



Inpatient Psychiatric Facility Quality Reporting Program New Measures and Non-Measure Reporting – Part 2

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Purpose

During this presentation participants will learn about the measures pertaining to transition records, the Screening for Metabolic Disorders measure, and non-measure reporting requirements.

Learning Objectives

At the conclusion of this presentation, attendees will:

- Understand the specifications as well as keys to implementing and abstracting the following measures:
 - Transition Record with Specified Elements Received by Discharged Patients
 - Timely Transmission of Transition Record
 - Screening for Metabolic Disorders Measure
- Know the reporting requirements for new measures and non-measure data

Acronyms

| | | | |
|--------------|---|--------------|------------------------------------|
| AMA | Against Medical Advice | IPF | Inpatient Psychiatric Facility |
| APA | American Psychiatric Association | LDL-C | Low Density Lipoprotein C |
| APN | Advanced Practice Nurse | NHSN | National Healthcare Safety Network |
| BMI | Body Mass Index | PA | Physician Assistant |
| CMS | Centers for Medicare and Medicaid Services | PCP | Primary Care Physician |
| CY | Calendar Year | PPS | Prospective Payment System |
| FDA | Food and Drug Administration | PRN | Pro Re Nata |
| FY | Fiscal Year | SGAs | Second Generation Antipsychotics |
| HBIPS | Hospital-Based Inpatient Psychiatric Services | SUB | Substance Use Measure |
| HbA1c | Hemoglobin A1c | TBD | To Be Determined |
| IMM | Immunization Measure | TOB | Tobacco Use Measure |
| | | UTD | Unable To Determine |

Inpatient Psychiatric Facility Quality Reporting Program New Measures and Non-Measure Reporting – Part 2

TRANSITION RECORD MEASURES OVERVIEW

Transition Record Measures Overview

- The American Medical Association-convened Physician Consortium for Performance Improvement is “a national, physician-led initiative dedicated to improving patient health and safety.” (80 FR 46702)
- This consortium developed the transition record measures to prevent gaps in care transitions caused by the patient receiving inadequate or insufficient information that lead to avoidable adverse events and cost CMS approximately \$15 billion due to avoidable patient readmissions. (80 FR 46702)

Transition Record Measures Overview

The transition record measures

- Focus on effective and timely communication of specified elements with patients and between treatment settings, thereby promoting care coordination and enhancing continuity of care.
- Assess the rate at which IPFs provide detailed, personalized discharge information to patient and/or caregiver in order to achieve the following:
 - Improve quality of care
 - Decrease costs
 - Increase beneficiary engagement
 - Reduce avoidable readmissions
 - Increase patient safety

Inpatient Psychiatric Facility Quality Reporting Program New Measures and Non-Measure Reporting – Part 2

**TRANSITION RECORD WITH SPECIFIED
ELEMENTS RECEIVED BY DISCHARGED
PATIENTS MEASURE**

Transition Record with Specified Elements Received by Discharged Patients

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

The Transition Record with Specified Elements Received by Discharged Patients measure does the following:

- Replaces the HBIPS-6 Post-Discharge Continuing Care Plan measure, per the FY 2016 IPF PPS final rule
- Includes 11 required elements in the numerator, compared to four in HBIPS-6

Transition Record with Specified Elements Received by Discharged Patients

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

Description: 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, 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.

Transition Record with Specified Elements Received by Discharged Patients

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

Numerator: 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 of 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

Transition Record with Specified Elements Received by Discharged Patients

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

Advance Care Plan

- Documentation of advanced directives or surrogate decision maker OR
- Documentation of 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

Transition Record with Specified Elements Received by Discharged Patients

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

Denominator: All patients, regardless of age, discharged from the inpatient facility to home/self care or any other site of care

Denominator Exclusions:

- Patients who died
- Patients who left AMA or discontinued care

Implementation of the Transition Record with Specified Elements Received by Discharged Patients Measure

- The key to high performance for the Transition Record with Specified Elements Received by Discharged Patients measure is to ensure that:
 - A transition record exists for each patient prior to discharge
 - **All** specified elements for the measure need to be reviewed with the patient/caregiver, and this needs to be clearly documented

Content is key!

- A higher rate indicates better performance for this measure.

Relevant Terms for the Transition Record Measures

Definitions of these terms can be found in the IPFQR Program Manual, which is located here:

<http://www.qualityreportingcenter.com/inpatient/ipf/tools/>.

1. **24-hour/7-day contact information including physician for emergencies related to inpatient stay**
2. **Advance directives**
3. **Contact information for obtaining results of studies pending at discharge**
4. **Contact information/plan for follow-up care**
5. **Current medication list**
6. **Documented reason for not providing advance care plan**
7. **Inpatient facility**
8. **Major procedures and tests performed during inpatient stay and summary of results**
9. **Patient instructions**
10. **Plan for follow-up care**
11. **Primary physician, other health care professional, or site designated for follow-up care**
12. **Studies pending at discharge**
13. **Surrogate decision maker**
14. **Transition record**
15. *Transmitted*
16. *Within 24 hours of discharge*

Plan for Follow-up Care

A plan for follow-up care describes treatment and other supportive services to maintain or optimize health.

- The plan should include dates/times and contact information for follow-up care appointments, post-discharge therapy needed, any durable medical equipment needed, family/psychosocial/outpatient resources available for patient support, self-care instructions, etc.
- The plan should be developed with consideration of the patient's goals of care and treatment preferences.

24-hour/7-day Contact Information

Including Physician for Emergencies Related to Inpatient Stay

The 24-hour/7-day contact information data element must include the name and contact information for a health care team member who has access to medical records and other information concerning the inpatient stay and who could be contacted regarding emergencies related to the stay.

- 800 numbers, crisis lines, or other general emergency contact numbers **do not** meet this requirement.

Contact Information / Plan for Follow-up Care

For patients discharged to home, all eleven elements of the transition record are to be shared with the patient and/or caregiver.

For patients discharged to an inpatient facility, the transition record may indicate that the following four elements are to be discussed between the discharging and the receiving facilities.

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

Advance Directives

The term Advanced Directives is defined as the following:

- A written, signed statement that details the patient's preferences for treatment should the patient become unable to make such decisions, including for mental health reasons.
- A legal document that informs others about what treatment the patient would want or not want to receive from psychiatrists or other health professionals **concerning both psychiatric and non-psychiatric care**. The care plan may be in the form of two separate documents or combined in a single document.

Advance Directives

- Additionally, the statement identifies a person, such as a health care surrogate, to whom the patient has given the authority to make decisions on his/her behalf.
- Advance directives should be compliant with state laws for the state in which the patient receives care.

Advance Directives

A traditional advance directive typically includes information in the following categories:

- Designation of health care surrogate
- Medication instructions
- Facility preferences
- Emergency contacts
- Instructions for hospital staff
- Other instructions and/or medical information
- Organ Donation
- Execution of directives

Advance Directives

The National Hospice and Palliative Care Organization CaringInfo website has information on **traditional advance directives** by state:
<http://www.caringinfo.org/4a/pages/index.cfm?pageid=3289>

The screenshot shows the CaringInfo website page for Advance Directives. The header includes the National Hospice and Palliative Care Organization logo and the CaringInfo logo. The navigation menu includes Home, Advance Care Planning, Caregiving, Hospice and Palliative Care, Grief & Loss, and Resources. The main content area features a large image of a couple walking on a pier by the water. Below the image, there is a breadcrumb trail: Advance Care Planning > Advance Directives. The main heading is "Advance Directives" with several sub-links: "What are Advance Directives?", "Selecting Your Healthcare Agent", "Download Your State's Advance Directives", "Preparing Your Advance Directives", and "Storing Your Advance Directives". The primary call to action is "Download Your State's Advance Directives", which is followed by a paragraph explaining that CaringInfo provides free advance directives and instructions for each state that can be opened as a PDF file. Below this, there is a paragraph about copyright and permission, followed by two bullet points: "HIPAA Privacy Rule Summary" and "Appendix A: Glossary of Terms". At the bottom of the main content area, there is a link for "Instructions for Downloading Your Advance Directive". On the right side of the page, there is a search bar and a "moments of life.org" advertisement with a "Learn more" button. Below the advertisement, there is a "Download your state specific Advance Directive" button and a "Find a hospice" button.

Advance Directives

In addition to the categories found in a typical traditional advance directive, a psychiatric advance directive usually includes the following information:

- Crisis symptoms
- Relapse risk factors
- Protective factors
- Electroconvulsive therapy preferences

Advance Directives

Additional information on **psychiatric advance directives** can be found at the National Resource Center on Psychiatric Advance Directives website:

<http://www.nrc-pad.org/>.

The screenshot shows the homepage of the National Resource Center on Psychiatric Advance Directives (NRC-PAD). The header includes navigation links: Home, Who We Are, Glossary, PAD Stories, and Contact Us. The main title reads "NRC-PAD National Resource Center on Psychiatric Advance Directives". A "NEWS" section on the right highlights a featured state action on PADs in Virginia and featured videos by Delaney Ruston, MD. A left sidebar lists various resources like Getting started, State by State info, FAQs, Educational Webcasts, Links, Current Research, In the News, Legal Issues, Search, and Feedback. The main content area features a welcome message and three columns: "PATIENTS AND CONSUMERS" with a testimonial and a "Read More..." link; "HEALTH AND LEGAL PROFESSIONALS" with practical information and a "Find out more..." link; and "FAMILY MEMBERS AND FRIENDS" with information on preparing for crisis and a "More details..." link. A "State-by-State Information" section includes a map of the United States. The footer contains social media sharing options (Like, Share, Tweet) and a copyright notice for 2015.

Advance Directives

Scenario #1: The patient chart includes documentation that the patient completed an advance care plan with only advance directives pertaining to psychiatric care. Does this discharge meet the Advance Directives requirement for the Transition Record with Specified Elements Received by Discharged Patients measure?

- If the facility only discussed completion of a psychiatric advance directive with the patient and did NOT discuss completing a medical advance directive with the patient, then this case would not meet the numerator requirement for this measure. The facility must discuss both the psychiatric and the medical advance directives with the patient.

Advance Directives

Scenario #2: The patient chart includes documentation that advance directives were discussed with the patient. However, the patient does not wish to, or is unable to, complete an advance care plan. Does this case meet the Advance Directives requirement for the Transition Record with Specified Elements Received by Discharged Patients measure?

- Yes. If advance directives were discussed with the patient, but the patient does not wish to or is unable to complete an advance care plan, then this would qualify as a “Documented Reason for Not Providing an Advanced Care Plan.”

Documented Reason for Not Providing Advance Care Plan

This term pertains to documentation ascertaining that an advance directive or a surrogate decision maker was discussed with the patient but one of the following conditions applied:

- The patient did not wish or was not able to name a surrogate decision maker or provide an advance directive.
- The appropriate documentation indicates that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning or a surrogate decision maker. Any discussion for advance care is documented as adverse to the patient's beliefs, and thus harmful to the physician-patient relationship.

Current Medication List

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

- **Medications to be taken by patient:** Medications prescribed or recommended prior to IPF stay to be continued after discharge and new medications started during the IPF stay to be continued after discharge, as well as newly prescribed or recommended medications to begin taking after discharge. Prescribed or recommended dosage, instructions, and intended duration must be included for each continued and new medication listed.
- **Medications not to be taken by patient:** Medications (prescription, over-the-counter and herbal products) taken by patient before the inpatient stay that should be discontinued or held after discharge and medications administered during the inpatient stay that caused an allergic reaction, as well as medications with which current prescriptions may react.

Primary Physician, Other Health Care Professional, or Site Designated for Follow-up Care

This term pertains to the 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.

Transition Record

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

Inpatient Psychiatric Facility Quality Reporting Program New Measures and Non-Measure Reporting – Part 2

TIMELY TRANSMISSION OF TRANSITION RECORD

Timely Transmission of Transition Record

(Discharges From an Inpatient Facility to Home/Self Care or Any Other Site of Care)

- The Timely Transmission of Transition Record measure achieves the following:
 - Replaces the HBIPS-7 Post-Discharge Continuing Care Plan Transmitted to the Next Level of Care Provider Upon Discharge measure, per the FY 2016 IPF PPS Final Rule
 - Includes patients in the numerator with transmission of a transition record within 24 hours of discharge, compared to those transmitted within five days of discharge for HBIPS-7
 - Includes only transition records containing all of the elements that are required for the Transition Record with Specified Elements Received by Discharged Patients measure in the numerator.

Timely Transmission of Transition Record

(Discharges From an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Description: The percentage 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 healthcare professional designated for follow-up care within 24 hours of discharge.

Timely Transmission of Transition Record

(Discharges From an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Numerator: The number of 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 transition record elements (as defined by the Transition Record with Specified Elements Received by Discharged Patients measure) must be captured and transmitted within 24 hours of discharge to satisfy the measure numerator.

Timely Transmission of Transition Record

(Discharges From an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Denominator: All patients, regardless of age, discharged from an inpatient facility to home/self care or any other site of care

Denominator Exclusions

- Patients who died
- Patients who left against medical advice or discontinued care

Implementation of the Timely Transmission of Transition Record Measure

- The key to high performance for the Timely Transmission of Transition Record measure is to ensure that:
 - The transition record for each patient is transmitted within 24 hours of discharge
 - Confirmation of the time of record transmission is clearly documented in the transition record

Timing is key!

- A higher rate indicates better performance for this measure.

Relevant Terms for the Transition Record Measures

Definitions of these terms can be found in the IPFQR Program Manual, which is located here:

<http://www.qualityreportingcenter.com/inpatient/ipf/tools/>.

1. *24-hour/7-day contact information including physician for emergencies related to inpatient stay*
2. *Advance directives*
3. *Contact information for obtaining results of studies pending at discharge*
4. *Contact information/plan for follow-up care*
5. *Current medication list*
6. *Documented reason for not providing advance care plan*
7. *Inpatient facility*
8. *Major procedures and tests performed during inpatient stay and summary of results*
9. *Patient instructions*
10. *Plan for follow-up care*
11. *Primary physician, other health care professional, or site designated for follow-up care*
12. *Studies pending at discharge*
13. *Surrogate decision maker*
14. *Transition record*
15. **Transmitted**
16. **Within 24 hours of discharge**

Transmitted

- A transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record.
- The time and method of transmission should be documented.

Within 24 Hours of Discharge

To meet the Timely Transmission of Transition Record measure requirements, the transition record must be transmitted within 24 hours of the patient's discharge from the index facility.

NOTE: Within 24 hours of discharge is calculated as 24 consecutive hours from the time the facility ordinarily records the patient discharge.

Transmitted / Within 24 Hours of Discharge

Scenario #1: The patient chart includes documentation that the transition record does not include all 11 specified elements, but the record was transmitted to the next care provider within 24 hours of discharge. Does this case meet the requirements for the Timely Transmission of Transition Record measure?

- All eleven transition record elements – as defined by the Transition Record with Specified Elements Received by Discharged Patients measure – must be captured and transmitted within 24 hours of discharge to satisfy the measure numerator. This case would be included in the denominator but would not meet the numerator requirements of the Timely Transmission of Transition Record measure.

Transmitted / Within 24 Hours of Discharge

Scenario #2: Our facility still creates post-discharge continuing care plans according to the specifications of the HBIPS-6 measure, as we transition our system to include the 11 required elements of the new transition record measure. Nonetheless, we have successfully transmitted the continuing care plans to the next care provider within 24 hours of discharge. Do these cases meet the requirements for the Timely Transmission of Transition Record measure?

- All eleven transition record elements – as defined by the Transition Record with Specified Elements Received by Discharged Patients measure – must be captured and transmitted within 24 hours of discharge to satisfy the measure numerator. If the transition records do not include all 11 required elements, then these cases would be included in the denominator but would not meet the numerator requirement of the Timely Transmission of Transition Record measure.

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SCREENING FOR METABOLIC DISORDERS MEASURE

Overview of the Screening for Metabolic Disorders Measure

The Screening for Metabolic Disorders measure is a chart-abstracted measure developed by CMS to assess the percentage of discharges from an IPF for which a structured metabolic screening for four elements was completed in the past year.

This measure applies only to patients discharged with one or more FDA-approved, routinely scheduled, antipsychotic medications during the measurement period.

Rationale for the Screening for Metabolic Disorders Measure

- This measure aligns with a consensus statement released by the ADA, the APA, the American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity, which 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.
- Additional information regarding the clinical support for this measure may be found in the FY 2016 IPPS Final Rule at <http://www.gpo.gov/fdsys/pkg/FR-2015-08-05/pdf/2015-18903.pdf>.

Screening for Metabolic Disorders

Description: The percentage of patients with one or more routinely scheduled antipsychotic medications for whom a structured metabolic screening for four elements was completed in the 12 months prior to discharge.

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: The total number of patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period

Metabolic Screening Tests

The metabolic screening must contain four tests:

1. BMI
2. Blood pressure
3. Glucose or HbA1c
4. A lipid panel that includes
 - total cholesterol
 - triglycerides
 - high density lipoprotein
 - LDL-C levels

Metabolic Screening Criteria

- Screenings 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 another facility for which records are available to the reporting facility.
- The presence or absence of each screening element is determined by identifying the documentation of numeric lab results in the medical record.

Screening for Metabolic Disorders

Denominator Exclusions

The following patients are excluded:

- Patients for whom a screening could not be completed within the stay 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 less than 3 days

Screening for Metabolic Disorders

Denominator Exclusion Details

- The exclusion “due to the patient’s enduring unstable medical or psychological condition” aligns with other screening measures developed by The Joint Commission.
- Patient stays fewer than three days were excluded based on the rationale that IPFs could not be expected to complete all metabolic screening tests within the short time period.
- Since the look-back period for the screening is one year, patient stays equal or greater than 365 days are excluded.
- Patients who refuse screening will be included in the denominator. CMS encourages providers to educate patients about the importance of metabolic screening.

FDA-Approved Antipsychotic Medications

A comprehensive list of routinely scheduled, FDA-approved antipsychotic medications can be found in the Specifications Manual for Joint Commission National Quality Core Measures, Appendix C, Table Number 10.0: Antipsychotic Medications, available at <https://manual.jointcommission.org/>

Patients who are on PRN (“as needed”) antipsychotic medications or short-acting intramuscular antipsychotic medications do not count towards the denominator of this measure.

Implementation of the Screening for Metabolic Disorders Measure

- The key to high performance for the Screening for Metabolic Disorders measure is to ensure that:
 - The results of a structured metabolic screening for the four elements in the 12 months prior to discharge are clearly documented in the patient record.
 - Confirmation of when and where a structure metabolic screening was performed is clearly documented in the patient record.

Content and timing are key!

- A higher rate indicates better performance for this measure.

Allowable Values for Metabolic Tests

- Y (Yes) Documentation in the medical record for this stay or at any time during the 12 months prior to discharge includes the numerical value of the following:
 - BMI
 - Blood pressure
 - Blood glucose
 - All four components of the lipid panel
- N (No) Documentation in the medical record for this stay or at any time during the 12 months prior to discharge does not include the numerical value of the following:
 - BMI
 - Blood glucose
 - Blood pressure
 - All four components of the lipid panel, or unable to determine from medical record documentation

Notes for Abstraction for Metabolic Tests

- Review the medical record for the current patient stay. If you do not find evidence that one of the four required metabolic tests was documented during this stay, review available medical records for the 12 months prior to the date of discharge.
- If the metabolic test values were from any time during the 12 months prior to discharge, documentation in the patient record for this stay needs to include the original date which the value was calculated and the source of the information (e.g., medical record of a prior hospital stay, information obtained from another provider and the name of this provider).

Screening for Metabolic Disorders Measure

Data Elements

1. Admission Date
2. ***Body Mass Index (BMI)***
3. ***Blood Glucose***
4. Blood Pressure
5. Discharge Date
6. ***Lipid Panel***
7. Number of Antipsychotic Medications Prescribed at Discharge
8. ***Reason for Incomplete Metabolic Screening***

Body Mass Index

Definition

- The 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.

Notes for Abstraction

- Documentation of height and weight only is NOT an acceptable substitute for BMI.

Blood Glucose

Definition

- A lab test of glucose levels in the blood that complies with the American Diabetes Association guidelines. The guidelines currently recommend using the HbA1c, a fasting plasma glucose, or the 2-hour plasma glucose value after a 75g oral glucose tolerance test (OGTT) to test for diabetes.

Notes for Abstraction

- To meet the screening element for blood glucose value, the abstractor can either check for documentation of HBA1c, a fasting plasma glucose, or the 2-hour plasma glucose value after a 75g OGTT to test for diabetes.

Lipid Panel

Definition

- A lab test including at least the following four components: total cholesterol, triglycerides, high density lipoprotein, and low density lipoprotein.

Notes for Abstraction

- To meet the screening element for lipid panel, numeric values for all four components of the lipid panel need to be documented in the medical record. If any one of the components is missing, select “No.”

Reason for Incomplete Metabolic Screening

Definition

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

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 psychologic 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.

Additional Specifications

Additional specifications for the Screening for Metabolic Disorders measure, including a data dictionary and algorithm, are in development and will be included in the next release of the IPFQR Program Manual.

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REPORTING REQUIREMENTS

Reporting and Submission Period for FY 2018

| Measure | Reporting Period | Submission Period | Measure Type | Sampling Allowed |
|--|---------------------------------|----------------------------|----------------------|------------------|
| Transition Record with Specified Elements Received by Discharged Patients | July 1– December 31, 2016 | July 1– August 15, 2017 | Chart- Abstracted | Yes |
| Timely Transmission of Transition Record | July 1– December 31, 2016 | July 1– August 15, 2017 | Chart- Abstracted | Yes |
| Screening for Metabolic Disorders | July 1– December 31, 2016 | July 1– August 15, 2017 | Chart- Abstracted | Yes |

FY 2018 Non-Measure Data Collection

| Total Annual Discharges |
|-------------------------|
| |

| Age Strata | Total Annual Discharges |
|--------------------------------------|-------------------------|
| Children (≥ 1yr. and < 13 yrs.) | |
| Adolescent (≥ 13 yrs. and < 18 yrs.) | |
| Adult (≥ 18 yrs. and < 65 yrs.) | |
| Older Adult (≥ 65 yrs.) | |

| Payer | Total Annual Discharges |
|--------------|-------------------------|
| Medicare | |
| Non-Medicare | |

| Diagnostic Categories | Total Annual Discharges |
|---|-------------------------|
| Anxiety disorders (651) | |
| Delirium, dementia, and amnesic and other cognitive disorders (653) | |
| Mood disorders (657) | |
| Schizophrenia and other psychotic disorders (659) | |
| Alcohol-related disorders (660) | |
| Substance-related disorders (661) | |
| Other diagnosis – Not included in one of the above categories | |

| Measure | Total Annual Sample Size |
|--|--------------------------|
| HBIPS-5 | |
| SUB-1, SUB-2/2a, IMM-2, TOB-1, TOB-2/2a, TOB-3/3a, Transition Record, Timely Transition, Screening for Metabolic Disorders | |

Annual Global Sampling Guidelines: FY 2018 Payment Determination Year Onward

| IPFQR Measures Global Population and Sampling (FY 2016 IPF PPS Final Rule) | |
|---|------------------------------------|
| Number of Cases in Initial Patient Population | Number of Records to be Sampled |
| ≥ 6,117 | 1,224 |
| 3,057–6,116 | 20% |
| 609–3,056 | 609 |
| 0–608 | All cases |

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HELPFUL RESOURCES

Upcoming IPFQR Program Educational Webinar Dates

- **February 2016**
NHSN Registration and Influenza among Healthcare Personnel Measure Refresher
- **March 2016**
Care Transition Measures
- **April 2016**
TBD

IPFQR Program Resources

Revised resources available online include:

- IPFQR Program Manual
- IPF Abstraction Tools for the following Measures:
 - Event Tracking Log for HBIPS-2 and HBIPS-3
 - HBIPS-5
 - IMM-2
 - SUB
 - TOB

Revised IPFQR program resources are available on *QualityReportingCenter.com* under IPFQR Program Resources and Tools: <http://www.qualityreportingcenter.com/inpatient/ipf/tools/>

These resources will be available on the *QualityNet.org* website at a later date.

Other Helpful Links

- **Psychiatric Advance Directives** information can be found at: <http://www.nrc-pad.org/>
- **Physician Consortium for Performance Improvement (PCPI®) approved Quality Measures Manual:**
<http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI>
- **FY 2016 IPF PPS Final Rule:**
<http://www.gpo.gov/fdsys/pkg/FR-2015-08-05/pdf/2015-18903.pdf>

IPFQR Program General Resources



Q & A Tool

<https://cms-ip.custhelp.com>



Email Support

IPFQualityReporting@area-m.hcjis.org



Phone Support

866.800.8765



Inpatient Live Chat

www.qualityreportingcenter.com/inpatient



Monthly Web Conferences

www.QualityReportingCenter.com



Secure Fax

877.789.4443



ListServes

Sign up on
www.QualityNet.org



Website

www.QualityReportingCenter.com

QUESTIONS?
