



# **Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program**

## **Support Contractor**

### **IPFQR Program: Keys to Successful FY 2018 Reporting**

#### **Presentation Transcript**

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**Louisa Heath:** Hello everyone and welcome to today’s presentation. My name is Louisa Heath and I am a Project Manager of the Hospital Inpatient Outreach and Education Support Contractor. I work primarily in the Inpatient Psychiatric Facility Quality Reporting Program. I am delighted to introduce you to our speaker for today’s presentation, Evette Robinson. Evette Robinson is the Project Lead for the IPFQR Program. She has over 17 years of cross-functional experience in the healthcare industry, ranging from biomedical and clinical research, to strategic planning and revenue cycle management consulting for a variety of healthcare providers. Evette earned a Master of Public Health degree in Health Management and Policy from Emory University.

Before we proceed with today’s webinar entitled, “Keys to Successful Fiscal Year 2018 Reporting,” I would like to cover a few more housekeeping items. As many of you know the slides for this presentation were posted to the *Quality Reporting Center* website prior to the event. If you did not receive the slides beforehand, please go to [qualityreportingcenter.com](http://qualityreportingcenter.com). On the right side of the screen you will see a list of upcoming events. Click on the link for this event, scroll down to the bottom of the page and there you will find the presentation slides available to download. This session is being recorded and the slides, transcript webinar recording, and questions and answers from this presentation will be posted on the *QualityNet* and *Quality Reporting Center* websites at a later date.

Please note that we do not recognize the “raise hand” feature in the chat window during the webinar. Instead you may submit any questions that are pertinent to the topic of this webinar to us via the chat tool. Questions that we receive via the chat tool will be reviewed and documented in a Q&A transcript, which will be available at a later date. Due to the volume of questions, and so that we can maximize the usefulness of the Q&A transcript, we will consolidate and remove duplicate questions so that we can focus on webinar-content specific questions. Questions that are submitted via the chat tool that are not related to the topic of the webinar

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will not be responded to in the chat tool, or in the questions and answers transcript for this webinar.

To obtain answers to questions that are not specific to the content of the webinar we recommend that you go to the *QualityNet* Q&A tool. You can access the Q&A tool using the link provided on this slide. The Q&A tool allows you to search for previously answered questions that are unrelated to this topic and submit new questions to us via the Q&A tool, which again you can access on the link on this slide.

This slide displays a list of the acronyms that will be referenced during today's presentation.

The purpose of this presentation is to summarize the fiscal year 2018 IPFQR Program requirements, provide keys to successful data submission and offer guidance on how to confirm the accuracy of your data.

By the end of this presentation, attendees will be able to:

- Summarize the fiscal year 2018 IPFQR Program requirements
- Delineate keys to successfully submit data in the *QualityNet Secure Portal*
- Utilize tips to avoid common submission errors, as well as
- Locate and access helpful IPFQR Program resources.

And now I will turn the presentation over to our speaker, Evette Robinson.

### **Evette Robinson**

Thank you Louisa. The next few slides will provide an overview of the reporting requirements for Fiscal Year 2018 for the IPFQR program.

In order to participate in the IPFQR program and obtain full APU for the fiscal 2018 payment year, an IPF must meet the following requirements by August 15, 2017, unless otherwise noted.

- An IPF must maintain at least one active *QualityNet* security administrator, though we recommend at least two.
- The IPFQR Notice of Participation, or NOP, must have a pledged status of "Participating."

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- The IPF must meet the two annual data submission deadlines, which are:
  - May 15, 2017 for the Influenza Vaccination Coverage Among Healthcare Personnel measure.
- And the remaining IPFQR Program data requirements must be submitted by the August 15th deadline. These measures include:
  - HBIPS-2, -3, -5; SUB-1, -2 and the subset -2a; IMM-2; TOB-1, TOB-2 and the subset-2a, as well as -3 and the subset of -3a; the use of the Electronic Health Record; and Assessment of Patient Experience of Care measures; and finally the non-measure data.
  - Finally, once the measure and non-measure data have been entered, an IPF must complete the data accuracy and complete acknowledgement, or DACA, as an attestation that the data entered is in fact accurate and complete.

IPFs that do not meet one or more of the IPFQR requirements by the August 15, 2017 deadline will be subjected to a two percentage point reduction to their annual payment update, or APU, for fiscal year 2018.

The table on this slide and the next slide display the reporting period, data submission deadline, measure type and indicates whether sampling is allowed for each measure.

This slide again shows the remaining measures required for the IPFQR program. And as a reminder, the Follow-Up After Hospitalization for Mental Illness measure is a claim-based measure and IPFs do need to take action for reporting for this measure.

The next several slides will describe our recommended keys to successful reporting for the fiscal year 2018 payment determination.

The first key to successful reporting for the IPFQR program is to access and log into the *QualityNet Secure Portal*. The *QualityNet Secure Portal* is the only approved method for IPFQR program data submission. All

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measure data and the DACA, are submitted via the secure online CMS web-based tool, which is accessible through the *QualityNet Secure Portal*. CMS highly recommends that all IPFs ensure that at least one person with knowledge of the data is able to verify the accuracy of the data entered into the *QualityNet Secure Portal*, even if data entry is done by a vendor.

If you are not already a registered *QualityNet* user with access to the *Secure Portal*, then go to the web link listed on this slide for the qualitynet.org website, select the Inpatient Psychiatric Facilities link on the left side of the *QualityNet* home page and follow the instructions to register.

Once registered, you will need to log into the *QualityNet Secure Portal*, select the log-in link on the right side of the *QualityNet* homepage under login to *QualityNet Secure Portal*.

If you are already enrolled in the *QualityNet Secure Portal*, then you will enter your *QualityNet* user ID, password and the Symantec VIP security code before clicking the submit button. If you are not already enrolled in the *QualityNet Secure Portal*, then select the “Start/complete new user enrollment” link and complete enrollment. Next, you will need to download a Symantec VIP access token and complete identity proofing.

The second key to successful reporting is to ensure that the IPF has at least two active security administrators. The security administrator is the person in the organization who can grant *QualityNet Secure Portal* access to those who need to enter, review and confirm accuracy of the data submitted. Each participating IPF must have at least one active SA at the time of the submission deadline. However, a second security administrator is highly recommended as a backup in case the primary security administrator’s account expires. All users must log in to the *QualityNet Secure Portal* every 30-60 days to keep their account active. Consider putting a reminder on your calendar to keep your account active.

The third key to successful reporting is to manage the IPFQR Program Notice of Participation, or NOP. As mentioned earlier an IPF must have an NOP status of “Participating” in the *QualityNet Secure Portal* by August 15, 2017 in

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order to be considered for the full fiscal year 2018 APU. To access the NOP for one or more IPFs you must be logged into the *QualityNet Secure Portal*. Once logged in:

1. You will first click the “Quality Programs” tab on the *QualityNet Secure Portal* home screen.
2. Then select the “Hospital Quality Reporting: IQR, OQR, ASCQR, IPFQR, PCHQR” option from the drop-down menu.
3. Next you will select the “View/Edit Notice of Participation, Contacts, Campuses” in the “Manage Notice of Participation” box, which you see here as part of second image on this slide.
4. And then you want to select “Inpatient Psychiatric Facility Notice of Participation.”
5. To continue accessing a facility’s NOP you will want to enter the facility’s six digit CCN, if you have access to more than one IPF’s information in the *QualityNet Secure Portal*. Otherwise the CCN for your facility should automatically appear and you will proceed to step six.
6. For step six you will want to click on the “Next” button to view the “IPFQR Notice of Participation menu.”
7. Then you’ll want to click on the “Notice of Participation” hyperlink in the lower right side of the page to view the NOP status.

The first screenshot on this slide is an example of what you can expect to see in the IPFQR Notice of Participation Summary Table if you already have a notice of participation on file that is carrying forward from the previous fiscal year, and you have at least two contacts listed in the *QualityNet Secure Portal*. In other words, if two or more contacts are not listed in the *QualityNet Secure Portal*, then the note highlighted in red in the second image on the slide will appear just above the Notice of Participation Summary Table. This is a reminder to add the main email address and mailing address of the individuals who will be contacted via email whenever there are any data changes to the IPFQR Program Notice of Participation, contacts, or campus data. Make sure that both contacts

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have “yes” indicated for email notifications. And once that information is saved in the *Secure Portal*, the note highlighted in red will go away. If the IPF closes or chooses not to participate, we ask that you contact the IPFQR Program support contractor to learn about the next steps.

CMS strongly recommends that IPFs carry out the fourth key to successful fiscal year 2018 reporting for the IPFQR program, which is to prepare and verify the accuracy of all data prior to submitting it to the web-based data collection tool. Being prepared encourages IPFs to provide accurate data, to be able to submit data in the web-based data collection tool, such as a vendor. It prevents IPFs from submitting extreme outlier values. It reduces or eliminates data entry editing and facilitates submission of data well in advance of the data submission deadline. And finally being prepared also ensures confidence in the final review of data submitted prior to completion of the DACA.

During your data preparation we recommend that you compare this year’s values to those submitted in previous years where applicable. Generally significant changes in values would not be expected and should invite closer review before finalizing submission. Measure values should always be reviewed by one or more persons familiar with the facility’s operations, annual census and population. Also values that seem out of line with general expectations should be reviewed to verify accuracy.

The first measure-specific suggestions that we will cover in this presentation will be with respect to HBIPS-2 and HBIPS-3 measures. The HBIPS-2 measure, hours of physical restraint use measure. In the numerator, that data should include the total numbers of hours that all psychiatric patients were maintained in physical restraint. While for the HBIPS-3 measure, you want to ensure that the numerator value reflects the total number of hours of seclusion. It is important to ensure that the numerator values entered are the total number of hours, not minutes or days, that all psychiatric inpatients were either placed in restraints for HBIPS-2 or seclusion for HBIPS-3. The system allows for entry of data that includes up to seven whole number digits and up to two decimal digits in the numerator field for these two measures. In other words, the value

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can be as low as zero or as high as 9,999,999.99. But please note that if the value is zero, then entering a single digit zero is adequate. Next check the denominator data by ensuring the correct number of days are calculated. You should ensure that the number of days does not exceed 366 times the facility's bed capacity because there were 366 days in calendar year 2016. Also, you may enter up to six digits for the denominator and it cannot be zero if the numerator is a non-zero number. If this occurs, please review your data. Remember, a zero or numeric value must be entered into each field. If you need to round your raw data to comply with this decimal format, use the traditional rounding convention, if the last number is a five or higher, round up; otherwise round down.

The aim of this and the next several slides is to emphasize instructions on how to identify incorrect data entry and extreme outliers. We want to ensure all IPFs understand the importance of submitting correct and accurate data to CMS, which will later be publicly displayed on the *Hospital Compare* website. We will begin with guidance on how to identify incorrect data entries starting with the HBIPS-2 and HBIPS-3 measures. In general, there are three key approaches one can use to spot incorrect data for these two measures:

1. First, the HBIPS-2 and HBIPS-3 measures should have the same or similar denominator values, which is the number of psychiatric inpatient days. If different denominator values are entered for these two measures, then it is likely that the data are incorrect and the data entries should be checked.
2. Second the denominator values should not be less than the IPF's total annual discharges. If the denominator values for HBIPS-2 or HBIPS-3 are less than the total number of patient discharges reported in the Non-Measure Data/Population Counts data entry page, then it is likely that the data are incorrect and the data entries should be checked.
3. And finally the denominator values should not exceed 366 times the total number of beds at the IPF. Again, if the aggregate



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number of inpatient days exceeds this value of 366 times the IPF's total bed size, it is likely that the data will need to be checked.

To help clarify the points described in the previous slide, we will review examples of data points that should be called into question when preparing the HBIPS-2 and HBIPS-3 measure data. At the top of this slide is an example of questionable HBIPS-2 and HBIPS-3 data in which the denominator values are not the same nor similar. We recommend that if you find such a discrepancy in the number of psychiatric inpatient days, that you re-evaluate those values for accuracy before entering them into the web-based data collection tool.

Another way to verify accuracy of HBIPS-2 and HBIPS-3 measure data is to compare the number of psychiatric inpatient days in the denominator of those measures with the total annual discharges for the facility. If the denominator for these measures are less than the total annual discharges, then the numbers should be re-evaluated for accuracy.

Another helpful calculation to confirm accuracy for these measures is to review the denominators against the product of 366 times the total number of IPF beds at the IPF. One would expect that the number of psychiatric inpatient days will not exceed the number of days in calendar year 2016 times the number of beds at the facility.

We have noted that in the last few years there have been some extreme data entries that needed to be corrected. So we wanted to take this time to share pointers on how to identify extreme outliers for the measures. CMS determined that a rate equal to or greater than four hours per 1,000 patient hours of physical restraint for the HBIPS-2 measure or seclusion for the HBIPS-3 measure is questionable and should be re-evaluated. This is a change compared to last year, in which a rate equal to or greater than five hours per 1,000 patient hours of care was considered questionable. And this update is based on the distribution of previous year's individual measure values. The screenshot on this slide is an example of an outlier

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rate for the HBIPS-2 measure in which the result is 8.33 hours per 1,000 patient hours.

Slide 32 summarizes the criteria for identifying extreme outliers for other measures for which IPFs will submit data during the upcoming data submission period. For the HBIPS-5 measure, CMS determined that no criteria are needed for this measure because prior mean and distribution of data values have been within expected parameters. For the SUB-1; TOB-1, -2/-2a, as well the IMM-2 measures, a zero numerator with a non-zero denominator is considered questionable and should be re-evaluated. Please note that there are no outlier guidelines for measures that will be newly reported to the IPFQR program for fiscal year 2018 such as SUB-2/-2a and TOB-3/-3a.

A few key guidelines for preparing data for other measures, as well as the non-measure data and population counts data entry pages are listed on this slide. Specifically, the numerator and denominator data must be entered in whole number digits for these data entry pages. Note, you will be able to enter up to five whole number digits for the numerator and up to six whole number digits for the denominator. As I mentioned earlier, if you enter zero as the value you need only enter a single digit of zero. Also the denominator cannot be zero if the numerator is a non-zero number.

The purpose of the non-measure data population counts screen is to collect annual aggregate data on discharges overall and by specific age, diagnostic and payer categories. Each category has a corresponding data entry field where the aggregate counts are entered. This screen also collects data pertaining to the sampling methodology that you may or may not have opted to apply to your population. There are additional parameters that are built in to the non-measure data population count screen to ensure that data are entered correctly. And we will review those guidelines the next few slides.

The first parameter we will discuss is that the sum of the values entered in to each subcategory must equal the value of the total annual discharges field located at the top of the Non-measure Data/Population Counts

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screen. As you can see from the image on this slide, the total annual discharges value represents the total number of annual Medicare and non-Medicare patients that were discharged after receiving care in the IPF. The following slide will include examples of correct and incorrect data entry for this data entry page based on this parameter.

Now at the top of slide 36, are two examples of incorrect data entry on the Non-measure Data Population Counts Data Entry page. The first example has 1,000 total annual discharges entered. However, the total number of annual discharges by payer of 900 plus 200 exceeds that total annual discharges that are indicated above. The second example, again in which there are 1,000 annual discharges entered, the total number of annual discharges by age strata of 75 annual children discharges, 225 adolescent discharges, 445 adult discharges and 250 of older adult dischargers exceeds the 1,000 value total annual discharges by a value of five. If the sum of the values that you enter into the subcategories of the data entry page does not equal the value entered in the total annual discharges field, then an error message will appear and you will not be able to submit until the entries are corrected. The examples at the bottom of this slide demonstrate how the values entered in to the subcategories equal the value entered in the total annual discharges field.

This slide demonstrates another example of how the data entered into the diagnostics category section must be equal to or less than the value entered in the total annual discharges field.

Once you have prepared and have verified the accuracy of the data, the next key is to access the web-based data collection tool for the IPFQR Program to enter the measure and non-measure data values, as well as sign the DACA. Now in order to access the IPFQR web-based data collection tool, in order to enter the facility's measured data:

1. You must first click the "Quality Programs" tab on the *QualityNet Secure Portal* home screen.
2. Then select the "Hospital Quality Reporting: IQR, OQR, ASCQR, IPFQR, PCHQR" option from the drop-down menu.

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3. Next, you will select “View/Edit Structural/Web- Based Measures/Data Acknowledgement (DACA)” hyperlink.
4. And then in step four you will select “Inpatient Psychiatric Facilities Web-Based Measures/DACA.”
5. The next step is to select the payment year, which is the payment determination year that will be impacted by the current submission period. For the upcoming data submission period, you will select payment year 2018 and then click the “Continue” button.

One must have a role assigned to their account in order to submit data. If you are an IPF with access to only your facility’s information, then you will not see the provider selection page displayed on this screen. Instead you will see the Measures Summary page which we will review in the next slide. For users such as vendors, who'll have access to multiple providers, a list of IPFs will appear from which to choose. One can hold down the control key and click on the names of providers for which they want to enter data, select all or choose to enter data for one provider at a time. The provider selection list includes the CCN and facility names. And only facilities associated with account currently logged into the *QualityNet Secure Portal* will appear in the provider’s selection list. The clear button de-selects providers from the provider’s selection list. If you click the “Cancel” button, then you will be returned to the Payment Year selection page. And finally if you click on the “Continue” button it will take you to the Measures Summary page, which you will find on the next slide.

You will note that the Measures Summary page, displays the submission period and reporting period, it also shows the provider ID of each facility selected and the status of reporting on each data entry page, as well as the DACA for each facility. The status will display as either incomplete or completed. The measure code at the top of each column is a link that will go to the data entry screen for that measure. You will also notice that in the first image on this slide that there are two scroll bars outlined in red. You must use the horizontal scroll bar to access all of the data entry pages on the web based data collection tool. I will repeat, you must use the horizontal scroll bar to access all of the data entry ages in the web-based

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data collection tool. The image below the red horizontal scrollbar on this slide displays non-measure data, measure data and the DACA entry pages. And when you click on one of those pages you may find that you need to use that vertical scroll bar to complete the data entry process. Prior to entering data into the web-based data collection tool, we advise you to have all of the aggregated data values for each of the data entry pages readily available to facilitate timely submission. Please note that IPFs have until August 15, 2017 to enter or edit measure data and complete the DACA. And no data can be entered or edited, nor the DACA completed, in the system after the submission deadline. Data that is entered as of 11:59:59 on Tuesday, August 15th, will be considered final. We highly recommend that you submit the data as far in advance of the deadline as possible. At this point I would like to draw your attention to the green rectangle on the “Measure Selection” bar, specifically to highlight that CMS does not require the Screening for Metabolic Disorders measure nor the Transition Record measures to be submitted for payment year 2018. The web-based data collection tool was created prior to CMS’ decision to postpone the reporting period for these measures. Data for these measures is not required until payment year 2019 and will not be submitted to CMS until the summer of 2018.

Before we dive into a specific example of how to submit data to CMS via the web-based data collection tool, let’s review the data entry process at a high level.

1. First you will of course enter the data values into the system.
2. Next you must click the calculate button if it is applicable for the given measure.
3. Then you will click submit and after clicking submit, the calculate button will be replaced by an edit button. You can edit data entered into the web-based data collection tool any time before the August 15, 2017 deadline. And if you do choose to edit your data, then you will need to click calculate again and submit.
4. Once you are satisfied that you have submitted accurate data, you have the option to print your data.

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5. After printing your results, you will need to click the “Return to Summary” button to be able to return the Measures Summary screen and to make you next data entry selection.

The aim is to repeat the data entry process until the data entry status is complete for all the options in the Measures Summary screen. Please note that the non-measure data, the structural measures and the DACA are simple submissions that do not require calculations and so will not have calculate buttons available. We will be discussing those measures later in the presentation. In the next several slides we will review the data entry process step by step using the HBIPS-2 measure as an example.

Here you can see what the data entry screen will look like for the HBIPS-2 measure. The numerator field requires the entry of the total annual aggregate number of hours that all psychiatric inpatients were maintained in physical restraints while the denominator field requires entry of the total annual aggregate number of psychiatric inpatient days. Remember sampling is not allowed for this measure. And a zero or numeric value must be entered into each field because results cannot be calculated until data entry is complete. If the numerator is larger than the denominator, then you will review a message the denominator must be equal to or greater than the numerator. If this occurs, please review your data.

After the accurate numerator and denominator values are entered, click the “Calculate” button and the results will appear as depicted on this slide. As you can see, the value is expressed as a rate per 1,000 patient hours to two decimal places for the HBIPS-2 measure. Upon reviewing the data entered and the results, click the “Submit” button and an informational message will appear at the top of the screen, indicating that the data was successfully submitted.

This slide displays the informational message that will appear at the top of the screen. And from here you can click on the “Return to Summary” button and repeat the process to enter data on another data entry page.

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You have two opportunities to edit data during a measure submission process. First you may edit after calculating and before submitting data or you may edit after submitting the data.

This slide describes the first scenario for editing data. After data has been calculated, an “Edit” button will appear and this will prompt you to ensure that your results were calculated correctly. It also allows you to edit any incorrect data. Select the “Edit” button on that data entry page and then complete steps one through four of the “How to complete a Submission Process” described on slides 42 through 44 of this presentation. Once you have corrected your data, you must select the “Calculate” button followed by the “Submit” button in order to save the changes. If you leave any data entry page before clicking the “Submit” button, the data entered will be lost. There will be an informational warning message to which you must respond.

This slide describes the second scenario available to correct data during the data submission process. If you realize that you need to correct data after clicking the “Submit” button then before you leave the data entry pages, simply place your cursor in the field that requires editing and change the value. Once you have corrected your data you will need to select the “Calculate” button again, followed by the “Submit” button in order to save the changes. Again, if you leave any data entry page before clicking the “Submit” button, the data entered will be lost. Once submitted, data can be edited through either of the scenarios described prior to the August 15, 2017 submission deadline.

The first image on this slide displays the “Return to Summary” button. Once you have successfully submitted data for a specific measure, you will select the “Return to Summary” button and repeat the process to enter data on another data entry page. At that point the system will generate a message box as indicated by the second image on this slide. If you made changes that you have not yet saved, then you can select the “Cancel” button and remain on the page to submit your measure data, at which point the submission will be saved and you can proceed with the “Return to Summary” selection again.

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The IPF Provider Participation Report will be available during the data submission period for providers to review facility-level data for accuracy. The IPF Provider Participation Report will provide IPFs with a summary of the requirements for participation in the IPFQR Program and assist IPFs in determining their facility's status towards meeting the program requirements by providing information about the data that is submitted to the CMS Clinical Data Warehouse, following entry into the web-based application. Please note that the information provided in the IPF Provider Participation report does not guarantee the hospital will receive the full APU.

We recommend that you refer to Section 7: Accessing and Reviewing Reports of the IPFQR Program Manual for guidance on how to run the IPF Provider Participation Report. CMS recommends that you review and print your IPF Provider Participation Report for your own records.

Here you can see what the data entry screen will look like for the HBIPS-3 measure. HBIPS-3 requires entry of the numerator, which is the total annual aggregate number of hours that all psychiatric inpatients were held in seclusion, and the denominator, which is the number of psychiatric inpatients days. Note sampling is not allowed for HBIPS-3. Remember, a zero or numeric value must be entered to each field and results cannot be calculated until data entry is complete. If the numerator is larger than the denominator, then you will receive a message the denominator must be equal to or greater than the numerator. If this occurs, please review your data. After the numerator and denominator values are entered, click the Calculate button to populate the percentages in the result sections. A link to the HBIPS-2 and HBIPS-3 events tracking log, which is an optional paper tool designed to assist IPFs with data collection for reporting these measures, is located in the Helpful Resources section of this presentation, as are links to other optional paper tools. Now let's review the HBIPS-5 data entry page.

This slide shows the data entry screen for HBIPS-5. You are required to enter your annual aggregate numerator data, which should reflect the number of psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification from



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your IPF. Then you are required to enter your annual aggregate denominator data, which should accurately reflect the number of psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications from your IPF. CMS noted that the Joint Commission's guidelines for abstracting for this measure changed mid-year in 2016, as the patient referral to next level of care provider data element was changed to patient status at discharge. This change impacts step four in the measure abstraction process as described in the optional paper tool for the HBIPS-5 measure. When entering data in to the web-based data collection tool for this measure, you should enter the aggregate number of patients abstracted, based on the correct data element for the time period designated. Remember, HBIPS-5 requires that denominator values are non-zero if the numerator value is non-zero. A value must be in every data entry field before the results can be calculated. If data are missing, then an error message will appear that states that you must first enter either zero or a positive whole number in all numerator or denominator fields. Results cannot be calculated until data entry is complete.

The SUB-1 data entry screen requires you to enter your annual aggregate numerator data, which should reflect the number of psychiatric inpatients who were screened for alcohol abuse, using a validated screening questionnaire for unhealthy drinking, as well as your annual aggregate denominator data which should accurately reflect the number of psychiatric inpatient discharged from your IPF. The SUB-1 data values must be whole numbers and a value must be entered into each field. The denominator values must be non-zero if the numerator is a non-zero. And after entering the numerator and denominator values and clicking on the "Calculate" button, the results table will populate with annual percentages. Keep in mind that sampling is allowed for the SUB-1 measure. This is also true for the SUB-2/-2a measure, as well as the tobacco use measure that will be described in subsequent slides.

Now let's review the new fiscal year 2018 measures of SUB-2 and its subset 2a. The SUB-2/-2a entry screen requires you to enter your annual aggregate numerator data which should reflect the number of psychiatric

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inpatients who screened positively for unhealthy alcohol use and received or refused a brief intervention during the hospital stay for SUB-2 in the “Numerator 1” field. And the number of patients who received the brief intervention during the hospital stay for the subset SUB-2a will be entered in the “Numerator 2” field. You must also enter the annual aggregate denominator which should reflect the number of psychiatric inpatients discharged from your IPF that were 18 years of age and older, which screened positive for unhealthy alcohol use or an alcohol use disorder. The next two measures will be reviewed as structural measure. And these are simple attestations that do not require any calculation.

IPFs are expected to attest to the status of the facility as of December 31, 2016 with respect to the patient experience of care and the use of Electronic Health Record measures. Please note that with these two measures, entering numeric data or a zero does not apply and there is no paper tool option. Here is a screenshot of the data entry page that will appear when the use of Electronic Health Record measure is selected. As you can see in the statement above the yellow box all measure questions are required to be answered in order to fulfil the annual payment update, or APU, requirement. The EHR attestation requires that the IPF select one of the three statements listed on this slide, based on IPF activities on December 31, 2016. And after selecting an attestation, the IPF will respond to the following questions. Did the transfers of health information at times of transitions in care include the exchange of interoperable health information with a health information services provider? Yes, or no. Once a selection is made for the two questions, click “Submit.” Ensure that the green box appears in the top left corner to indicate that the data was entered and saved. And then either return to the Measures Summary page or in the case of a user entering information from multiple providers, you can click “Next Provider.”

To meet the Assessment of Patients’ Experience of Care measure requirements, IPFs will respond to the question: Did your facility routinely assess patient experience of care using a standardized collection protocol and a structured instrument? If the response is “yes,” then a

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prompt will appear requiring the name of the survey that the facility administers. If the response is “no,” then the “Submit” button will be selected and the requirement completed. To clarify some of the terminology pertaining to this measure, a survey is considered a structured instrument. The standardized collection protocol describes the process used to administer a survey or structured instrument. The image on this slide provides a visual of what you can expect to see when completing this attestation in the *QualityNet Secure Portal*.

The IMM-2 data entry screen requires you to enter your annual aggregate numerator data, which should accurately reflect the number of inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. As well as your annual aggregate denominator data, which should accurately reflect the number of inpatients six months and older discharged during the months of October, November, December, January, February or March. Be sure to check your IMM data entry for extreme outliers and/or incorrect data. As a reminder, a zero or numeric value must be entered into each field and results cannot be calculated until the data entry is complete.

The TOB-1 data entry screen requires you to enter your annual aggregate numerator data which should accurately reflect the number of patients who were screened for tobacco use within the first three days of admission. The TOB-1 data entry screen requires you to enter your annual aggregate numerator data which should accurately reflect the number of patients who were screened for tobacco use within the first three days of admission, as well as your annual aggregate denominator data, which should accurately reflect the number of hospitalized inpatients, 18 years of age and older. Keep in mind that sampling is allowed for the TOB-1 measure, as well as the other TOB measures.

CMS noted that the Joint Commission’s guidelines for abstracting for this measure, changed mid-year 2016 from calculating the number of patients who were screened within three days of admission to those screened within one day of admission. When entering data into the web-based data collection tool for this measure, you should enter the aggregate number of

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patients screened within those parameters during the time period designated by the joint commission. Again, as with the SUB measures described earlier, we want to emphasize the importance of verifying your TOB-1 data entry for extreme outliers and/or incorrect data. We recommend you review the guidance provided on slides 32 and 33 of this presentation pertaining to that information. And after entering the numerator and denominator values, clicking on the “Calculate” button, the results table will populate with the aggregate percentage value.

You will see here that the TOB-2/-2a data entry screen requires you to enter data for two numerators. The first numerator requires your annual aggregate data for TOB-2 which reflects the number of patients who received or refused practical counseling to quit, and received or refused the FDA approved cessation medications, or had a reason for not receiving the medication during the first three days after admission. The second numerator requires your annual aggregate data for TOB-2a which should accurately reflect the number of patients who received practical counselling to quit and received FDA-approved cessation medication, or had a reason for not receiving the medication during the first three days after admission. The denominator requires that you enter data pertaining to the number of hospitalized patients 18 years of age or older, identified as current tobacco users.

As with the TOB-2/-2a data entry screen, the TOB-3a screen also requires that you enter data for two numerators. The first numerator requires your annual aggregate data for TOB-3 which should accurately reflect the number of patients who were referred to, or refused evidence-based outpatient counselling, and received or refused a prescription for FDA-approved cessation medication upon discharge. The second numerator should reflect the annual aggregate data for TOB-3a, the subset of TOB-3a, which should reflect the number of patients who were referred to evidence-based outpatient counseling and received prescription for FDA-approved cessation medication upon discharge, as well as those who were referred to outpatient counseling and have reasons for not receiving a prescription for medication. The denominator involves data for the

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number of hospitalized patients 18 years of age or older identified as current tobacco users. Keep in mind that again, as with the other TOB measures, the TOB-3/-3a measures does allow for sampling. And, as described on slide 32, CMS has not determined criteria for identifying extreme outlier data because this is the first year that IPFs will report this data.

As for the non-measure data/population count entry screens, any data entered that is outside of the parameters described on slides 34 to slide 37 of this presentation, will need to be reviewed for accuracy and corrected. The non-measure data collection tool is an optional paper tool that you can use to collect information on population age categories, diagnostic categories and payer source categories. The tool also asks whether global sampling methodology was applied to the data. Providers that opted to sample their cases are prompted to submit their annual aggregate count of the sample size that was used. 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. Please remember, IPFs are not required to sample.

The purpose of this slide is to demonstrate the difference in what will appear depending on your response to the question: Did your facility use global sampling? If the answer is “yes,” another statement and field will appear. And if you select “no,” then this portion of the data entry page is complete.

Once you have successfully completed data entry for your measure data, structural data, and non-measure data, you will need to return to the Measure Summary page to verify that all the measures show a status of completed as displayed on the following slide. Each time you complete your data submission on a data entry page the web-based Measure Summary page will show a status of completed under the hyperlink of that page. We recommend that you retain printouts of each data entry page as well as the Measure Summary page for your records. When you are satisfied that you have submitted all of the requirements indicated on the Measure Summary screen you can proceed to the Data Accuracy and Completeness Acknowledgement, or DACA, screen.

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The sixth and final key to successful reporting for fiscal year 2018 is to review your submission before signing the DACA form. It is important that IPFs review all measure data for accuracy and completeness before and after it is submitted into the WBDCT and only then complete and submit the DACA. IPFs can submit or edit previously submitted measure data and complete the DACA prior to the submission deadline of August 15, 2017. A third-party vendor may submit data on an IPFs behalf if the vendor has been previously authorized. However, the facility must complete the online DACA form prior to the August 15, 2017 deadline. Again, it is the facility's responsibility to complete the DACA form, not the vendor.

The DACA is the only opportunity for IPFs to attest to the accuracy and completeness of the data submitted to CMS, which will be publicly displayed at a later date. IPFs cannot enter or edit data after the submission deadline. Again, we highly recommended that IPFs enter the data as far in advance of the August 15, 2017 deadline as possible.

All the data entered for the measures and non-measure data has been reviewed, verified and confirmed to be accurate, then it is time to complete the DACA form. This requires that a representative of the IPF click "Yes, I acknowledge" and then type in his or her position at the IPF. As a reminder, a third party vendor may submit data on an IPF's behalf if the vendor has been previously authorized. However, the facility must complete the online DACA form prior to the August 15<sup>th</sup> deadline.

Let's review the six keys to successful reporting.

1. First and foremost, you must ensure you have access to and are capable of logging in to the *QualityNet Secure Portal*.
2. The second key is that while one active security administrator is required, we strongly recommend that each IPF have at least two active security administrators so that one can serve as a back up to the other.
3. Third, be sure to manage the IPFQR Program Notice of Participation for your facility.

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4. The fourth key is to prepare and verify the accuracy of data prior to submitting.
5. The fifth key is to enter and verify accuracy of the data.
6. And finally you should review submissions to confirm that all IPFQR Program data reporting requirements are met before completing the DACA. Remember, policies do not allow for changes of data nor the completion of the DACA form after the data-submission deadline.

Remember to inform the IPFQR Program support contractor about key personnel changes, such as a change in leadership, at the CEO or administrator level, as well as any other quality reporting contacts. The best way to send us update of this nature is to send a completed Hospital Contact Correction Form via fax. The Hospital Contact Correction Form can be accessed from this slide and is also located on [qualityreportingcenter.com](http://qualityreportingcenter.com) website where you will click on:

- Inpatient, then
- IPF program, then
- Resources and Tools. And the form is the first item listed on the page.

This concludes my portion of today's webinar. I will now turn the presentation over to our moderator, Louisa Heath.

**Louisa Heath:** Thank you Evette. The next several slides include links to Helpful Resources.

CMS recommends that IPFs refer to the Program Manual for information pertaining to the IPFQR Program. This document is available for download at the *QualityNet* and *Quality Reporting Center* websites, at the links on this slide.

Here is a list of the optional paper tools that can assist you as you prepare IPF's data prior to engaging in the data submission process. You may access these tools by clicking on the links on this slide. The aim of these tools is to facilitate your preparation of the required measure and non-

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measure data to be submitted on or before August 15, 2017 for the fiscal year 2018 payment determination. We strongly recommend that you prepare your data prior to actually entering it in the *QualityNet Secure Portal*.

Another consideration to keep in mind as you prepare your data is that sampling is optional for the IPFQR program. IPFs can choose to use 100% of their inpatient population and therefore not sample. IPF may sample using previously used methodology as defined by the Joint Commission and Hospital Inpatient Quality Reporting Specifications Manuals. Or IPFs may choose to sample using the global population and sampling table located in the fiscal year 2016 IPF PPS final rule. Remember, sampling is not allowed for the HBIPS-2, HBIPS-3, or for the Influenza Vaccination Coverage Among Healthcare Personnel measures. For additional guidance and sampling options, please refer to the IPFQR Program Manual.

This slide includes active links that you can click on to send us your questions about the IPFQR Program. We encourage you to use the Q&A Tool in particular, because it provides the best means by which we can track questions and answers, and also deliver our responses straight into your email inbox. This is also a great way for you to let us know what types of questions and topics you would like for us to address in future webinars. We also recommend that you sign up for the IPFQR Program ListServe, if you have not done so already. Subscribing to ListServe will ensure that you receive communications that we send out to the IPFQR community pertaining to webinars, program updates and other announcements. You can sign up to be added to the ListServe on the *QualityNet* ListServe registration page. We encourage you to utilize available resources found on the *QualityNet* website in the “Inpatient Psychiatric Facilities” dropdown menu to ensure appropriate knowledge of the IPFQR Program requirements and deadlines.

Here is a list of our upcoming educational webinars for the IPFQR Program. As you can see, we do not have a webinar scheduled for the month of July. Our next scheduled webinar will be presented in August to discuss the fiscal year 2018 Final Rule as it pertains to the IPFQR Program, as well as, an overview of the Annual Payment Update



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reconsideration process. Additional webinar topics planned for later this year include a review of public reporting in the fiscal year 2018 data, as well as, a review of the dry run for the IPF Readmission measure. As a reminder, please ensure that you are signed up for the IPFQR Program ListServe where we will send the up-to-date information regarding the date and time of upcoming webinars. At this time, I'd like turn the presentation over to Deb Price who will explain a continuing education credit process for today's event.

**Deb Price:**

Thank you. This event has been approved for one continuing education credit. You must report your own credits to your respective board. Complete your survey and then register for your certificate. Registration is automatic and instantaneous. Therefore, if you do not get a response right away, there is a firewall blocking your link. You will need to register as a new user, using your personal email and phone number.

If you are a new user or have had any problems getting your credits, use a new user link. If you have not had any issues getting your credits, use the existing user link.

Thank you for joining us today. We hope you learned something. All questions will be answered and posted on our [qualityreportingcenter.com](http://qualityreportingcenter.com) website at a later date. Enjoy the rest of your day. Goodbye.