record of Specified Elements Received by Discharged Patients) and #0648 (Timely Transmission of Transition Record) measures, which can be downloaded from the NQF website: <http://www.qualityforum.org/ProjectMeasures.aspx?projectID=83375>.

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.

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.

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) 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 or psychological condition and patients with a length of stay equal to or greater than 365 days or equal to or less than 3 days.

Additional details about the Screening for Metabolic Disorders measure, including a data dictionary and algorithm, are in Appendix D of this program manual.

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).

Claims-Based Measures

Claims-Based Measure: Follow-Up After Hospitalization for Mental Illness (FUH) – Version 1.0

This measure assesses the percentage of IPF hospitalizations for treatment of select mental health disorders that were followed by an outpatient mental healthcare 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 measurement period used to identify cases in the denominator is 11 months of the measurement year. The measurement year begins on July 1 and ends on May 30 of the following year. Data from July 1 through June 30 of the following year are used to identify follow-up visits in the numerator.

Facilities are not required to collect and submit data for this claims-based measure. 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 fee-for-service (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. Completion of this measure does not affect an IPF's payment determination.

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

Claims-Based Measure: 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF) – Version 1.0

Readmission to acute care settings following discharge from IPF is both costly to Medicare and undesirable for patients. Readmission is an undesirable outcome because it represents deterioration in a patient's mental and/or physical health status severe enough to require a return to an acute level of care. Additionally, another hospitalization exposes patients to risks of healthcare-acquired complications. While not all readmissions are preventable, there is evidence that improvements to the quality of care for patients in the IPF setting can reduce readmission rates which, in turn, would reduce costs to Medicare and the burden to patients and their caregivers.

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

readmission rate and a national readmission rate. This incentive for quality improvement could lead to a reduction in the national rates and a reduction in the variation in rates across facilities.

As this is a claims-based measure, CMS will calculate the measure outcome using information from the following three sources: Medicare Denominator file, Medicare FFS Part A records, and Medicare FFS Part B records. The Medicare Denominator file contains patient demographic, enrollment, and vital status information for all beneficiaries enrolled during the calendar year. Part A data contain final action claims submitted by institutional providers for reimbursement of inpatient and outpatient services provided to beneficiaries. Institutional providers include acute care and critical access hospitals, inpatient psychiatric facilities, home health agencies, and skilled nursing facilities. Part B data contain final action claims submitted by non-institutional providers including physicians, physician assistants, clinical social workers, nurse practitioners, and other providers, such as clinical laboratories and ambulance providers.

This approach requires no additional data collection or reporting by IPFs. Completion of this measure does not affect an IPF's payment determination.

NOTE: This measure is collected by CMS through claims data. There is no action required by facilities to collect and submit data for this measure.

The **eligible population** includes any eligible admission to an inpatient psychiatric facility during the measurement period to which 30-day unplanned admissions are attributed. Index admissions define the measure denominator.

The **denominator** includes admissions to IPFs for patients:

- Age 18 or older at admission
- Discharged alive
- Enrolled in Medicare FFS Parts A and B during the 12 months prior to, the month of, and at least one month after the index admission
- Discharged with a psychiatric principal diagnosis included in one of the Agency for Healthcare Research and Quality (AHRQ) Clinical Classification Software (CCS) ICD groupings.

The **denominator** excludes admissions for patients:

- Discharged against medical advice (AMA) because the IPF may have limited opportunity to complete treatment and prepare for discharge.
- With unreliable demographic and vital status data defined as the following:
 - Age greater than 115 years
 - Missing gender
 - Discharge status of “dead” but with subsequent admissions
 - Death date prior to admission date
 - Death date within the admission and discharge dates but the discharge status was not “dead”
- With readmissions on the day of discharge or day following discharge because those readmissions are likely transfers to another inpatient facility. The hospital that discharges the patient to home or a non-acute care setting is accountable for subsequent readmissions.
- With readmissions two days following discharge because readmissions to the same IPF within two days of discharge are combined into the same claim as the index admission

and do not appear as readmissions due to the interrupted stay billing policy. Therefore, complete data on readmissions within two days of discharge are not available.

The **numerator** is defined as an admission to an inpatient psychiatric or acute care hospital, including critical access hospitals, within 30-days of discharge from an eligible inpatient psychiatric admission (index admission). The numerator excludes readmissions that are considered planned by the CMS 30-Day HWR Planned Readmission Algorithm, Version 3.0.

The measure is **risk adjusted** using hierarchical logistic regression model. Four types of risk factors are included in the model:

1. Demographics
2. Principal discharge diagnosis of the IPF index admission
3. Comorbidity risk variables
4. Other risk factor variables from the literature that are available in Medicare FFS claims

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

Attestations

Assessment of Patient Experience of Care

Improvement of experience of care for patients, families, and caregivers is one of the objectives within the CMS Quality Strategy and is not currently addressed in the IPFQR Program. Surveys of individuals about their experience in all healthcare settings provide important information as to whether high-quality, person-centered care is actually provided and address elements of service delivery that matter most to recipients of care.

The measure asks IPFs whether they routinely assess patient experience of care using a standardized collection protocol and a structured instrument. The attestation should be based on the hospital's activities on December 31.

NOTE: This is a measure that does not depend on systems for collecting and abstracting individual patient information and only requires simple attestation.

Use of Electronic Health Record

A measure of the degree of EHR implementation provides important information about an element of healthcare service delivery shown to be associated with the delivery of quality care. It provides useful information to consumers and others in choosing among different facilities. A key issue in EHR adoption and implementation is the use of this technology to support health information exchange. The Office of the National Coordinator for Health Information Technology (ONC) and CMS work to promote the adoption of health information technology. The use of certified EHRs by IPFs can effectively and efficiently help providers improve internal care delivery practices, support the exchange of important information across care partners and during transitions of care, and could enable the reporting of electronically specified clinical quality measures (eCQMs).

The measure will assess the degree to which facilities employ EHR systems in their service program and use such systems to support health information exchange at times of transitions in care. It is a structural measure that only requires the facility to attest to one of **three** statements that best describes the facility's highest level typical use of an EHR system (excluding the billing system) during the reporting period, and whether this use includes the exchange of interoperable health information with a health information service provider. The three statements are as follows:

- The facility most commonly used paper documents or other forms of information exchange (for example, email) not involving the transfer of health information using EHR technology at times of transitions in care.
- The facility most commonly exchanged health information using non-certified EHR technology (that is, not certified under the ONC HIT Certification Program) at times of transitions in care.
- The facility most commonly exchanged health information using certified EHR technology (certified under the ONC HIT Certification Program) at times of transitions in care.

The attestation should be based on the hospital's activities on December 31.

After selecting the appropriate statement regarding the facility's typical use of an EHR system, an IPF must then respond to the following question with a Yes or No answer:

Did the transfers of health information at times of transitions in care include the exchange of interoperable health information with a health information service provider (HISP)?

A HISP manages security and transport of health information exchange among health care entities or individuals using the Direct standard for transport. HISP functions can be performed by existing organizations (such as EHR vendors or hospitals or HIE organizations) or by standalone organizations specializing in security and transport of health information.

NOTE: This is a measure that does not depend on systems for collecting and abstracting individual patient information and only requires simple attestation.

NHSN-Collected Measure: Influenza Vaccination Coverage Among Healthcare Personnel (HCP)

The Influenza Vaccination Coverage Among HCP measure assesses the percentage of HCP who receive the influenza vaccination. The measure is designed to ensure that reported HCP influenza vaccination percentages are consistent over time within a single healthcare facility, as well as comparable across facilities.

The denominator includes the number of HCP working in the healthcare facility for at least one working day between October 1 and March 31 of the following year, regardless of clinical responsibility or patient contact, and is calculated separately for employees, licensed independent practitioners, and adult students/trainees and volunteers. The measure has no exclusions.

The numerator includes the HCP from the denominator population who met the following criteria between October 1 (or when the vaccine became available) and March 31 of the subsequent year:

- Received an influenza vaccination administered at the healthcare facility, reported in writing (paper or electronic), or provided documentation that influenza vaccination was received elsewhere
- Had a medical contraindication/condition of severe allergic reaction to eggs or to other component(s) of the vaccine, or has a history of Guillain-Barre Syndrome within six weeks after a previous influenza vaccination
- Declined influenza vaccination
- Had an unknown vaccination status or did not otherwise fall under any of the above-mentioned numerator categories

NOTE: IPFs will use the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) infrastructure and protocol to report the measure for IPFQR Program purposes. Step by step instructions on the NHSN enrollment and Influenza Vaccination Coverage Among HCP measure data submission processes are available at the following websites:

- IPF NHSN Enrollment/Location Mapping
 - [Detailed Checklist for IPFs](#)
 - Free-standing IPFs: Complete the [NHSN Enrollment](#) process
 - IPFs within Acute Care and Critical Access Hospitals
 - Ensure that the main hospital has completed the [NHSN Enrollment](#) process
 - Complete [NHSN Location Mapping for IPFs within Hospitals](#)
- HCP Measure Data Submission
 - [Training Slides for IPFs](#)
 - [Training, Protocols, Data Collection forms, CMS Supporting Materials, FAQs](#)

For further information, refer to <http://www.cdc.gov/nhsn>.

Data Submission

The following tables list information pertinent to data submission for the FY 2019 and FY 2020 measures.

Table 4: IPFQR Program Measures for FY 2019 Payment Determination

<u>Measure</u>	<u>Reporting Period</u>	<u>Submission Period</u>	<u>Measure Type</u>	<u>Sampling Allowed</u>
HBIPS-2: Hours of Physical Restraint Use	January 1– December 31, 2017	July 1– August 15, 2018	Chart- Abstracted	No
HBIPS-3: Hours of Seclusion Use	January 1– December 31, 2017	July 1– August 15, 2018	Chart- Abstracted	No
HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	January 1– December 31, 2017	July 1– August 15, 2018	Chart- Abstracted	Yes
Transition Record with Specified Elements Received by Discharged Patients	January 1– December 31, 2017	July 1– August 15, 2018	Chart- Abstracted	Yes
Timely Transmission of Transition Record	January 1– December 31, 2017	July 1– August 15, 2018	Chart- Abstracted	Yes
Screening for Metabolic Disorders	January 1– December 31, 2017	July 1– August 15, 2018	Chart- Abstracted	Yes
SUB-1: Alcohol Use Screening	January 1– December 31, 2017	July 1– August 15, 2018	Chart- Abstracted	Yes
SUB-2: Alcohol Use Brief Intervention Provided or Offered and SUB-2a: Alcohol Use Brief Intervention	January 1– December 31, 2017	July 1– August 15, 2018	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, 2017	July 1– August 15, 2018	Chart- Abstracted	Yes

<u>Measure</u>	<u>Reporting Period</u>	<u>Submission Period</u>	<u>Measure Type</u>	<u>Sampling Allowed</u>
TOB-1: Tobacco Use Screening	January 1– December 31, 2017	July 1– August 15, 2018	Chart- Abstracted	Yes
TOB-2: Tobacco Use Treatment Provided or Offered and TOB-2a Tobacco Use Treatment	January 1– December 31, 2017	July 1– August 15, 2018	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, 2017	July 1– August 15, 2018	Chart- Abstracted	Yes
IMM-2: Influenza Immunization	October 1, 2017– March 31, 2018	July 1– August 15, 2018	Chart- Abstracted	Yes
Influenza Vaccination Coverage Among Healthcare Personnel (HCP)	October 1, 2017– March 31, 2018	October 1, 2017–May 15, 2018	Web- Based reported on NHSN website ¹	No
Use of Electronic Health Record	As of December 31, 2017	July 1– August 15, 2018	Structural Web- Based	N/A
Assessment of Patient Experience of Care	As of December 31, 2017	July 1– August 15, 2018	Structural Web- Based	N/A
FUH: Follow-Up After Hospitalization for Mental Illness	July 1, 2016– June 30, 2017	Calculated by CMS	Claims- Based	N/A
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	July 1, 2015–June 30, 2017	Calculated by CMS	Claims- Based	N/A

¹ Each new entry overwrites the previous entry, as the system does not calculate cumulative data.

Table 5: IPFQR Program Measures for FY 2020 Payment Determination

<u>Measure</u>	<u>Reporting Period</u>	<u>Submission Period</u>	<u>Measure Type</u>	<u>Sampling Allowed</u>
HBIPS-2: Hours of Physical Restraint Use	January 1–December 31, 2018	July 1–August 15, 2019	Chart-Abstracted	No
HBIPS-3: Hours of Seclusion Use	January 1–December 31, 2018	July 1–August 15, 2019	Chart-Abstracted	No
HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	January 1–December 31, 2018	July 1–August 15, 2019	Chart-Abstracted	Yes
Transition Record with Specified Elements Received by Discharged Patients	January 1–December 31, 2018	July 1–August 15, 2019	Chart-Abstracted	Yes
Timely Transmission of Transition Record	January 1–December 31, 2018	July 1–August 15, 2019	Chart-Abstracted	Yes
Screening for Metabolic Disorders	January 1–December 31, 2018	July 1–August 15, 2019	Chart-Abstracted	Yes
SUB-1: Alcohol Use Screening	January 1–December 31, 2018	July 1–August 15, 2019	Chart-Abstracted	Yes
SUB-2: Alcohol Use Brief Intervention Provided or Offered and SUB-2a: Alcohol Use Brief Intervention	January 1–December 31, 2018	July 1–August 15, 2019	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, 2018	July 1–August 15, 2019	Chart-Abstracted	Yes
TOB-1: Tobacco Use Screening	January 1–December 31, 2018	July 1–August 15, 2019	Chart-Abstracted	Yes
TOB-2: Tobacco Use Treatment Provided or Offered and TOB-2a Tobacco Use Treatment	January 1–December 31, 2018	July 1–August 15, 2019	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, 2018	July 1–August 15, 2019	Chart-Abstracted	Yes

<u>Measure</u>	<u>Reporting Period</u>	<u>Submission Period</u>	<u>Measure Type</u>	<u>Sampling Allowed</u>
IMM-2: Influenza Immunization	October 1, 2018–March 31, 2019	July 1–August 15, 2019	Chart-Abstracted	Yes
Influenza Vaccination Coverage Among Healthcare Personnel	October 1, 2018–March 31, 2019	October 1, 2018–May 15, 2019	Web-Based reported on NHSN website ¹	No
Use of Electronic Health Record	As of December 31, 2018	July 1–August 15, 2019	Structural Web-Based	N/A
Assessment of Patient Experience of Care	As of December 31, 2018	July 1–August 15, 2019	Structural Web-Based	N/A
FUH: Follow-Up After Hospitalization for Mental Illness	July 1, 2017–June 30, 2018	Calculated by CMS	Claims-Based	N/A
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	July 1, 2016–June 30, 2018	Calculated by CMS	Claims-Based	N/A

¹ Each new entry overwrites the previous entry, as the system does not calculate cumulative data.

NOTE: The reporting period for the IMM-2 and Influenza Vaccination Coverage Among Healthcare Personnel measures crosses over two calendar years, from October 1, 2017, through March 31, 2018, for the FY 2019 payment determination and from October 1, 2018, through March 31, 2019, for the FY 2020 payment determination. While the annual data submission timeframe for IMM-2 aligns with the other measures (July 1 through August 15), IPFs will submit the Influenza Vaccination Coverage Among Healthcare Personnel data from October 1, 2017, through May 15, 2018, for the FY 2019 payment determination and October 1, 2018, through May 15, 2019, for the FY 2020 payment determination.

Submission of Non-Measure Data

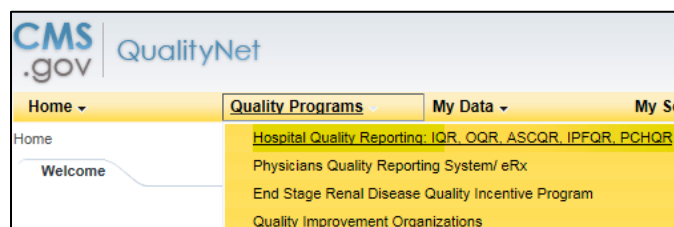
Beginning with the FY 2017 payment determination and subsequent years, CMS no longer requires non-measure data by quarter, but as an aggregate, yearly count. It is vital for IPFs to accurately determine and submit general population data for CMS to assess data reporting completeness for their total population, both Medicare and non-Medicare. This information is expected to improve CMS' ability 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). 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

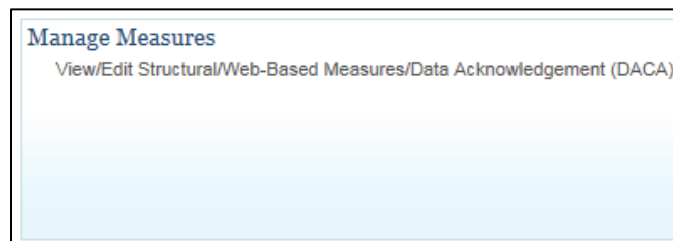
IPFs submit measure and non-measure data submissions as well as complete the Data Accuracy and Correctness Acknowledgement (DACA) form via the web-based data collection tool (WBDCT) located on the *QualityNet Secure Portal*. The only measure data not submitted via the WBDCT are the Influenza Vaccination Coverage Among HCP (submitted to the CDC), the Follow-Up after Hospitalization for Mental Illness, and the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF) measures (claims-based, calculated by CMS).

To begin the data submission process:

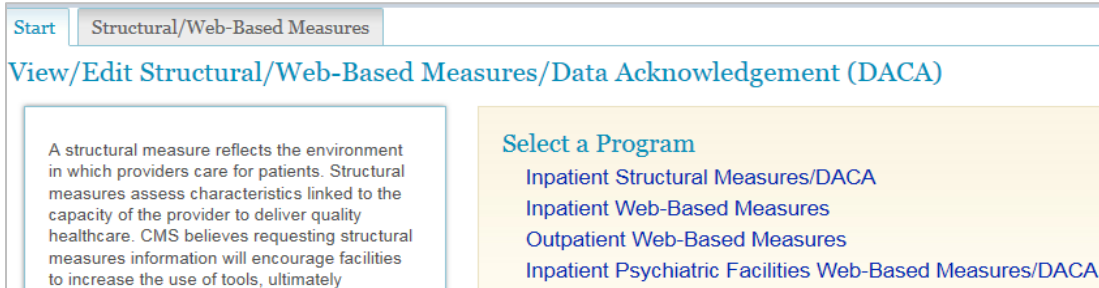
1. Log into the *QualityNet Secure Portal*, select **Quality Programs** then the **Hospital Quality Reporting: IQR, OQR, ASCQR, IPFQR, PCHQR** option from the drop-down menu.



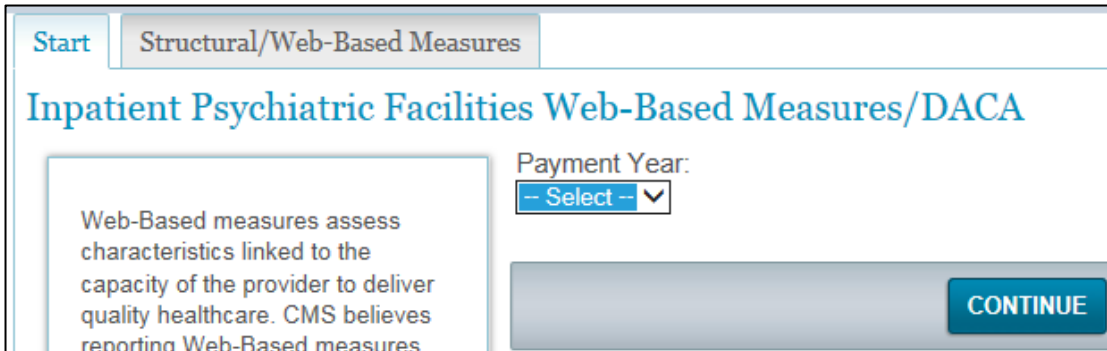
2. From the Quality Reporting Systems: My Tasks page, select **View/Edit Structural/Web-Based Measures/Data Acknowledgement (DACA)** under Manage Measures



- On the next screen, you may have the option to choose from several quality reporting programs, depending on user access settings. Select **Inpatient Psychiatric Facilities Web-Based Measures/DACA**



- Select the appropriate Payment Year from the drop-down menu (i.e., for data collected in CY 2017 to be entered in 2018, select Payment Year 2019, and for data collected in CY 2018 to be entered in 2019, select Payment Year 2020).



On the landing page of the WBDCT are hyperlinks to the data submission pages and the DACA form. The submission status will remain “Incomplete” until data is entered and saved for each submission page. The screenshot below illustrates the hyperlinks to the submission pages, which will appear in a single row across the screen.

Provider ID	Non-Measure Data	HBIPS-2	HBIPS-3	HBIPS-5	Screening for Metabolic Disorders	Transition Record with Specified Elements	Timely Transmission of Transition Record		
	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete		
Assessment of Patient Experience of Care	Use of an Electronic Health Record	SUB-1	SUB-2/-2a	SUB-3/-3a	TOB-1	TOB-2/-2a	TOB-3/-3a	IMM-2	DACA
Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete	Incomplete

Non-Measure Data/Population Counts

If the response is “Yes” to the question “Did your facility use global sampling?” under Global Sample, then an additional data entry field will appear. Enter the sample size used for the measures that allow sampling in the data entry field.

Guidance for Responding to Global Sampling Question in the WBDCT

If the IPF used the global sampling methodology (described on page 14 of this program manual) to sample any of the SUB, TOB, or IMM-2 measures collected for PY 2019, even if global sampling was not used for HBIPS-5, then the IPF should answer “Yes” to the sampling question followed by the sample volume in the Global Sample Size field.

If the IPF only sampled HBIPS-5 and no other measure that allows sampling, then the IPF should select “No” to the global sampling question.

If IMM-2 was the only measure sampled, take the sum of the two quarters of IMM-2 data collected in calendar year 2017, (i.e., January–March 2017 and October–December 2017) and multiply it by two to calculate the annualized sample size. If there are differing sample sizes between measure sets, select the larger sample size as it is more representative of the aggregate annual patient population.

As a reminder, sampling is not allowed for the HBIP-2 and HBIPS-3 measures.

HBIPS-2: Hours of Physical Restraint Use

Numerator * The total number of hours that all psychiatric inpatients were maintained in physical restraint <input type="text"/>
Denominator * Number of psychiatric inpatient days <input type="text"/>

HBIPS-3: Hours of Seclusion Use

Numerator * The total number of hours that all psychiatric inpatients were held in seclusion <input type="text"/>
Denominator * Number of psychiatric inpatient days <input type="text"/>

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 <input type="text"/>
Denominator * Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications <input type="text"/>

Screening for Metabolic Disorders

<p>Numerator</p> <p>* Total number of patients who received a metabolic screening either prior to, or during, the index IPF stay.</p> <input type="text"/>
<p>Denominator</p> <p>* Number of patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period.</p> <input type="text"/>

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

<p>Numerator</p> <p>* 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.</p> <input type="text"/>
<p>Denominator</p> <p>* Number of patients, regardless of age, discharged from your facility to home or other site of care, or their caregiver(s).</p> <input type="text"/>

Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

<p>Numerator</p> <p>* 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.</p> <input type="text"/>
<p>Denominator</p> <p>* Number of patients, regardless of age, discharged from your facility to home or other site of care, or their caregiver(s).</p> <input type="text"/>

Assessment of Patient Experience of Care

If the response to “Did your facility routinely assess patient experience of care using a standardized collection protocol and a structured instrument?” is “Yes,” then a data entry field will appear. Enter the name of the survey administered by the facility in the blank field.

*** Did your facility routinely assess patient experience of care using a standardized collection protocol and a structured instrument?**

Yes
 No

*** Please indicate the name of the survey that your facility administers:**

Use of an Electronic Health Record

*** Please select which of the following statements best describes your facility's highest level typical use of an EHR System (excluding the billing system) during the reporting period:**

The facility most commonly used paper documents or other forms of information exchange (for example, email) not involving the transfer of health information using EHR technology at times of transitions in care.
 The facility most commonly exchanged health information using non-certified EHR technology (that is, not certified under the ONC HIT Certification Program) at times of transitions in care.
 The facility most commonly exchanged health information using certified EHR technology (certified under the ONC HIT certification Program) at times of transitions in care.

*** Did the transfers of health information at times of transitions in care include the exchange of interoperable health information with a health information service provider (HISP)?**

Yes
 No

SUB-1: Alcohol Use Screening

Numerator

*** Number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking**

Denominator

*** Number of hospitalized patients 18 years of age or older**

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

Numerator 1 * Number of patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. <input type="text"/>
Numerator 2 * Number of patients who received the brief intervention during the hospital stay. <input type="text"/>
Denominator * 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). <input type="text"/>

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

Numerator 1 * 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. <input type="text"/>
Numerator 2 * 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. <input type="text"/>
Denominator * 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). <input type="text"/>

TOB-1: Tobacco Use Screening

Numerator * Number of patients who were screened for tobacco use status within the first three days of admission. <input type="text"/>
Denominator * Number of hospitalized inpatients 18 years of age and older. <input type="text"/>

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

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

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

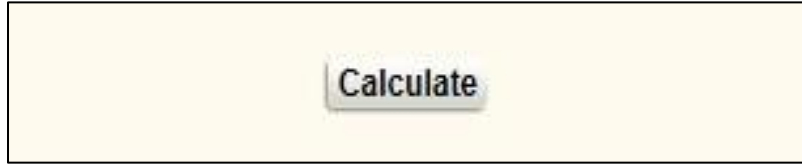
Numerator 1
* Number of patients who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication upon discharge.
<input type="text"/>
Numerator 2
* Number of patients who were referred to evidence-based outpatient counseling 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"/>
Denominator
* Number of discharged patients 18 years of age and older who have used tobacco products within 30 days of admission.
<input type="text"/>

IMM-2: Influenza Immunization Information

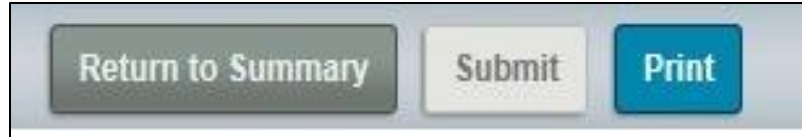
Numerator
* Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated.
<input type="text"/>
Denominator
* Inpatients age 6 months and older discharged during the months of October, November, December, January, February or March.
<input type="text"/>

A **Calculate** button will appear at the bottom of the data entry pages for the following measures: HBIPS-2, -3, -5; SUB-1, -2/-2a, -3/-3a; TOB-1, -2/-2a, -3/-3a; IMM-2. Data must be entered in

all required fields **before** the **Calculate** button is selected. After the **Calculate** button is selected, click the **Submit** button to save the measure data.



The bottom of each data entry page includes the options to **Return to Summary**, **Submit** the entered data, or **Print** the data entry page.



DACA

See instructions about completing the DACA form in **Section 6: Data Accuracy and Completeness Acknowledgement**.

**Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
Data Accuracy and Completeness Acknowledgement FY 2018**

I acknowledge that to the best of my ability all of the information reported for this Inpatient Psychiatric Facility (IPF) Quality Reporting (IPFQR) Program, as required for the Fiscal Year 2018 IPFQR Program requirements, is accurate and complete. This information includes the following:

- Aggregated data for all required measures
- Non-measure data
- Current Notice of Participation and
- Active QualityNet Security Administrator

I understand that this acknowledgement covers all IPFQR information reported by this inpatient psychiatric hospital or psychiatric unit (and any data vendor(s) acting as agents on behalf of this IPF) to CMS and its contractors, for the FY 2018 payment determination year. To the best of my knowledge, this information was collected in accordance with all applicable requirements. I understand that this information is used as the basis for the public reporting of quality of care.

I understand that this acknowledgement is required for purposes of meeting any Fiscal Year 2018 IPFQR Program requirements.

Enter your Position and click 'Submit'.

* Yes, I Acknowledge

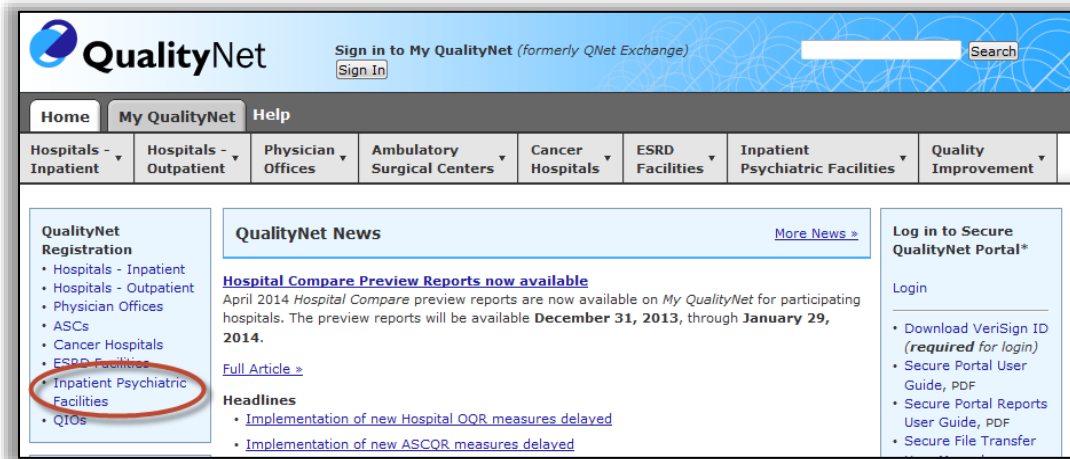
* Position

Section 3: QualityNet Registration

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

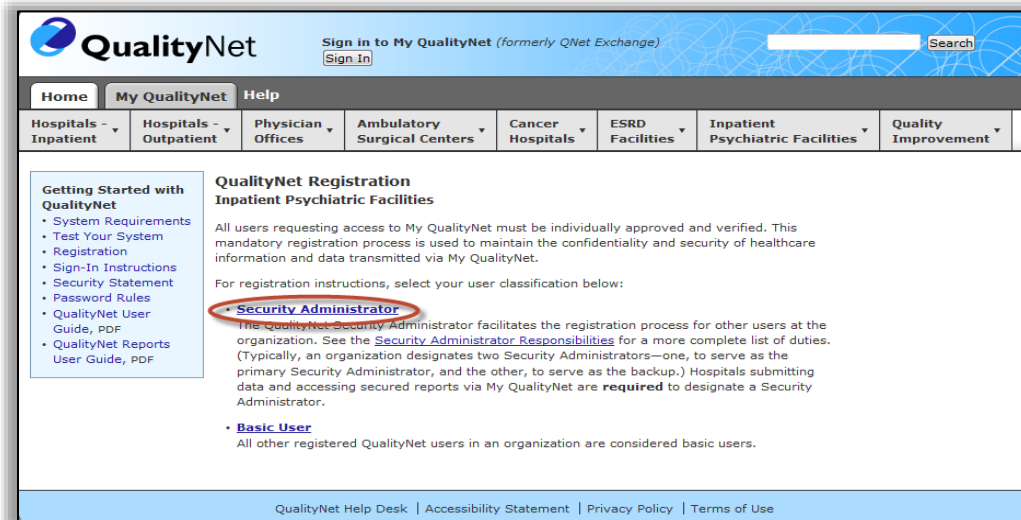
To begin *QualityNet* Registration:

1. Access the internet, and then navigate to the *QualityNet* website located at <http://www.QualityNet.org>.



The screenshot shows the QualityNet website homepage. At the top, there is a search bar and a "Sign in to My QualityNet" button. Below the search bar is a navigation menu with tabs for "Home", "My QualityNet", and "Help". Under "My QualityNet", there are several dropdown menus: "Hospitals - Inpatient", "Hospitals - Outpatient", "Physician Offices", "Ambulatory Surgical Centers", "Cancer Hospitals", "ESRD Facilities", "Inpatient Psychiatric Facilities", and "Quality Improvement". The "Inpatient Psychiatric Facilities" dropdown is currently selected, and its sub-menu is visible, showing options like "Hospitals - Inpatient", "Hospitals - Outpatient", "Physician Offices", "ASCs", "Cancer Hospitals", "ESRD Facilities", "Inpatient Psychiatric Facilities" (circled in red), and "QIOS". The main content area features "QualityNet News" and "QualityNet Registration" sections. The "QualityNet Registration" section lists various facility types, with "Inpatient Psychiatric Facilities" circled in red. The "QualityNet News" section includes a headline about "Hospital Compare Preview Reports now available" and a "Full Article" link. The "QualityNet Registration" section also includes a "Log in to Secure QualityNet Portal*" link and a list of resources for login, such as "Download VeriSign ID (required for login)", "Secure Portal User Guide, PDF", "Secure Portal Reports User Guide, PDF", and "Secure File Transfer".

2. Select the **Inpatient Psychiatric Hospitals** link located under *QualityNet Registration*. The Inpatient *QualityNet* Registration page appears.



The screenshot shows the QualityNet website registration page for Inpatient Psychiatric Facilities. The page title is "QualityNet Registration Inpatient Psychiatric Facilities". The main content area includes a "Getting Started with QualityNet" section with links for "System Requirements", "Test Your System", "Registration", "Sign-In Instructions", "Security Statement", "Password Rules", "QualityNet User Guide, PDF", and "QualityNet Reports User Guide, PDF". The "QualityNet Registration" section explains that all users requesting access to My QualityNet must be individually approved and verified. It states that for registration instructions, users should select their user classification below. The "Security Administrator" link is circled in red. The "Security Administrator" section explains that the QualityNet Security Administrator facilitates the registration process for other users at the organization. It also mentions that typically, an organization designates two Security Administrators—one to serve as the primary Security Administrator, and the other to serve as the backup. Hospitals submitting data and accessing secured reports via My QualityNet are required to designate a Security Administrator. The "Basic User" section states that all other registered QualityNet users in an organization are considered basic users. The footer includes links for "QualityNet Help Desk", "Accessibility Statement", "Privacy Policy", and "Terms of Use".

The *QualityNet* Registration page contains an overview of the registration process and helpful links for getting started with *QualityNet*.

3. Review the **System Requirements** and test the system to ensure compatibility.
4. Select the **Security Administrator** link.

The *QualityNet* Security Administrator Registration page appears.

The screenshot shows the QualityNet website interface. At the top left is the QualityNet logo. To its right is a search bar with the text "Log in to QualityNet Secure Portal (formerly MyQualityNet)" and a "Log In" button. Below the search bar is a navigation menu with tabs for "Home", "My QualityNet", and "Help". Under "My QualityNet", there are several dropdown menus: "Hospitals - Inpatient", "Hospitals - Outpatient", "Physician Offices", "Ambulatory Surgical Centers", "PPS-Exempt Cancer Hospitals", "ESRD Facilities", "Inpatient Psychiatric Facilities", and "Quality Improvement". The main content area is titled "QualityNet Security Administrator Registration" and "Inpatient Psychiatric Facilities". It contains the following text: "It is highly recommended that each organization designate two people as QualityNet Security Administrators." "To register as a QualityNet Security Administrator:" followed by a numbered list: 1. Download the [QualityNet Security Administrator Registration Packet](#) (PDF-78 KB). 2. Follow the instructions for completing the Registration Form and Authorization Form. The Registration Form. The Authorization Form must be completed by the highest level executive at your organization. 3. Mail the original, completed forms (keeping a copy for your records) to: **QualityNet Help Desk**
12000 Ridgemont Drive
Urbandale, IA 50323-2317. Below this is a paragraph: "You will be notified by e-mail when registration is complete and your QualityNet account has been activated. The e-mail will also contain your **User ID**. A **Temporary Password** will be sent in a separate e-mail. You will need both to complete enrollment for access to the QualityNet Secure Portal." At the bottom, it says "Accessing the QualityNet Secure Portal" and "For access to the QualityNet Secure Portal, complete the [New User Enrollment Process](#). (As part of the process, you'll be asked to change your password and answer a set of security questions.)"

5. Select the **QualityNet Security Administrator Registration Packet** link and follow the instructions in the packet for completing and submitting the registration and authorization forms.

QualityNet Security Administrator

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

Best Practice: We recommend facilities designate a minimum of two *QualityNet* Security Administrators (SA) – one to serve as the primary *QualityNet* SA and the other to serve as the alternate SA. To keep the facility's account active, your SA 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 Responsibilities

The security administrator has the following responsibilities:

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

Non-Administrative User

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

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

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

Completing the *QualityNet* Registration Form

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

QualityNet Security Administrator Registration Form			
*NOTE: All fields marked with an asterisk are required and must be completed to obtain approval.			
Access Request			
*Request Date:	*First Name:	Middle Initial:	*Last Name:
*Business E-Mail Address:			
*Job Title:			
*Business Name:			
*Specify Setting: (Check all that apply)			
<input type="checkbox"/> ASC	<input type="checkbox"/> ESRD Facility	<input type="checkbox"/> Home Health Agency	<input checked="" type="checkbox"/> Inpatient Psychiatric Facility
<input type="checkbox"/> CMS	<input type="checkbox"/> ESRD Network	<input type="checkbox"/> Hospital-Inpatient	<input type="checkbox"/> Long-Term Care Facility
<input type="checkbox"/> EHR	<input type="checkbox"/> Healthcare System	<input type="checkbox"/> Hospital-Outpatient	<input type="checkbox"/> Nursing Home
			<input type="checkbox"/> Physician Office
			<input type="checkbox"/> PPS-Exempt Cancer Hospital
			<input type="checkbox"/> QIO

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

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

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

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

QualityNet Help Desk
1401 50th St., Suite 200
West Des Moines, IA 50266

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

QualityNet Help Desk
Monday through Friday
7:00 a.m. to 7:00 p.m. Central Time
E-mail: qnetsupport@hcqis.org
Phone: 866.288.8912
TTY: 877.715.6222

Activating the Security Administrator Account

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

To begin account activation:

1. Go to the QualityNet.org website.



2. Select the **Log In** button or **Login** link.
3. Enter the individual assigned username and a temporary password provided via the email notification.
4. Follow the instructions to establish a new password.

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

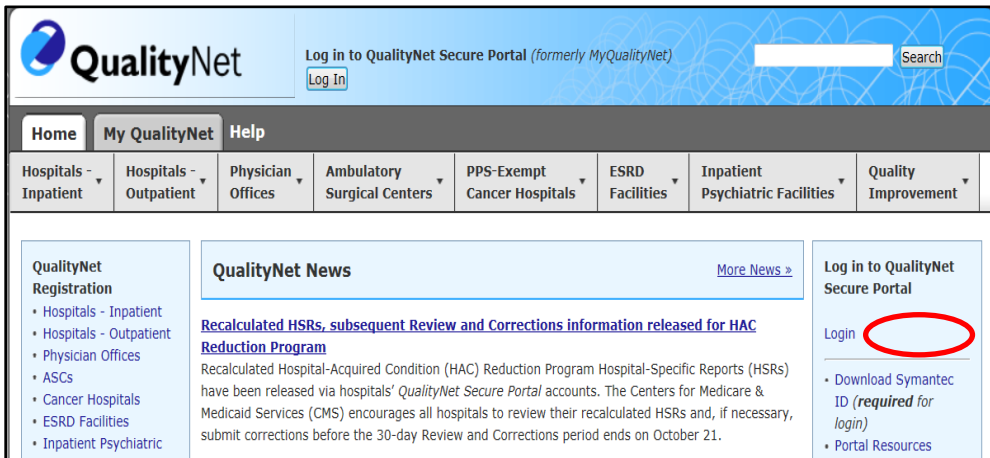
QualityNet Secure Portal Access

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

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

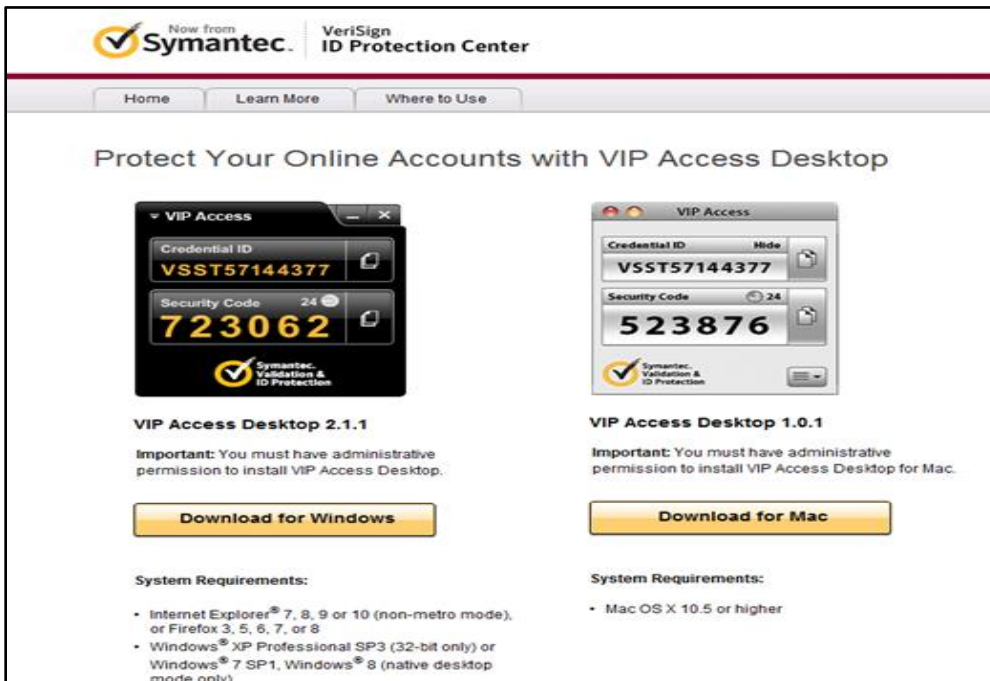
To download the multifactor authentication application to a PC or tablet:

1. Go to the QualityNet.org website.



2. Select the **Download Symantec ID** link.

The VeriSign ID Protection Center page will appear.

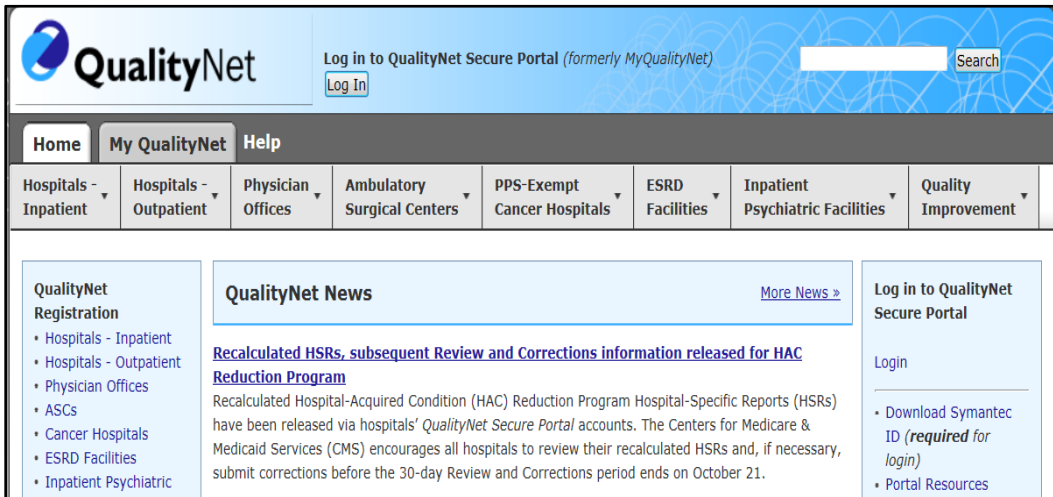


3. Select the download option that is appropriate to the device being used, either for Windows® or Mac®.

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

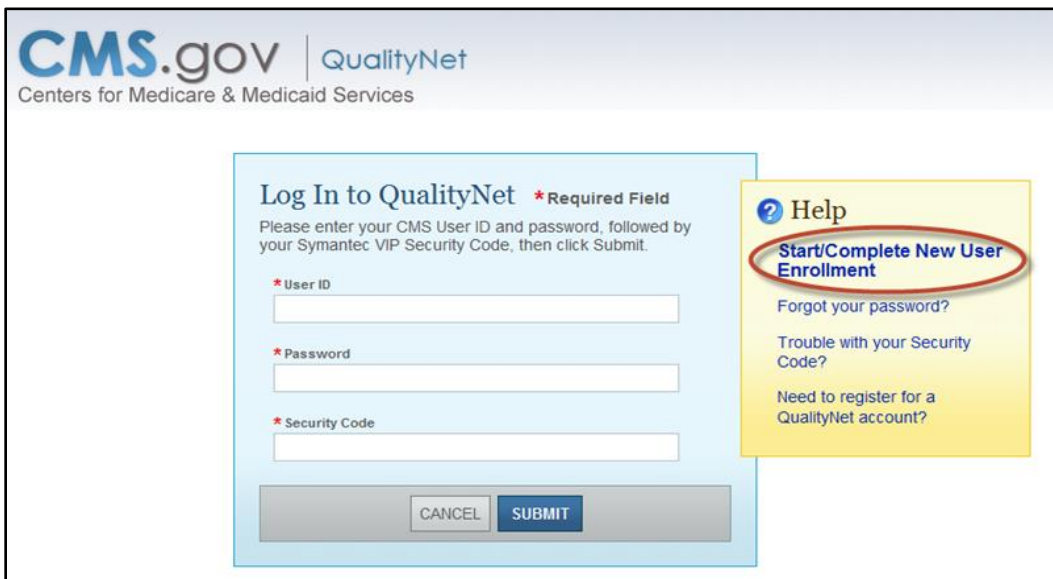
Once the Symantec multifactor authentication application download is on the computer, users are ready to access the *QualityNet Secure Portal*.

4. Access the *QualityNet Secure Portal* on the QualityNet.org website.



5. Select the **Log In** button or **Login** link.

The *Log In to QualityNet* window appears.



Each IPFQR user must complete the authenticating (proofing), required by the Federal Information Security Management Act (FISMA), for accessing government systems.

6. Select the link **Start/Complete New User Enrollment** on the login page to begin the enrollment process.

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

CMS.gov | QualityNet
Centers for Medicare & Medicaid Services

Progress Bar: Login (selected), Verify Identity, Identity Questions, Identity Confirmed, Enroll Credential, Enrollment Confirmed

Starting and Completing New User Enrollment

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

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

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

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

Log In to QualityNet * Required Field

* User ID

* Password

CANCEL SUBMIT

Help
Forget your password?

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

Verifying Identity

To verify a user's identity:

1. Access the *QualityNet Starting and Completing New User Enrollment* page and Log In. The Verify Identity page appears.

CMS.gov | QualityNet
Centers for Medicare & Medicaid Services

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

Verify Your Identity

To verify your identity, CMS uses an Identity Proofing Service provided by Experian.

You will be asked for personal information about yourself; this information will be securely encrypted and sent to Experian. Experian will return a series of personal questions for you to answer. After you answer the questions, Experian will confirm whether you provided the right information to prove you are who you say you are. For a better understanding on the data collected and how it is used, please visit the identity proofing frequently asked questions.

[Remote Proofing FAQs](#)

Please enter the answers to the following information and click Submit.

Experian
VeriSign Secure Site
click-to-verify

Personal Information *Required Field

* First Name: Heather Middle Name: Last Name: Fox

Suffix: -Select-

* Street Address: 213 East Bradford Ct. Additional Address Information:

* City: Middletown * State/Province: Delaware * Country: United States

* ZIP/Postal Code: 19709

* Personal Phone Number: (302) 287-0240 * Full Social Security Number: * Date of Birth (mm/dd/yyyy):

US users must enter a Social Security Number

* CMS is highly aware of the privacy concerns around disclosure of your personal data including your Social Security Number. CMS is collecting the Personally Identifiable Information (PII) on this screen and on the identity question screen to verify your identity only. Your information will be disclosed to Experian, an external authentication service provider to help us verify your identity. Your Social Security Number will be masked and encrypted during this transaction to assure it is secure. Other than your name, none of the PII data collected in this process is retained.

CANCEL SUBMIT

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

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

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

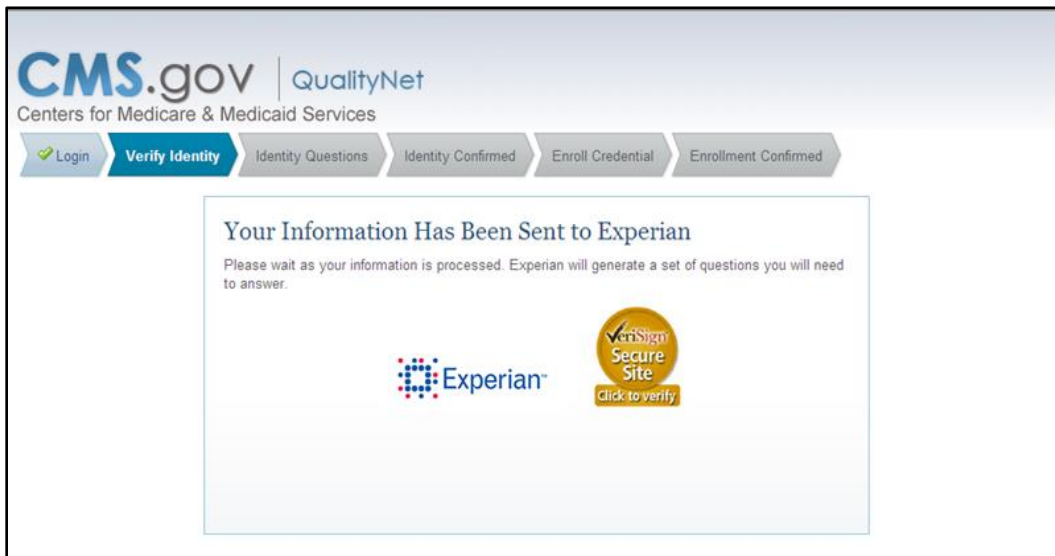
CMS is aware of the privacy concerns regarding disclosure of personal data, including social security numbers. CMS is collecting the Personally Identifiable Information (PII) on this screen and on the identity question screen to verify identity only. Verifying a user's identity meets the National Institute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

FISMA was passed as Title III of the E-Government Act (Public Law 107-347) in December 2002. FISMA requires each federal agency to develop, document, and

implement an agency-wide program to provide information security for the information and information systems that support the operations and assets of the agency, including those provided or managed by another agency, contractor, or other source. This Act assigned NIST the responsibility to develop standards to be used by Federal agencies to categorize information and information systems based on the objectives of providing appropriate levels of information security according to a range of risk levels.

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

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



A set of questions will appear that will need to be answered.

CMS.gov | QualityNet
Centers for Medicare & Medicaid Services

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

Identity Challenge Questions

* Required Field

1. You may have opened a mortgage loan in or around March 2004. Please select the lender to whom you currently make your mortgage payments. If you do not have a mortgage, select 'NONE OF THE ABOVE/DOES NOT APPLY':

- CAP ONE NA
- SELECT MTG
- PRUDENTIAL HOME MORT
- CHAMPION MORTGAGE
- NONE OF THE ABOVE/DOES NOT APPLY

2. You may have opened a Home Equity Line of Credit type loan in or around May 2007. Please select the lender to whom you currently make your payments or made your payments.

- CAP ONE NA
- GMAC MORTGAGE
- CITICORP MORT
- FREDDIE MAC
- NONE OF THE ABOVE/DOES NOT APPLY

3. You may have opened an auto loan in or around February 2001. Please select the lender for this account. If you do not have such an auto loan, select 'NONE OF THE ABOVE/DOES NOT APPLY':

- NISSAN MOTOR ACCEPTANCE
- MELLON BANK
- GEC AUTO LEASE
- CHASE MANHATTAN BK
- NONE OF THE ABOVE/DOES NOT APPLY

4. Which of the following is a current or previous employer? If there is not a matched employer name, please select 'NONE OF THE ABOVE':

- PHENA PARTNERS LLC
- NORTH AMERICAN COMMUNIC
- GRACE WOLFE
- PRINCE GEORGE S COMMUNI
- NONE OF THE ABOVE

Identity Challenge Questions from Experian

On this screen you will find four (4) questions about yourself. All questions must be answered.

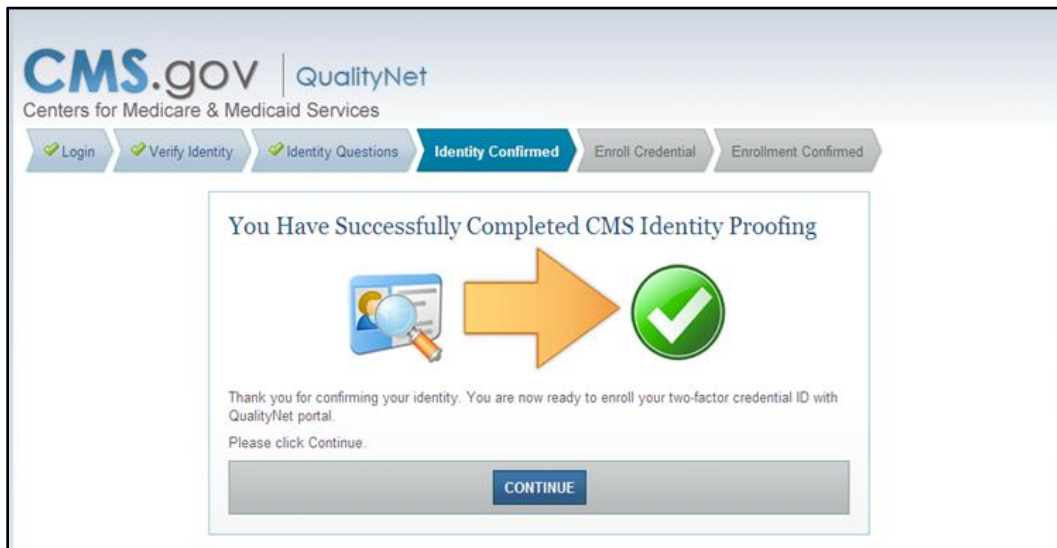
Please answer the following questions and click Submit when you are finished.

VeriSign Secure Site
click to verify

Example questions may be downloaded from the User Guide located on *QualityNet*. Typical Types of Identity Proofing Questions include:

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

Once a user has completed the identity proofing questions correctly, the verification will display on the computer screen indicating successful completion of the CMS identity proofing.



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

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

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

Enrolling the Credentials

To enroll credentials, access the *QualityNet Starting and Completing New User Enrollment* page. After, entering identity questions, the penultimate step is *Enroll Credentials*.

Steps for enrolling the credentials are as follows:

1. Access the previously downloaded Symantec VIP Application from your desktop.

The Symantec VIP window appears.



2. Enter the credential ID number in the first field.
3. Enter a security code within the 30-second freshness period.

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

4. Select **Submit**.

NOTE: For additional information on the New User Enrollment Process, select the *QualityNet Secure Portal User Guide* link:

<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetBasic&cid=1228773343598>.

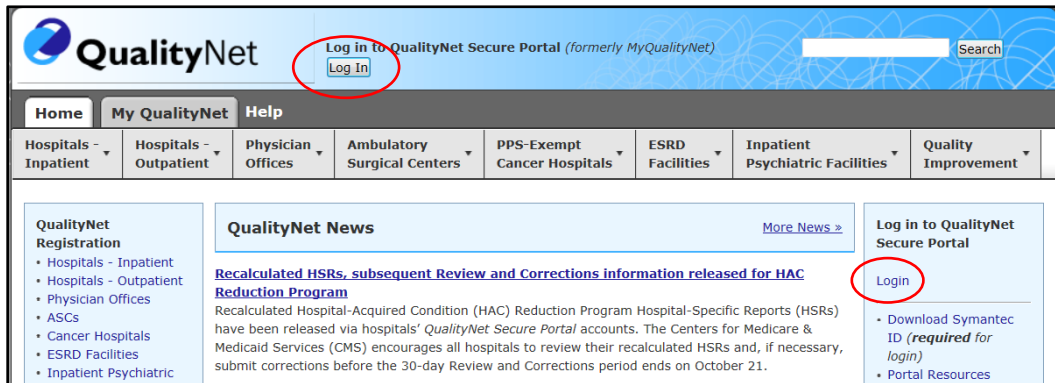
The New User Enrollment Process information is contained in Section 4 of the guide.

Logging In to the QualityNet Secure Portal

After completing all necessary paperwork and the New User Enrollment, user will have access to the *QualityNet Secure Portal*.

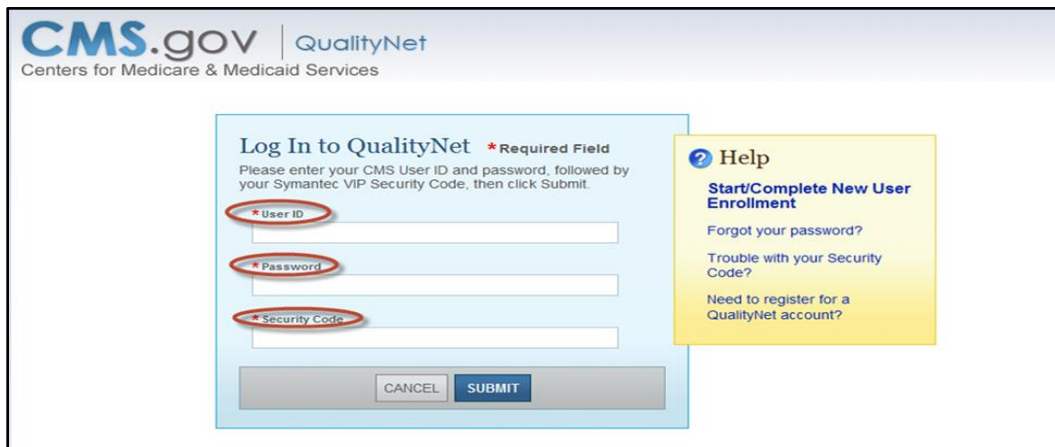
To access the *QualityNet Secure Portal*:

1. Go to the QualityNet.org website.



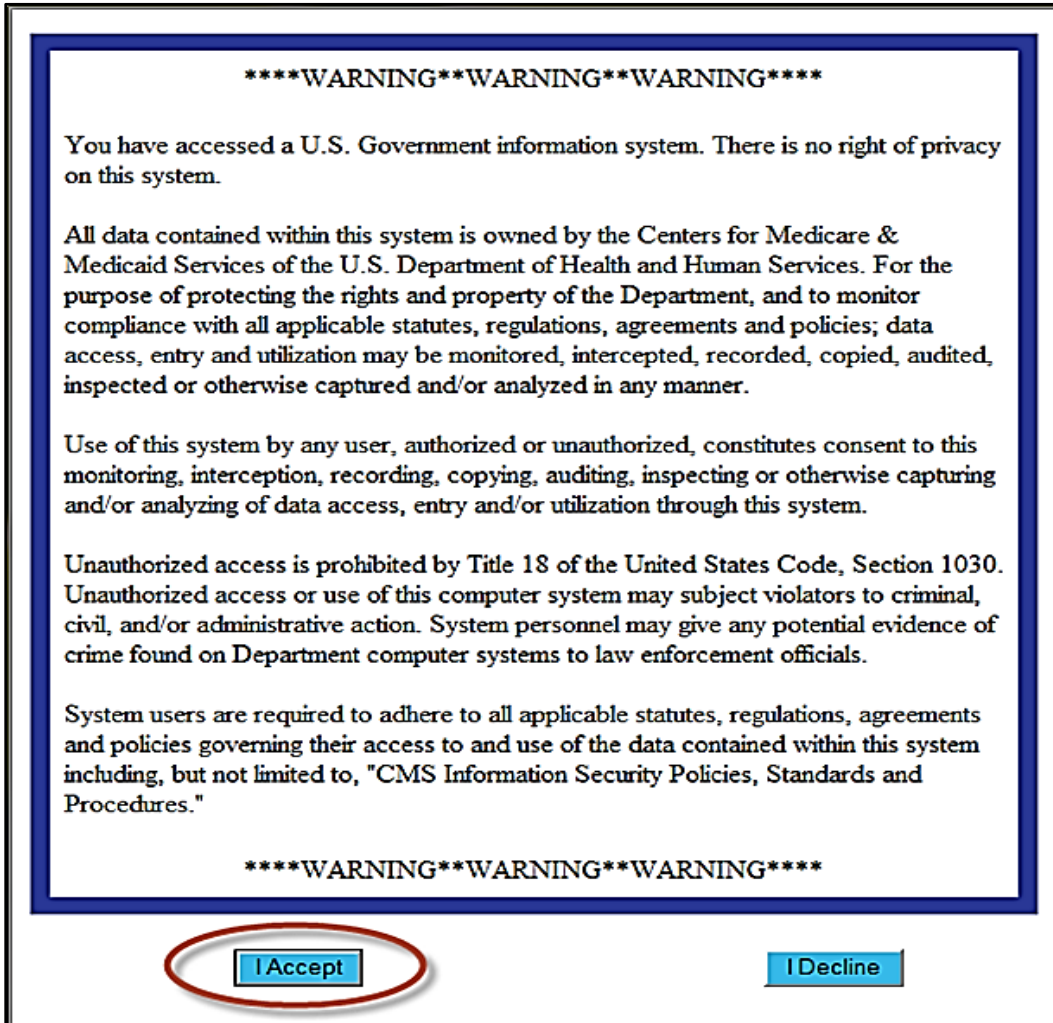
2. Select the **Log In** button or **Login** link.

The *Log In to QualityNet* screen appears.

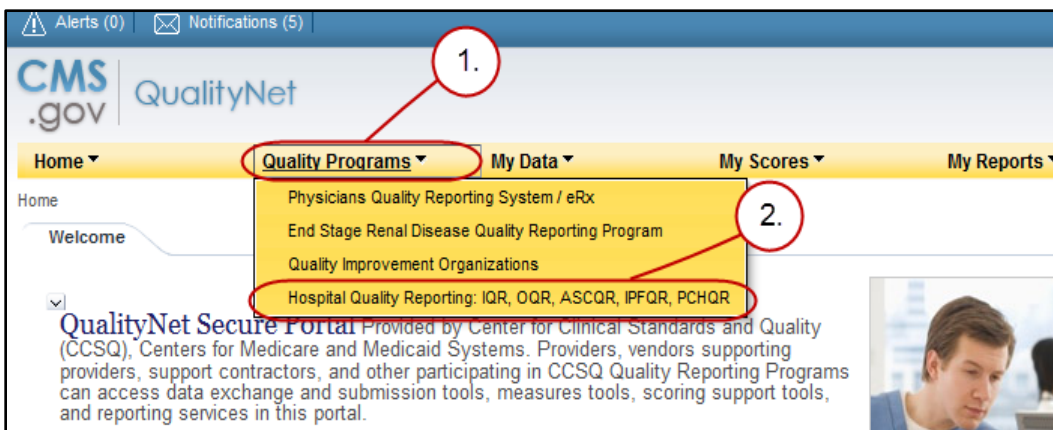


3. Open the previously downloaded Symantec VIP application for the time sensitive Security Code.
4. Enter the **User ID**, **Password**, and **Security Code**.
5. Select **Submit**.

The security screen will be displayed, indicating the user has accessed a U.S. Government Information system.



6. Accept the terms to be granted access to the *QualityNet Secure Portal*.
7. To access the IPFQR Program, select **Quality Program** (1.) then the **Hospital Quality Reporting: IQR, OQR, ASC, IPFQR, PCHQR** option (2.) from the drop-down menu.



After selecting the Quality Program, the My Tasks page is displayed on the next screen. The content of the My Tasks page is dependent upon the user roles assigned to the individual. If assigned the appropriate roles, the user may perform one or more of the following tasks:

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

User Roles

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

Below is a list of roles that must be assigned to a user.

IPFQR Notice of Participation

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

IPFQR Web-Based Measure/DACA Application

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

IPFQR Reports

- IPFQR Reports Read
- IPFQR Reports Update

IPFQR Vendor Authorization

- IPF Vendor Authorization
- Hospital Reporting Feedback - IPFQR

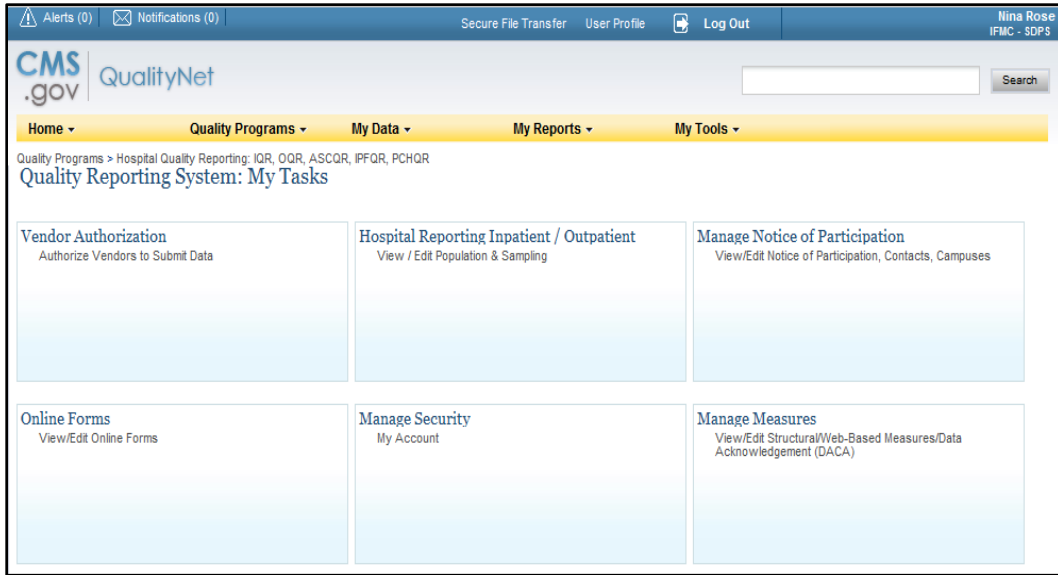
Online Forms

- Online Forms View - Inpatient Psych
- Online Forms - Upload - Inpatient Psych

File Exchange

- File Search and Exchange

Below is an example of the Quality Reporting System: My Tasks page.



Section 4: Vendor Authorization

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

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

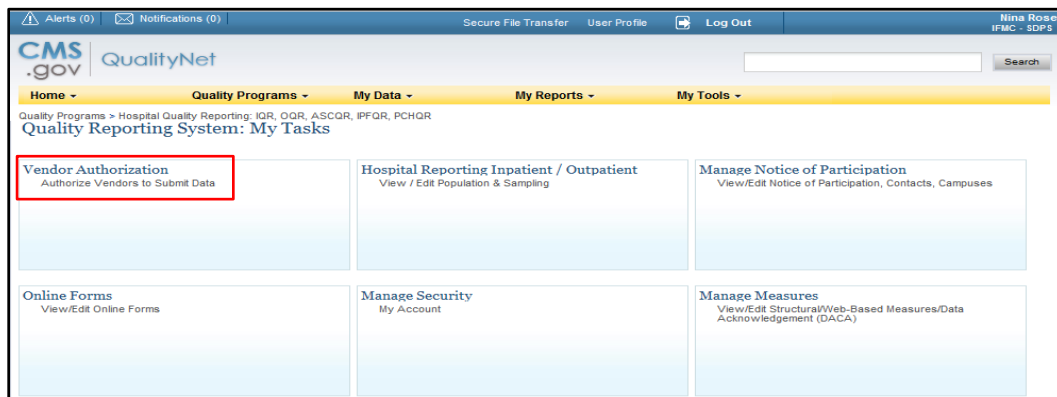
NOTE: IPFs may authorize a vendor to submit data on behalf of the facility. However, CMS maintains that **an IPF is responsible for ALL data submission, even when contracting with a vendor.**

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

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

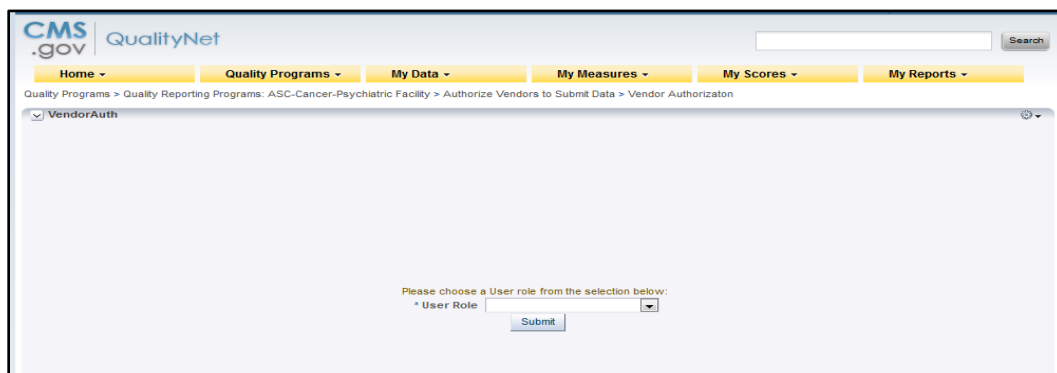
1. From the Quality Programs tab on the *QualityNet Secure Portal* Landing page, select the **Quality Programs: Hospital Quality Reporting: IQR, OQR, ASCQR, IPFQR, PCHQR** link.

The *Quality Reporting System: My Tasks* page appears:

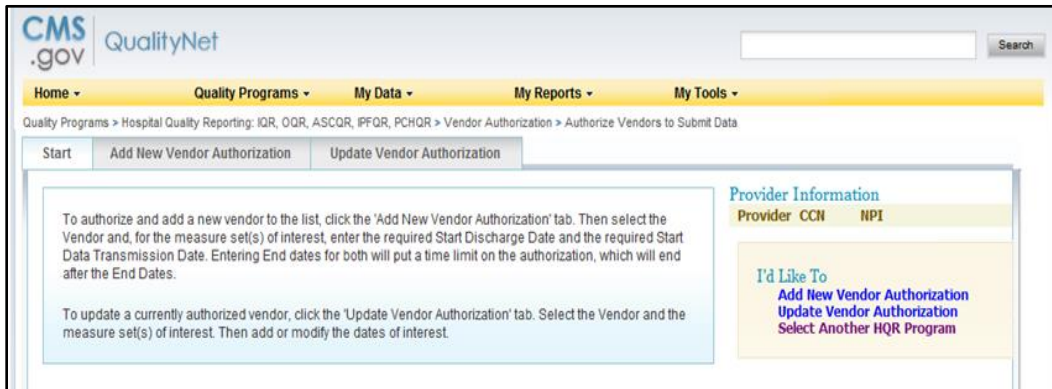


2. Choose the **Vendor Authorization** link.

The *Vendor Authorization* screen appears.



3. Select the IPF Vendor Authorization role from the drop-down box and click **Submit**.
The *Authorize Vendor to Submit* screen appears.



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

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

The Authorized Vendors to Submit Data page appears.

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

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

6. Scroll to the measure.

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

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

Recommendations

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

If you are terminating a vendor relationship at the end of a submission period, it is recommended that you do not enter the submission deadline date as the Data Transmission Date>End Date, due to the possibility of a submission date extension. It is recommended that you enter the Data Transmission Date>End Date when all data have been transmitted.

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

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

The Approve New or Changed Vendor Authorization page appears.

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

NOTE: Once an authorization has been submitted, the only dates that can be modified are future dates. If incorrect dates were entered and need to be modified, please send an email to qnetsupport@hcqis.org or call 866.288.8912.

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

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

NOTE: Additional information is available in the Using the *QualityNet* Secure Portal Applications User Guide, available at the following link:
<https://www.QualityNet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetBasic&cid=1228773343598>.

The screenshot shows the QualityNet website interface. At the top left is the QualityNet logo. To its right is a sign-in section with the text "Sign in to My QualityNet (formerly QNet Exchange)" and a "Sign In" button. Further right is a search bar with a "Search" button. Below this is a navigation bar with "Home" and "My QualityNet" tabs, and a "Help" link on the right. A secondary navigation bar contains several dropdown menus: "Hospitals - Inpatient", "Hospitals - Outpatient", "Physician Offices", "Ambulatory Surgical Centers", "Cancer Hospitals", "ESRD Facilities", "Inpatient Psychiatric Facilities", and "Quality Improvement".

The main content area features a yellow announcement box titled "QualityNet Secure Portal available" with the text: "Enhancements to the QualityNet Secure Portal are complete, and registered QualityNet users may access the Portal for data submission and other functions."

Below the announcement is a "Resources" section titled "QualityNet Secure Portal". It contains a paragraph explaining that the portal houses various applications for CMS' Ambulatory Surgical Centers, Inpatient Psychiatric Facilities, and PPS-Exempt Cancer Hospitals Quality Reporting programs. It then lists links for "Secure Portal Enrollment and Identity Proofing Questions" and "Portal User Training".

The "Portal User Training" section includes several links, with "Portal User Guide, PDF-1.9 MB (07/16/14)" circled in red. Other links include "New User Enrollment Training, WMV-19 min. (07/16/14)", "Quick Start Guides" (with sub-links for "QualityNet account holders, PDF" and "Non-QualityNet account holders, PDF"), "Portal Registration, PDF-576 KB (04/03/14)", "Secure File Transfer User Manual, PDF", "How to Add and Remove Credentials in the QualityNet Portal, PDF-784 KB (03/18/14)", and "Identity Proofing Instructions for Users with Multiple Accounts, PDF-18 KB (06/03/14)".

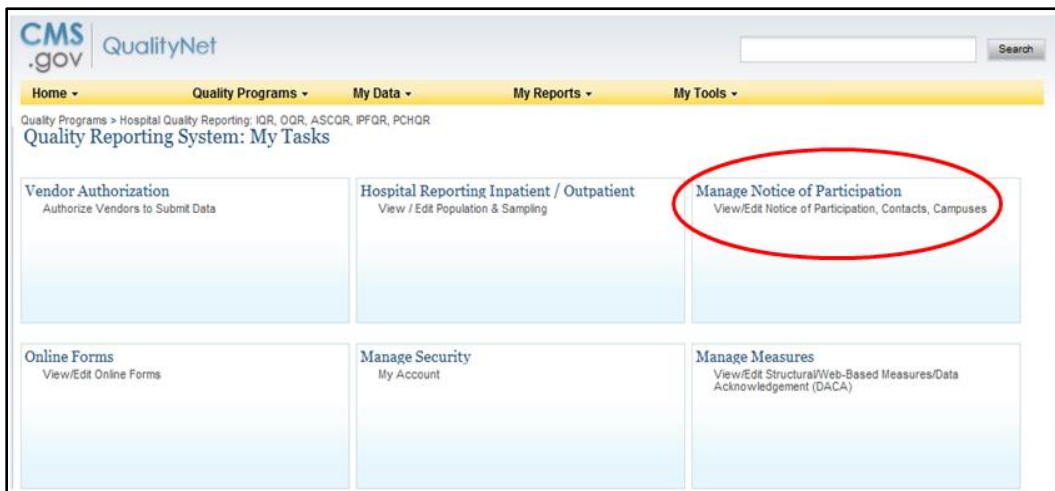
The "CMS E-mail Notifications" section includes links for "QualityNet Java Issue Resolution, PDF-16 KB (issued 07/18/13)", "QualityNet Secure Portal Updates, PDF-44 KB (issued 07/16/13)", and "Clarification Regarding Portal Enrollment Process, PDF-38 KB (issued 06/25/13)".

At the bottom of the page is a footer with links for "QualityNet Help Desk", "Accessibility Statement", "Privacy Policy", and "Terms of Use".

Section 5: Notice of Participation

To participate in the IPFQR Program, each facility must complete a Notice of Participation (NOP). During the first year of the program, facilities had the option of submitting a paper NOP or completing the NOP online. 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 an NOP and plan to continue to participate in the IPFQR Program do not need to complete an 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 (which is typically August 15). For example, IPFs must ensure that the NOP status is “Participating” by August 15, 2017, to meet the NOP requirement for the FY 2018 payment determination.

NOTE: Once an IPF has submitted an 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.

Accessing the Online Notice of Participation Application

To access the NOP application:

1. Ensure the IPFQR NOP Read or IPFQR NOP Update (to add or edit) Role has been assigned by the Security Administrator.
2. Access the *View/Edit Notice of Participation* screen.

Users that are affiliated with only one facility will see their facility's 6-digit CMS Certification Number (CCN) after selecting the **Manage Notice of Participation** link under the *My Tasks* screen.

Users that are affiliated with more than one facility will be prompted to enter the 6-digit CCN as shown below.

Home ▾ Quality Programs ▾ My Data ▾ My Scores ▾ My Reports ▾ My Tools ▾

Quality Programs > Hospital Quality Reporting: IQR, OQR, ASCQR, IPFQR, PCHQR > Manage Notice of Participation > View/Edit Notice of Participation, Contacts, Campuses

Start: Notice of Participation

Instructional Text:

* Required

Select your Program Type

Enter a 6-digit CCN

Enter a 10-Character NPI

* Identify Program Type

Inpatient Notice of Participation

Outpatient Notice of Participation

Inpatient Psychiatric Facility (IPF) Notice of Participation

PPS - Exempt Cancer Hospital (PCH) Notice of Participation

Ambulatory Surgical Center (ASC) Notice of Participation

* Enter a 6-digit CCN

* Enter a 10-Character NPI

NEXT

3. Select the action to be completed.

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

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

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

Home ▾ Quality Programs ▾ My Data ▾ My Scores ▾ My Reports ▾ My Tools ▾

Quality Programs > Hospital Quality Reporting: IQR, OQR, ASCQR, IPFQR, PCHQR > Manage Notice of Participation > View/Edit Notice of Participation, Contacts, Campu

IPFQR Notice of Participation | Menu

Provider Name	Provider ID	Medicare Accept Date	Facility Close Date
ST. JOSEPH'S HOSPITAL	000001	07/01/1966	07/01/1966

Notice of Participation

Select the activity you would like to perform.

I'd Like To View, Add or Update

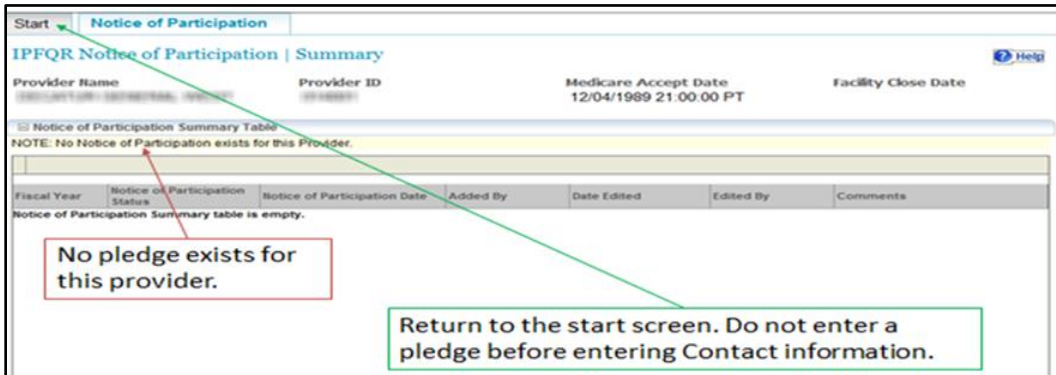
[Notice of Participation](#)

[Contacts](#)

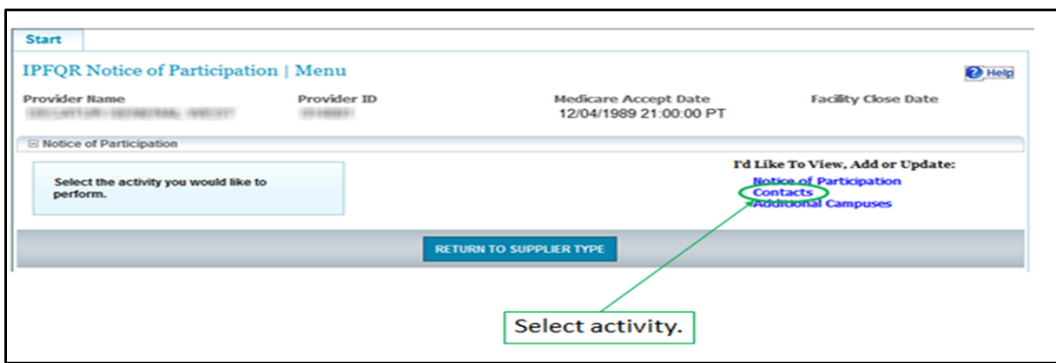
[Additional Campuses](#)

RETURN TO PREVIOUS SCREEN

4. Enter the contact information, if this is the first time the NOP is being added.



5. Select Contacts from the list.



6. Enter at least **two** facility contacts within the contact screen.

The contact information is used for sending email alert notifications if edits are made within the NOP application.

If the facility completed a paper NOP, then there will not be any contact information entered in the application. It is recommended that the facility log in and update the contact information.

IPFQR Notice of Participation | Text Print

Provider Name	Provider ID	Medicare Accept Date	Facility Close Date
		07/01/1966	

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

Please review the Notice of Participation below.

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

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

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

* We entities operating under the submitted Provider ID:

Agree to participate

Do not agree to participate

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

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

By entering this pledge, I agree to:

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

7. Select the desired pledge option and the acknowledgement check box.
Upon initial completion of the NOP, two pledge options are available: **Participate** or **Do not agree to participate**.
8. Following the pledge selection select the **Save** button.

A confirmation screen appears asking the user to confirm the selection to save the document.

the IPFQR Notice submitted for participation in FY 2014 program year or later, an IPF that indicated its intent to participate will be considered an active IPFQR Program participant until CMS determines a need to resubmit the IPFQR Notice, or the IPF submits a request for withdrawal to CMS.

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

* We entities operating under the submitted Provider ID:320001

Agree to participate
 Do not agree to participate
 Request to be withdrawn from participation.

Rationale for Withdrawal.
Wish to Change NOP Status

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

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

By entering this pledge, I agree to:

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

Confirm SAVE?
Click "YES" to confirm, save and submit your action(s), or click Cancel to return back to the pledging page.

CANCEL SAVE YES Cancel

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.

Detailed information about the NOP application is accessible on the *QualityNet* Home page by logging in through the *QualityNet Secure Portal*. Here is the direct link:
<http://www.QualityNet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPPage%2FQnetHomepage&cid=1120143435363>.

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, prior to the respective payment determination year.

After submitting data select the Return to the Summary button to return to the summary screen and continue submitting data for each measure.

As you complete data submission on each data entry page, the status will change from “Incomplete” to “Completed,” indicated by #1 below.

When you have completed submitting data for all measures select the **DACA** link to complete your “Data Accuracy and Completeness Acknowledgement,” denoted by #2 below.

Provider ID	Non-Measure Data	HBIPS-2	HBIPS-3	HBIPS-5	Screening for Metabolic Disorders	Transition Record with Specified Elements	Timely Transmission of Transition Record
	Completed	Completed	Completed	Completed	Completed	Completed	Completed

1.

Assessment of Patient Experience of Care	Use of an Electronic Health Record	SUB-1	SUB-2/-2a	SUB-3/-3a	TOB-1	TOB-2/-2a	TOB-3/-3a	IMM-2	DACA
Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed

2.

The following page appears:

**Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
Data Accuracy and Completeness Acknowledgement FY 2019**

I acknowledge that to the best of my ability all of the information reported for this Inpatient Psychiatric Facility (IPF) Quality Reporting (IPFQR) Program, as required for the Fiscal Year 2019 IPFQR Program requirements, is accurate and complete. This information includes the following:

- Aggregated data for all required measures
- Non-measure data
- Current Notice of Participation and
- Active QualityNet Security Administrator

I understand that this acknowledgement covers all IPFQR information reported by this inpatient psychiatric hospital or psychiatric unit (and any data vendor(s) acting as agents on behalf of this IPF) to CMS and its contractors, for the FY 2019 payment determination year. To the best of my knowledge, this information was collected in accordance with all applicable requirements. I understand that this information is used as the basis for the public reporting of quality of care.

I understand that this acknowledgement is required for purposes of meeting any Fiscal Year 2019 IPFQR Program requirements.

Enter your Position and click 'Submit'.

* Yes, I Acknowledge 1.

* Position 2.

3.

1. Select the **Yes, I Acknowledge** radio button.
2. Enter your position or title.
3. Select the **Submit** button.

Section 7: Accessing and Reviewing Reports

Report(s) described in this section are helpful in monitoring IPF status as it relates to the IPFQR Program. The reports should be used as a reference tool and do not guarantee a facility will receive its full APU.

Facility, State, and National Report

The Facility, State and National Report provides information about the data that is 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.

To run a Hospital Reporting-Inpatient Psychiatric Facility, State, and National Report:

1. Select **Run Reports** from the **My Reports** drop-down menu in the yellow tool bar near the top of the summary screen.
2. Select the **Run Report(s)** tab.
3. Select **IPFQR** for Report Program and **Hospital Reporting Feedback – IPFQR** for Report Category. Then, select the **VIEW REPORTS** button.
4. Select **Hospital Reporting – Inpatient Psychiatric Facility, State and National Report**.
5. Enter your desired report parameters and the Payment Year.
6. Select the **Run Report** button.
7. Select the **Search Reports** tab.
8. Select the new report and open it.

Provider Participation Report

The Provider Participation Report will be available in the future. This 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.

To run a Hospital Reporting-Inpatient Psychiatric Facility Participation Report:

1. Select **Run Reports** from the **My Reports** drop-down menu in the yellow tool bar near the top of the summary screen.
2. Select the **Run Report(s)** tab.
3. Select **IPFQR** for Report Program and **Hospital Reporting Feedback – IPFQR** for Report Category. Then, select the **VIEW REPORTS** button.

4. Select **Hospital Reporting – Inpatient Psychiatric Facility Participation Report**.
5. Enter your desired report parameters and the Payment Year.
6. Select the **Run Report** button.
7. Select the **Search Reports** tab.
8. Select the new report and open it.

Section 8: Public Reporting of IPFQR 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.

The Department of Health & Human Services (HHS) hosts the Hospital Compare website, <http://www.hospitalcompare.hhs.gov/> which publicly reports hospital performance on numerous measures. Quality performance information is collected from more than 4,000 participating hospitals. Hospital Compare is designed to make meaningful, relevant and easily understood information about hospital performance accessible to the public and to inform and encourage efforts to improve care quality. Accessibility and use of performance information spurs positive changes in healthcare delivery.

Effective April 17, 2014, the IPFQR Program data are located at the following link: <http://medicare.gov/hospitalcompare/search.html>.

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 website, facilities are given the opportunity to preview data for 30 days. Preview reports will be accessible for download by the facility, via the *QualityNet Secure Portal*, beginning with the April 2015 preview. Providers will be notified via list serve when the reports are available.

Preview Report Content

The *Hospital Compare* Preview Report Help Guide: Inpatient Psychiatric Facility Quality Reporting Program is a tool that provides detailed information about the Hospital Compare Preview Report. Some of the highlights include:

- An overview of *Hospital Compare* website
- 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 the Hospital Compare Preview Report content.

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

- [QualityNet](#) on the IPFQR Program Landing page in the News section
- [Quality Reporting Center](#) on the IPFQR Program Resources and Tools page

Medicare.gov Hospital Compare Website

Direct Link: <http://medicare.gov/hospitalcompare/search.html>

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

Access IPFQR Program Data Tables

1. From [Medicare.gov](http://medicare.gov) scroll down through the “Find doctors, providers, hospitals, plans & suppliers” section and select the **Find Hospitals** link.

The screenshot displays the Medicare.gov homepage. At the top, there is a search bar and navigation tabs for various services. Below this is a large banner with the text "Is my test, item, or service covered?" and a search input field. Underneath the banner are three buttons: "Find health & drug plans", "Apply for Medicare", and "Get started with Medicare". A yellow bar below the banner says "Find out how much Medicare costs in 2017" with a "Get costs" link. The main content area is divided into two columns. The left column has a sidebar with a list of links: "Find doctors, providers, hospitals, plans & suppliers", "Find doctors & other health professionals", "Find nursing homes", "Find hospitals", "Find home health services", "Find dialysis facilities", "Find health & drug plans", and "Find suppliers of medical equipment & supplies". The right column has a large heading "Find doctors, providers, hospitals, plans & suppliers" followed by a list of links: "Find doctors & other health professionals", "Find nursing homes", and "Find hospitals". A red box highlights the "Find hospitals" link in the right column, and a red arrow points to it from the "Find doctors, providers, hospitals, plans & suppliers" link in the left sidebar.

2. In the “Spotlight” section click on the link to access IPFQR updated measures.

NOTE: The “Find a hospital” function does not provide access to the quality measures submitted by IPFs.

The screenshot shows the Medicare.gov Hospital Compare website. At the top, there is a navigation bar with links for 'Hospital Compare Home', 'About Hospital Compare', 'About the data', 'Resources', and 'Help'. Below this is a search bar with a 'Home' button and a '+ Share' link. A yellow banner states: 'You can now view Department of Defense hospital performance data using our Interactive datasets and downloadable databases.' The main section is titled 'Find a hospital' and contains a search form with fields for 'Location' (with an example '45802 or Lima, OH or Ohio'), 'ZIP code or City, State or State', 'Hospital name (optional)', and 'Full or Partial Hospital Name'. A green 'Search' button is at the bottom of the form. To the right of the search form is an image of a healthcare professional checking a patient's blood pressure. Below the search form are three columns: 'Spotlight', 'Tools and Tips', and 'Additional Information'. The 'Spotlight' column contains a list of updates, with the last item, 'Inpatient Psychiatric Facility Quality Reporting measures. Updated December 2017.', highlighted by a red box. The 'Tools and Tips' column lists resources for choosing a hospital, printing information, and comparing providers. The 'Additional Information' column lists various Medicare programs and their update dates.

3. A new IPFQR Program tab or window will appear. This is the [Inpatient Psychiatric Facility Quality Reporting Program landing page](#), which lists the IPFQR Program measures at the top of the page, and displays three SOCRATA tables with the Facility, State and National level measure results farther down the page.
 - The IPFQR Program landing page includes a brief description of the program and the measures.
 - It includes public access to performance measure data provided by IPFs; however, it does not generate a report equivalent to the Facility, State, and National report available to a facility through the *QualityNet Secure Portal*.

Print
Medicare.gov | Hospital Compare Home | Close window



The Official U.S. Government Site for Medicare

Inpatient Psychiatric Facility Quality Reporting

Data details

Inpatient Psychiatric Facility Quality Reporting Program

The Inpatient Psychiatric Facility Quality Reporting program measures allow consumers to find and compare the quality of care given at psychiatric facilities where patients are admitted as inpatients. Inpatient psychiatric facilities are required to report data on these measures. Facilities that are eligible for this program may have their Medicare payments reduced if they do not report.

The tables that follow contain [facility \(provider\) results](#), [state results](#), and [national results](#). You can also visit data.medicare.gov to [download these datasets in access or csv format](#).

Data for the following measures are displayed in the tables below:

- Hours of physical restraint use (HBIPS-2) – *lower numbers are better*
- Hours of seclusion use (HBIPS-3) – *lower numbers are better*
- Patients discharged on multiple antipsychotic medications with appropriate justification (HBIPS-5) – *higher numbers are better*
- Percent of patients screened for alcohol use using a validated screening questionnaire (SUB-1) – *higher numbers are better*
- Alcohol use brief intervention provided or offered (SUB-2) – *higher numbers are better*
- Alcohol use brief intervention (SUB-2a) – *higher numbers are better*
- Tobacco use screening (TOB-1) – *higher numbers are better*
- Tobacco use treatment provided or offered (TOB-2) – *higher numbers are better*
- Tobacco use treatment (TOB-2a) – *higher numbers are better*
- Tobacco Use Treatment Provided or Offered at Discharge (TOB-3) – *higher numbers are better*
- Tobacco Use Treatment at Discharge (TOB-3a) – *higher numbers are better*
- Attestation of patient experience of care (PEoC) routinely assessed using standardized collection protocol
- Attestation of facility's highest level typical use of an electronic health records system (EHR) and exchange of interoperable health information with a health information service provider (HISP) at times of transitions in care
- Percent of patients receiving follow-up care within 30 days (FUH-30) or within 7 days (FUH-7) after hospitalization for mental illness - *higher numbers are better*

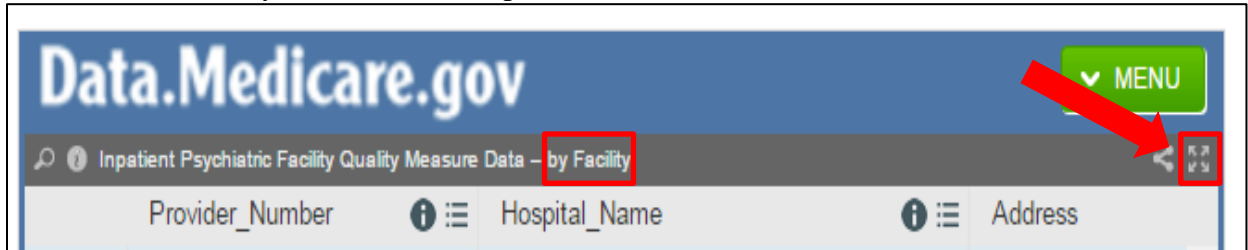
Note: Due to an error in the calculation of the Follow-Up After Hospitalization for Mental Illness (FUH) measures, the data in the measure tables labeled "Inpatient psychiatric facility quality measure data" for facility, state, and nation display the FUH data as "Not Available." Recalculated data for the FUH measures is provided in separate tables below labeled, "Inpatient psychiatric facility follow-up after hospitalization for mental illness (FUH) quality measure data" for facility, state, and nation.

- Influenza immunization (IMM-2) – *higher numbers are better*
- Influenza vaccination coverage among health care personnel (FluVac HCP)—*higher numbers are better*

Get more details about these measures.

4. To access the Facility-level data on the SOCRATA table, select the **Expand Icon** located in the top right corner, as indicated in the example below. A new tab or window will appear.

NOTE: You may also select the expand icon for the State- and National-level data tables.



Sort and Filter Tables within the Hospital Compare Website

In the new tab or window that appears, you will see several columns of data, each with an information symbol and a three bullet/line menu icon. By clicking on the three bullet/line icon, you have the following options:

- Sort Ascending
- Sort Descending
- Filter This Column
- Hide Column

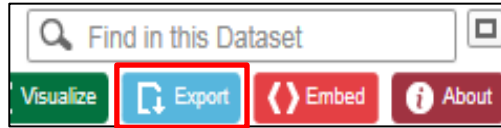
You can easily clear any sorting and the tables will display as they did when you originally opened the data file.



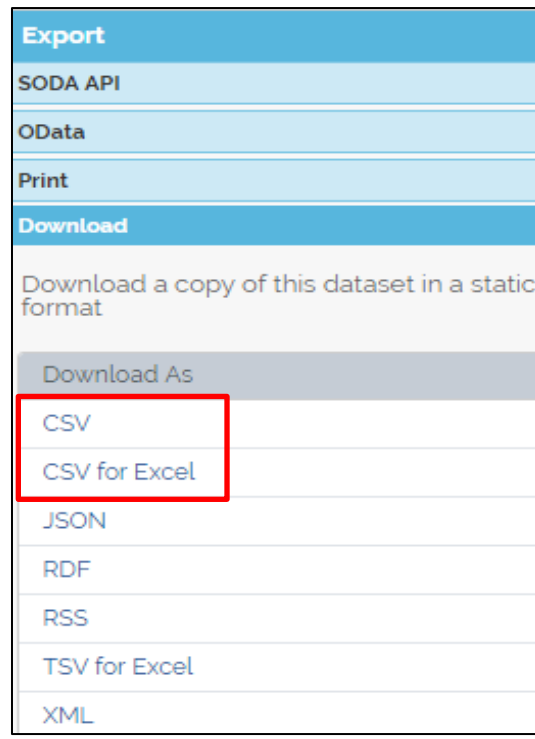
Download Tables for Further Analysis

The following instructions describe how to download the data set in CSV Excel format by Facility for further analysis; however, these instructions are also applicable for the State and National level data tables.

1. Select the **Export** button in the top right of the screen.



2. A menu of download options will appear. To sort and/or filter the dataset, we recommend downloading it as a CSV or CSV for Excel file.



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**.

Section 9: Resources

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

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 under the Inpatient Psychiatric Facilities tab by selecting the **Webinars/Calls** link from the drop-down menu.

For resources and tools from the IPFQR Support Contractor, access the website <http://www.QualityReportingCenter.com>. Data collection tools, timelines, and calendars, and other valuable resources are on this website. In the drop-down menu for the **Inpatient** tab, select **IPFQR Program**.

IPFQR ListServe

To receive important IPFQR Program updates and notifications, please subscribe to the ListServe on the *QualityNet* website. On the left side of the *QualityNet* home page, navigate to the “Join ListServes” box and select the **Notifications and Discussions** link. Check the box next to Inpatient Psychiatric Facility Quality Reporting Program, enter your User Information, 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. Users can access the Q&A tool from *QualityNet* by selecting the **Inpatient Psychiatric Facilities** link from the Questions & Answers section on the right side of the page and then choosing the **Inpatient Psychiatric Facility Quality Reporting** link. The direct link is: <https://cms-ip.custhelp.com/app/homeipf/p/831/session/L3RpbWUvMTUwNzg0MDc2My9zaWQvNnBRX2oqdW4%3D>.

If other information is needed, select the **Ask a Question** link to submit a question to the IPFQR Support Contractor. 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@hcqis.org

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://www.QualityNet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772250192>.

The *QualityNet* home page (www.QualityNet.org) offers a User Guide for the Secure Portal and User Guide for the Secure Portal Reports. Links are located on the right side of the webpage, below “Log in to *QualityNet* Secure Portal” at the following link:

<http://www.QualityNet.org/dcs/ContentServer?pagename=QnetPublic/Page/QnetHomepage>.

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

Specification Manuals

Specifications Manual for Joint Commission National Quality Core Measures Manual

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

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

Specifications Manual for National Hospital Inpatient Quality Measures

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

<https://www.QualityNet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228774725171>

Claims-Based Measures Specifications

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

- [QualityNet](#) > Inpatient Psychiatric Facilities > [Resources](#)
- [Quality Reporting Center](#) > Inpatient > 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: Components of the Specifications Manual for National Hospital Inpatient Quality Measures and the Specifications Manual for Joint Commission National Quality Core Measures

Table of Contents – The Table of Contents provides a list of all the documents contained within the respective manual with corresponding page numbers. The electronic online version of the manual is bookmarked and contains hyperlinks to easily navigate through documents.

Introduction – The Introduction contains a history of the CMS/Joint Commission Measure alignment and activities.

Using the Manual – This document provides a brief description of the content in each section of the manual and the appendices.

Data Dictionary Section – The Data Dictionary is provided to define data elements and provide guidance for abstraction of data. To ensure standardized and comparable data across all hospitals, it is of primary importance that all hospitals using the National Quality Core Measures (HBIPS) and the National Quality Inpatient Measures (SUB-1) gather and use the data elements as defined in the Data Dictionary.

Introduction to the Data Dictionary – The Introduction to the Data Dictionary describes the data elements required to calculate the measures. It contains general abstraction guidelines; however, the instructions under each data element take precedence over general guidelines.

Data Element List – The Data Element List contains an alphabetical list of all the data elements that are collected for the measures/measure sets included in the Specification Manual.

Alphabetical Data Dictionary – The Alphabetical Data Dictionary is the largest of all the documents contained within the manual. It is extremely important for the abstractor to have the correct version of the document based on the discharge period as abstraction instructions can change from period to period.

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.

Data Element Sections – Each data element is described in detail following the comprehensive list. There are multiple sections within the data element information.

- **Data Element Name** – A short phrase identifying the data to be collected. For ease of identification, the data element name is italicized.
- **Collected For** – Identifies the measures and the organization for which the element is collected: CMS, The Joint Commission, both, or neither organization.
- **Definition** – A detailed explanation of the data element.
- **Suggested Data Collection Question** – Provided as an example of wording for a data element question that may be found in a data abstraction tool.

Data Element Sections (continued)

- **Format** – Identifies the criteria (length, type, occurs) of data that is being collected for transmission purposes.
 - Length – Number of characters or digits allowed for the element.
 - Type – Identifies the allowed data value: numeric, alphanumeric, date, character or time.
 - Occurs – Number of times the data element occurs in a single episode of care record.
- **Allowable Value** – A list of acceptable responses for the element. In some data elements, the response may be limited to one while others may allow for multiple values.
- **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.
- **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.
- **Guideline for Abstraction** – Designed to assist abstractors in determining how a data element should be answered. The instructions can reference inclusions abstracted as a positive finding. Unless specified within the data element, the inclusions listed are **not** considered all inclusive. The data element can contain specific exclusions or unacceptable terms abstracted as negative findings. Also, the instructions can reference an appendix in the *Specifications Manual*, such as a medication table. Element specific notes and guidelines take precedence over the “General Abstraction Guidelines” found in the “Introduction to the Data Dictionary.”

Measure Information Form (MIF) – The measure information section in the *Specifications Manual for National Hospital Inpatient Quality Measures* and the *Specifications Manual for Joint Commission National Quality Core Measures* is divided by measure sets. There is a list of measures comprising each set, including the set measure identification number (alphanumeric number to identify a measure within a set) and the measure short name. For example, in the Hospital Based Inpatient Psychiatric Services (HBIPS) measure set, the measure that addresses Hours of Physical Restraint Use is listed as: HBIPS-2a and measure short name: Physical Restraint-Overall Rate. This is followed by a data element list for the measure set, including the general data elements, algorithm output data elements, and the specific measure set data elements. Next is a document that describes the Initial Patient Population and the sample size requirements for each measure set. Also included are subsections for each specific measure. These contain a MIF and the Measure Algorithm.

The MIF has an identification section which includes name and identification code information. As with other documents within the manual, the notation in the top right corner indicates when the document was last revised. Each measure has a notation indicating whether it is endorsed by the National Quality Forum (NQF).

Measure numerator and denominator information is provided with included and excluded populations specified.

Numerator Statement – Represents the portion of the denominator satisfying the conditions of the performance measure. When the measure is reported as a rate (proportion or ratio), the Numerator and Denominator Statement are completed.

- **Included Populations** – Describes the population(s) comprising the numerator, not contained in the numerator statement, or not applicable.
- **Excluded Populations** – Describes the population(s) not included in the numerator or none.
- **Data Elements** – Data elements necessary or required to determine (or establish) the numerator.

Denominator Statement – Represents the population evaluated by the performance measure. When the measure is reported as a rate (proportion or ratio), the Numerator and Denominator Statement are completed.

- **Included Populations** – Describes the population(s) comprising the denominator, not contained in the denominator statement, or not applicable.
- **Excluded Populations** – Describes the population(s) not included in the denominator or none.
- **Data Elements** – Data elements required to determine (or establish) the denominator.

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. For example, “Appendix E” of the manual provides more details and the definition of each field contained within the MIF. Data elements used in the calculation of the measure are italicized within the algorithm.

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.

Appendix B: 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 healthcare 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

B. _____ It is my intention that this advance directive will automatically expire two years from the date it was executed.

If my choice above is not valid under state law, then it is my intention that this advance directive remain in effect for as long as the law permits.

PART 6: Signature Page

By signing here I indicate that I understand the purpose and effect of this document.

Your Signature _____ Date

The directive above was signed and declared by the "Declarant," (your name) _____, to be his/her mental health care advance directive, in our presence who, at his/her request, have signed names below as witness. We declare that, at the time of the execution of this instrument, the Declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. We further declare that none of us is: 1) a physician; 2) the Declarant's physician or an employee of the Declarant's physician; 3) an employee or a patient of any residential health care facility in which the Declarant is a patient; 4) designated as agent or alternate under this document; or 5) a beneficiary or creditor of the estate of the Declarant.

Dated at _____ (county, state),
this _____ day of _____, 20_____.

Witness Signatures

Witness 1:

Signature of Witness 1

Name of Witness 1 (printed)

Home address of Witness 1

City, State, Zip Code of Witness 1

Witness 2:

Signature of Witness 2

Name of Witness 2 (printed)

Home address of Witness 2

City, State, Zip Code of Witness 2

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:

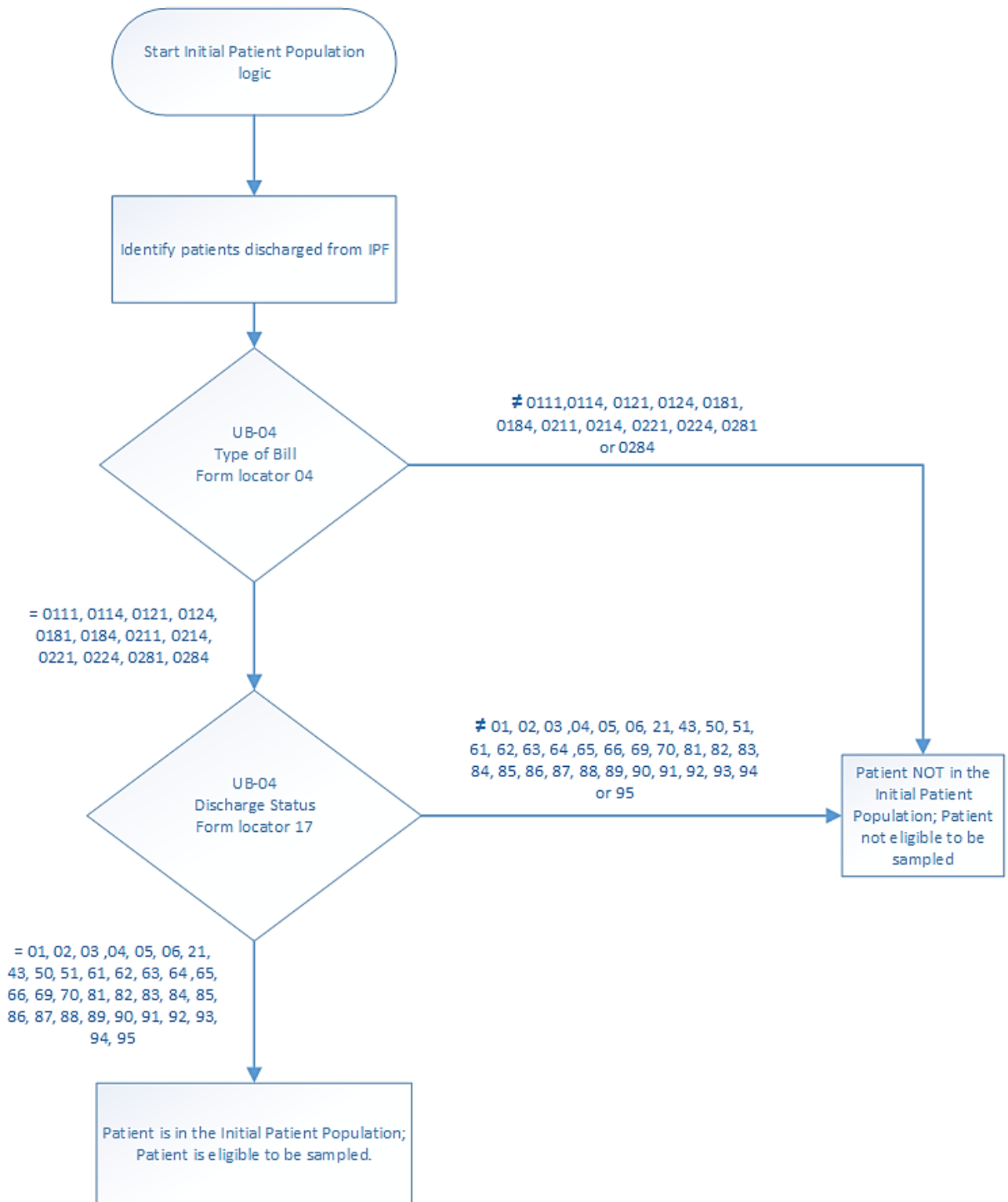
Appendix C: Initial Patient Population (IPP) for the Transition Record Measures

The initial selection of cases (i.e., patient medical records) intended for data abstraction under the IPFQR Program must meet the following criteria. The cases must be all patients (i.e., both Medicare and non-Medicare) receiving care in a psychiatric hospital or psychiatric unit paid under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS).

If the facility bills Medicare for inpatient psychiatric services under the IPF PPS, it is considered to be an IPF eligible to participate in the IPFQR Program and thereby all patient discharges from that facility would be identified as patients discharged from an IPF. This applies to inpatient psychiatric services furnished by Medicare-participating entities in the United States and Puerto Rico that are classified as free-standing psychiatric hospitals or psychiatric units within acute care or critical access hospitals.

To use the following IPP algorithm, the facility must initially sort the cases as discharges from the IPF. After identifying the cases discharged from the IPF, the codes listed in the algorithm below would be used to determine the IPP for the transition record measures.

Figure 1: IPP Algorithm for the Transition Record Measures, Starting January 1, 2018



Appendix D: Screening for Metabolic Disorders

Measure Information Form

Performance Measure Name: Screening for Metabolic Disorders

Description: Percentage of patients discharged with antipsychotics from an IPF 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 American Diabetes Association (ADA), the American Psychiatric Association (APA), the American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity 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 or psychological condition
- Patients with a length of stay 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

For the list of routinely scheduled antipsychotic medications, refer to the current version of the *Specifications Manual for Joint Commission National Quality Core Measures*, Appendix C, Table Number 10.0: Antipsychotic Medications, available at:

https://www.jointcommission.org/specifications_manual_joint_commission_national_quality_core_measures.aspx.

PRN (“as needed”) antipsychotic medications or short-acting intramuscular antipsychotic medications do not count towards the denominator of this measure. For the list of the short-acting intramuscular antipsychotic medications, refer to the current version of the *Specifications Manual for Joint Commission National Quality Core Measures*, Appendix C, Table Number 10.1: Short-Acting Intramuscular Antipsychotic Medications, available at:

https://www.jointcommission.org/specifications_manual_joint_commission_national_quality_core_measures.aspx .

Please note that the Joint Commission may update these lists of medications up to two times per year to ensure that they are in line with current clinical guidelines. Refer to these lists on a quarterly basis for the most up-to-date specifications.

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 13–14 of this program manual.

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

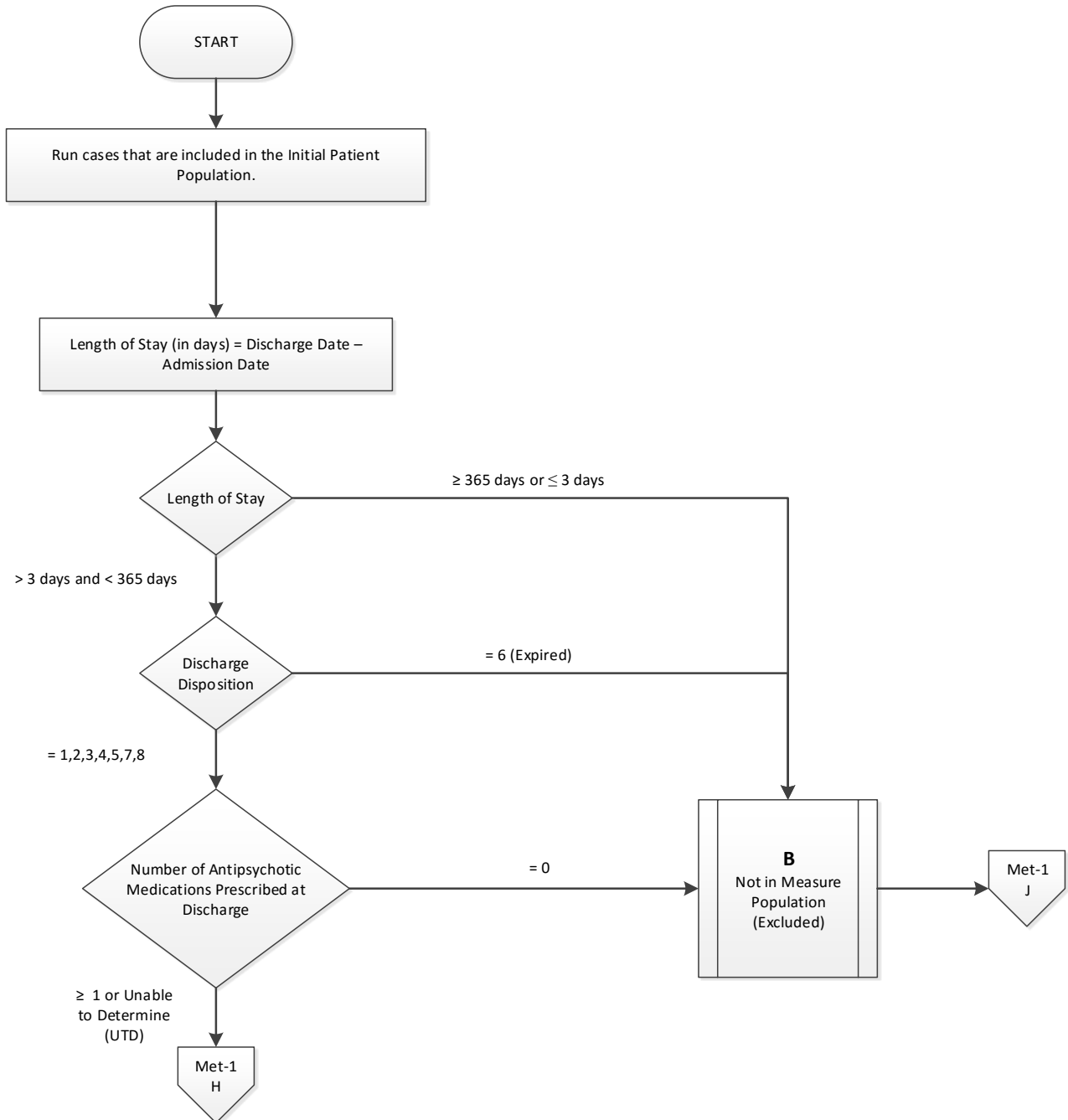
Selected Reference:

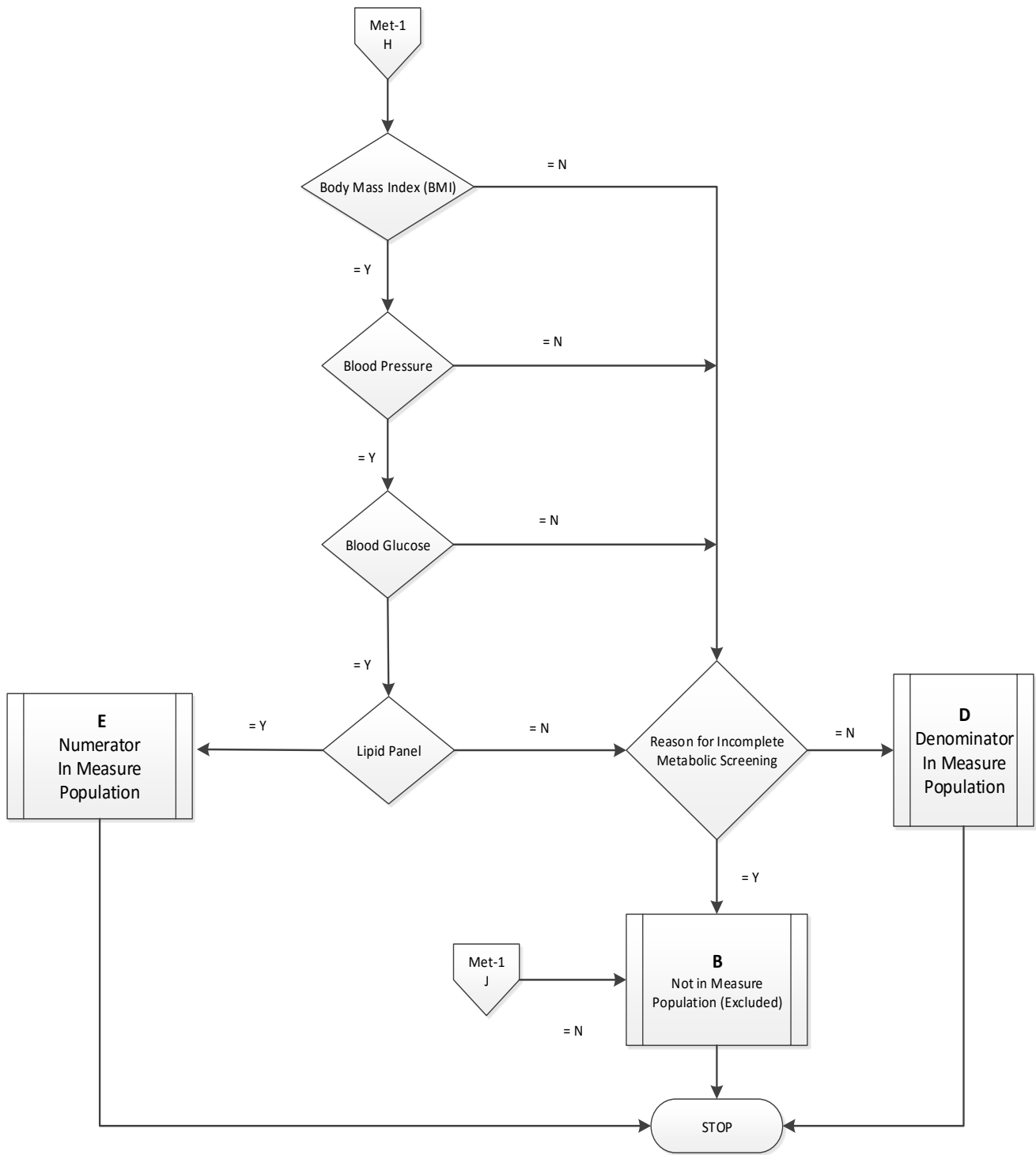
1. The American Diabetes Association, American Psychological Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. *Diabetes Care*. 2004;27(596–601).

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 case will be 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 case will be 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 case will be excluded. Stop processing.
 - b. If Number of Antipsychotic Medications 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 case will be included in the Numerator. Stop processing.
10. Check Reason for Incomplete Metabolic Screening
 - a. If Reason for Incomplete Metabolic Screening equals No, the case will be included in the Denominator only. Stop processing.
 - b. If Reason for Incomplete Metabolic Screening equals Yes, the case will be excluded. Stop processing.

Alphabetical Data Dictionary

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

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Data Element Name: *Admission Date*

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

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

Format:

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

Type: Date

Occurs: 1

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (20xx)

Notes for Abstraction:

- The intent of this data element is to determine the date that the patient was actually admitted to an inpatient psychiatric facility. 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, the ‘Statement Covers Period’ is not synonymous with the ‘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 04-05-20xx. On 04-06-20xx, the physician writes an order to admit to inpatient psychiatric care, effective 04-05-20xx. The Admission Date would be abstracted as 04-06-20xx-; 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 should first check for at least one documented result of HbA1c, fasting plasma glucose, or plasma glucose after an oral glucose tolerance test (OGTT).
- If results are obtained from a Comprehensive Metabolic Panel or Basic Metabolic Panel indicated for serum or for which indication of plasma or serum is missing, documentation that the patient fasted prior to the test is required. If there is no indication that the patient fasted, 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 level
- Fasting sugar
- HbA1c
- 2-hour glucose level after OGTT

Exclusion Guidelines for Abstraction:

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

Data Element Name: *Blood Pressure*

Definition: 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 should check for 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: Weight-to-height ratio, calculated by dividing one's weight in kilograms (kg) by the square of one's 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 should check for 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 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx, 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 04-06-20xx 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. Contradictory documentation, use latest. Select value "1" (Home).
- Physician order on discharge states Discharge to ALF. Discharge instruction sheet completed after the physician order states patient discharged to SNF. 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 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 should check for 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 (i.e., normal, abnormal, etc.)
- 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 the phenothiazines, butyrophenones or serotonin-dopamine antagonists, which are used to treat psychosis. An antipsychotic medication is also called neuroleptic (refer to Appendix C, Table 10.0- Antipsychotic Medications in the current version of the Joint Commission National Quality Measures Manual:
https://www.jointcommission.org/specifications_manual_joint_commission_national_quality_core_measures.aspx.
- All antipsychotic medications should be counted regardless of the indication for use or the reason documented for prescribing the antipsychotic medication.
- 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:

Refer to *Specifications Manual for Joint Commission National Quality Core Measures*, Appendix C, Table 10.0 - Antipsychotic Medications in the current version of the *Joint Commission National Quality Measures Manual*:

https://www.jointcommission.org/specifications_manual_joint_commission_national_quality_core_measures.aspx

Exclusion Guidelines for Abstraction:

- PRN antipsychotic medications
- Short-acting intramuscular antipsychotic medications (refer to Appendix C, Table 10.1 - Short-Acting Intramuscular Antipsychotic Medications in the current version of the *Joint Commission National Quality Measures Manual*:

https://www.jointcommission.org/specifications_manual_joint_commission_national_quality_core_measures.aspx

Data Element Name: *Reason for Incomplete Metabolic Screening*

Definition: A statement by the physician/APN/PA in the current medication record indicating that the screening elements could not be completed due to patient’s enduring unstable medical or 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 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 unstable medical or psychological condition

N (No) Documentation in the medical record for this stay does not specify that the patient’s 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 the patient has an enduring unstable medical or psychological condition that prevents completion of a metabolic screening.

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”

Exclusion Guidelines for Abstraction: None