



Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Support Contractor

IPFQR Program: Keys to Successful FY 2019 Reporting

Presentation Transcript

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Louisa Heath: Hello everyone and welcome to today's presentation. My name is Louisa Heath. I am a Project Manager for the Hospital Inpatient [Value, Incentives, and Quality Reporting] 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 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, titled *Keys to Successful FY 2019 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*. 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 for download. This session is being recorded and the slides, transcript, webinar recording, and questions and answers (Q&A) from this presentation will be posted on the *QualityNet* and *Quality Reporting Center* website at a later date. As a reminder, we do not recognize the Raised Hand feature in the Chat tool during webinars, and we will only respond to questions in the Chat tool pertaining to today's webinar topic.

The purpose of this presentation is to summarize the Fiscal Year (FY) 2019 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, the attendees will be able to summarize the Fiscal Year 2019 IPFQR Program requirements, follow the steps to avoid common submission errors in order to successfully submit data in the *QualityNet Secure Portal*, as well as locate and access helpful IPFQR

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Program resources. Now, I will turn the presentation over to our speaker, Evette Robinson.

Evette Robinson: Thank you, Louisa. The next couple of slides provide an overview of the data submission requirements for Fiscal Year 2019. In order to participate in the IPFQR Program and obtain full annual payment updates, or APU, for the Fiscal Year 2019 payment year, an IPF must meet the following requirements by August 15, 2018, unless otherwise noted. An IPF must maintain at least one active *QualityNet* Security Administrator, or SA, though we recommend at least two. The IPFQR Notice of Participation, or NOP, must have a pledge status of “participating.” The IPF must meet the two annual data submission deadlines. The first was the Influenza Vaccination Coverage among Healthcare Personnel measure data, which was due on May 15 of this year. The remaining IPFQR Program data requirements must be submitted by the August 15, 2018 deadline. These include the [Hospital-Based Inpatient Psychiatric Services] HBIPS-2, HBIPS-3 and HBIPS-5 measures; SUB-1, -2/-2a, -3/-3a measures, IMM-2, TOB-1, -2/-2a, -3/-3a; as well as the Use of Electronic Health Record and Assessment of Patient Experience of Care measures; the Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record measures; and the Screening for Metabolic Disorders, as well as non-measure data. Finally, once the measure and non-measure data have been entered, an IPF must complete the Data Accuracy and Completeness Acknowledgement, or DACA, form as an attestation that the data entered are in fact accurate and complete.

IPF’s that do not meet one or more of the IPFQR Program requirements by the August 15, 2018 deadline will be subject to a two percentage-point reduction to their APU for Fiscal Year 2019.

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.

Again, this slide shows you additional measures required for the IPFQR Program.

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Slide 14 shows the remaining measures required for the IPFQR Program. Also, as a reminder, the Follow-Up After Hospitalization for Mental Illness measure and the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF measure are claims-based measures. IPFs do not need to take any action for reporting these measures as they are calculated by CMS.

The next several slides will describe our recommended keys to successful reporting for the Fiscal Year 2019 payment determination.

The first key to successful reporting for the IPFQR Program is to access and log in to the *QualityNet Secure Portal*. The *QualityNet Secure Portal* is the only approved method for IPFQR Program data submission. All 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 two people with knowledge of the data are able to verify the accuracy of the data entered into the *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 link listed on this slide in step one, select the **[Inpatient Psychiatric Facility]** link on the left side on the *QualityNet* homepage, then follow the instructions to register.

Once registered, you will need to log in to the *QualityNet Secure Portal*, select the **[Login]** link on the right-hand side of the *QualityNet* homepage under *Log in to QualityNet Secure Portal*. If you are not enrolled in the *QualityNet Secure Portal* yet, you will be able to enroll at this time. If you are enrolled already, you will be able to log in at this step.

If you are already enrolled in the *QualityNet Secure Portal*, then enter your *QualityNet* user ID, password, and the Symantec VIP security code, then click 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. Then, you'll need to download a Symantec VIP access token and complete identity proofing.

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The second key to successful reporting is to ensure that the IPF has at least two active Security Administrators. A Security Administrator is a 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 Security Administrator at the time of the submission deadline, which will be August 15, 2018. A second Security Administrator is highly recommended as back-up in case the primary Security Administrators account expires. All users must log in to the *QualityNet Secure Portal* every 30 to 60 days to keep their accounts active. Consider putting a reminder on your calendar.

The next key to successful reporting is to manage the IPFQR Program Notice of Participation, or NOP. As mentioned earlier, an IPF must have a NOP status of “Participating” in the *QualityNet Secure Portal* by August 15, 2018, in order to be considered for the full Fiscal Year 2019 annual payment update. To access the NOP for one or more IPFs, you must be logged into the *QualityNet Secure Portal*. Once logged in, you will first click the **[Quality Programs]** tab on the *QualityNet Secure Portal* home screen. Then, select the **[Hospital Quality Reporting IQR, OQR, ASCQR, IPFQR, PCHQR]** option from the drop-down menu. Next, select **[View, Edit, Notice of Participation, Contacts, Campuses]** in the *Manage Notice of Participation* box, and then select **[Inpatient Psychiatric Facility (IPF) Notice of Participation]**.

To continue accessing a facility’s NOP, you must then 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, which is to click the Next button to view the IPFQR Notice of Participation menu. Click the **[Notice of Participation]** hyperlink in the lower right side of the page to view the NOP status.

The first image 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*

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Secure Portal. In other words, if two or more contacts are not listed in the *QualityNet Secure Portal*, then the notes highlighted in red in the second image on this slide will appear just above the Notice of Participation Summary Table. This is a reminder to add the names, 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, contact, or campus data. Make sure that both contacts have “Yes” indicated for email notifications, and once that information is saved in the *Secure Portal*, the notes highlighted in red will go away. If the IPF closes or chooses not to participate, contact the IPFQR Program support contractors to learn about next steps.

CMS strongly recommends that IPFs carry out the fourth key to successful Fiscal Year 2019 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 those who will submit data in the web-based data collection tool such as a vendor, but it also prevents IPFs from submitting extreme outlier values. It reduces or eliminates data entry editing. It also facilitates submission of data well in advance of the data submission deadlines and 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 facilities 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 we will review will be with respect to HBIPS-2 and HBIPS-3. The HBIPS-2, Hours of Physical Restraint Use measure, numerator data should include the total number of hours that all psychiatric inpatients were maintained in physical restraint while, for HBIPS-3, you will want to ensure that the values and the numerator for

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this measure reflect the total number of hours of seclusion. It is important to ensure that the values entered are the total number of hours, not minutes or days, that all psychiatric inpatients were placed in physical 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. Next, check the denominator data. By ensuring that the correct number of days are entered for the denominator, you should ensure that the number of days does not exceed 365 times the facility's bed capacity. 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, then use traditional rounding conventions. 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 entries and extreme outliers. We want to make sure that 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 with respect to 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. First of all, the HBIPS-2 and HBIPS-3 measures should have the same denominator values, which is the number of psychiatric inpatient days. If different denominator values are entered for HBIPS-2 and -3, then it is likely that the data are incorrect, and the data entries should be checked. Secondly the denominator values should not be less than the IPFs total annual discharges. If the denominator values for HBIPS-2 or 3 are less than the total number of patient discharges reported in the Non-Measure Data/Populations Counts data entry page, then it is likely that the data are incorrect, and the data entry should be reviewed. Finally, the denominator values should not exceed 365 times the total number of beds at the IPF. Again, if the aggregate number of patient days exceeds 365 times to get IPF total bed

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size, then it is likely that this data are incorrect, and data entries should be reviewed again.

To help clarify the points described in the previous slides, we will review examples of data points that should be called into question when preparing the HBIPS-2 and the 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 a discrepancy and the number of psychiatric inpatient days that you re-evaluate the values for accuracy before entering them into the web-based data collection tool.

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

Another helpful calculation to confirm accuracy for these measures is to review the denominators against the products of 365 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 2017 times the number of beds at this facility.

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 questionable data for the various measures. CMS determined that a rate equal to or greater than four hours per 1,000 patient hours of physical restraint for HBIPS-2, or seclusion for HBIPS-3, is considered questionable and should be reevaluated. The screen shot on this slide is an example of a questionable rate for the HBIPS-2 measure, in which the result is 8.33 hours per 1,000 patient hours.

This slide summarizes criteria for identifying questionable data for other measures for which IPFs will submit data during the data submission period. For all chart-abstracted measures listed in the first bullet of this

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slide, data are considered questionable if the numerator exceeds the denominator. For the Screening for Metabolic Disorders measure, CMS identified two additional criteria for determining whether the data are questionable. The first one is, if an IPF reports a zero value for the numerator and denominator of the Screening for Metabolic Disorders measures but reports values greater than 1 in the numerator and denominator of the HBIPS-5 measure, that would be considered questionable. Also, if a denominator value for the Screening for Metabolic Disorders measure is smaller than the denominator value for the HBIPS-5 measure, then the data for this Screening for Metabolic Disorders measure would be considered questionable.

A few key guidelines for preparing data for other measures as well as the Non-Measure Data/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 that 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. The denominator cannot be zero if the numerator is a non-zero number. Again, the denominator cannot be zero if the numerator is a non-zero number. There are additional guidelines that must be followed to prepare and verify accuracy of data that will be submitted on the Non-Measure Data/Population Counts screen, which we will review in the next few slides.

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, and this is where the aggregate counts are entered. This screen also asks for data pertaining to any sampling methodology that you may or may not have opted to apply to your population. Now, I would like to take a look at the parameters that are built into the Non-Measure Data/Population Counts tool and the data entry page to ensure that the data are entered correctly.

For example, the sum of the values entered into each subcategory on this data entry page must be equal the value of the Total Annual Discharges

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field located at the top of the Non-Measure Data/Population Counts screen. As you can see from the image on this slide, the Total Annual Discharge value represents the total number of annual Medicare and non-Medicare patients that were discharged after receiving care in the IPF.

The purpose of this slide is to show examples of the correct and incorrect examples of how to enter data by payer source and by age strata.

This slide shows examples of the incorrect as well as the correct way to enter data by diagnostic category.

Once you have prepared and verified the accuracy of the data, you will want to access the web-based data collection tool for the IPFQR Program to enter the measure and the non-measure data values. In the web-based data collection tool, the user will be able to enter and submit IPFQR Program structural and web-based data, as well as sign the DACA. To access a facility's measure data, you will need to first, click the **[Quality Programs]** tab on the *QualityNet Secure Portal* home screen. Then, select the **[Hospital Quality Reporting IQR, OQR, ASCQR, IPFQR, PCHQR]** option from the drop-down menu. Next, you will select the **[View/Edit Structural/Web-Based Measures/Data Acknowledgement (DACA)]**. Then, step four, you will select **[Inpatient Psychiatric Facilities Web-Based Measures/DACA]**.

The next step is to select the payment year which is the payment determination year that will be impacted by the current submission period. Select payment year **[2019]** and click the Continue button. One must have a role assigned 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. Instead, you will see the Measure Summary page, which we will review on the next slide. For users, such as vendors, who will 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 names of providers for which to enter data. Select all or choose to enter data for one provider at a time. The provider selection list includes the CCN and the facility names. Only facilities associated with the accounts currently

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logged in to the *QualityNet Secure Portal* will appear in the provider selection list. Upon selecting Continue you will see the web-based data collection tool for the IPFQR Program.

You will note that the measure summary page displays the submission period, the reporting period, 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 “Incomplete” or “Completed.” It also displays the measure code at the top of each column, which is a link that will go to the data entry screen for that measure or non-measure data entry page. You will also notice 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 in web-based data collection tool. The image below the red horizontal scrollbar on this slide displays all of the data entry pages. When you click on one of those pages, you may find that you will need to use these vertical scrollbars 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 aggregate data values for each of the data entry pages readily available to facilitate timely submission. Please note that IPFs have until August 15, 2018, to enter or edit measure data, non-measure data, and complete the DACA. 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 Pacific Time on August 15 will be considered final. We highly recommend that you submit the data as far in advance of the deadline as possible.

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. First, you will, of course, enter the data values into the system, and next you must click the Calculate button if it is applicable for the given measure. Then, you will click Submit. 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, 2018 deadline, at which point you would click Calculate again and then click Submit. Once you are satisfied that you have submitted accurate

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and correct data, you have the option to print your data. However, remember that the IPF participation and Facility, State and National Reports are available. After printing your results, you will need to click the Return to Summary button to be able to return to the Measures Summary screen and make your next data entry selection. The aim is to repeat the data entry process until the data entry status is complete for all of 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 a calculation and will not have Calculate buttons available. We'll be discussing those data entry pages 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 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 receive an error information message which will prompt you to review your data to ensure that the denominator is equal to or greater than the numerator. If this occurs, please be sure to 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 1000 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 were successfully submitted.

This slide displays the informational message that will appear at the top of the screen indicating that the measure data were saved and, therefore, successfully submitted. From here you can click on the Return to

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Summary button and repeat the process to enter data on another data entry page.

In fact, you have two opportunities to edit data during a measure submission period. First, you may edit after calculating and before submitting data, or you may edit after submitting the data. The next few slides will display the steps for each edit option in a couple of scenarios that we've put together to help explain this process.

This slide describes the first scenario available to correct the data during the process of submitting for any given measure. After data has been calculated, an Edit button will generate, and this will prompt you to ensure that your results have calculated correctly and allows you to edit incorrect data. Select the Edit button on that data entry page and then complete steps 1 through 4 of the How to Complete Data Submission Process described on the previous slides. Once you have corrected your data using the Edit button as described above, 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. Once submitted, data can be edited prior to the August 15 submission deadline.

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, before you leave the data entry page, simply place your cursor in the field that requires editing and change the value. Once you have corrected your data, you must select the Calculate button 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 and there will be an informational warning message to which you must respond. Again, once submitted, data can be edited prior to the August 15 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

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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 which will tell you that, if you made any changes and did not submit them, they will not be saved. If you do have changes that have not saved, 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.

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

Refer to Section 7: Accessing and Reviewing Report 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 Participation Report for your own records. In the next several slides, we will review the measure data and non-measure data entry screens. Refer to slides 12 through 14 of this webinar for information on which measures allow for sampling. Also, review slides 25 through 37 for guidance on how to ensure entry of accurate data. Here you can see what the data entry screens will look like for the HBIPS-2 measure. HBIPS-2 requires entry of the numerator, which is the total annual aggregate number of hours that all psychiatric inpatients were maintained in a physical restraint, and the denominator value, which is the number of psychiatric inpatient days.

The HBIPS-3 measure data entry screen requires entry of the numerator value, which is the total annual aggregate number of hours that all

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psychiatric inpatients were held in seclusion, and the denominator value, which is the number of psychiatric inpatient days.

On the data entry screen for HBIPS-5, you are required to enter the 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 the IPF. Then, you are required to enter the annual aggregate denominator data, which would accurately reflect the number of psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications from the IPF.

The SUB-1 data entry screen requires you to enter the annual aggregate numerator data, which should reflect the number of psychiatric inpatients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking within the first day of admission. It also requires entry of the annual aggregate denominator value, which should accurately reflect the number of psychiatric inpatients 18 years of age or older discharged from the IPF.

The SUB-2/-2a data entry screen requires that you enter the annual aggregate numerator data for the SUB-2 measure in the Numerator 1 field, and this should reflect the number of psychiatric inpatients who screened positively for unhealthy alcohol use and received or refused a brief intervention during the hospital stay. The Numerator 2 field should be populated with the numerator value for the SUB-2a measure, and that will reflect the number of patients who received the brief intervention during the hospital stay. You must also enter the annual aggregate denominator data which should accurately reflect the number of psychiatric inpatients discharged from your IPF that were 18 years of age and older who screened positive for unhealthy alcohol use or an alcohol-use disorder.

The SUB-3/-3a data entry screen requires you to enter the annual aggregate numerator data value for the SUB-3 measure in the Numerator 1 field, and that would reflect 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

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treatment. The Numerator 2 field is to be populated by the number of patients who, at discharge, received a prescription for medication for treatment of alcohol or drug use disorder or a referral for addictions treatment. You must also enter the annual aggregate denominator value, and that would accurately reflect the number of hospitalized patients 18 years of age or older who screened positive for unhealthy alcohol use or an alcohol-use disorder.

IPFs are expected to attest to the status of the facility as of December 31, 2017, with respect to the two structural measures, specifically the Use of an Electronic Health Record measure and the Assessment of Patient Experience of Care measure. Here, on slide 57, you can see the data entry screen for the Use of Electronic Health Record measure. The EHR attestation requires that the IPF select one of the three statements listed on this slide based on IPF activities on December 31, 2017. After selecting one of these attestations, the IPF will then respond to the following question: 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 (or HISP)? Once a selection is made for the two questions, select submit.

To meet the Assessment of Patient Experience of Care measure requirement, 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 prompt will appear requiring the name of the survey that the facility administered. 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 and the standardized collection protocol describes the process used to administer a survey or structured instrument.

The Transition Record with Specified Elements Received by Discharged Patients measure data entry screen requires you to enter the annual aggregate numerator data, which should accurately reflect the total number of patients regardless of age discharged from your facility to home or

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other site of care or their caregivers who received a transition record and with whom a review of all included information was documented at the time of discharge. The annual aggregate denominator data should reflect the total number of patients regardless of age discharged from your facility to home or other site of care.

The Timely Transmission of Transition Record measure data entry screen requires you to enter the annual aggregate numerator value, which should reflect the total number of patients regardless of age discharged from your facility to home or 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. The denominator value should accurately reflect the number of patients regardless of age discharged from your facility to home or other site of care.

The Screening for Metabolic Disorders data entry screen requires you to enter the annual aggregate numerator data, which should accurately reflect the total number of patients who received a screening for metabolic disorders either prior to or during the index IPF stay, and the denominator value, which should reflect the total number of discharges from the IPF during the measurement period with a prescription for one or more routinely scheduled antipsychotic medications.

The IMM-2 measure data entry screen requires you to enter the annual aggregate numerator data, which should reflect the number of inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge as indicated as well as the annual aggregate denominator data value, which should reflect the number of inpatients six months of age or older discharged during the months of October, November, and December of 2017, as well as January, February and March of 2018.

The TOB-1 data entry screen requires you to enter the annual aggregate numerator data, which should accurately reflect the number of patients who were screened for tobacco use within the first day of admission as well as an annual aggregate denominator data value, which should reflect

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the number of hospitalized inpatients 18 years of age and older. You will note a slight error in the numerator statement on the data entry screen. The numerator statement should read as follows: number of patients who were screened for tobacco use status within the first day of admission.

In the TOB-2/-2a data entry screen, the first numerator value that you're required to enter should reflect the annual aggregate data for TOB-2, which should equal the number of patients who received or refused practical counseling to quit and received or refused FDA-approved cessation medication or had a reason for not receiving the medication within the first day of admission. The second numerator value to be entered on this screen requires the entry of data pertaining to the TOB-2a subset measure, and that should reflect the number of patients who received practical counseling to quit and received FDA-approved cessation medication or had a reason for not receiving the medication within the first day of admission. The denominator value should reflect the number of hospitalized patients 18 years of age or older identified as current tobacco users.

The TOB-3/-3a data entry screen requires you to enter data for the first numerator which should reflect the value for TOB-3 and includes the 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. The second numerator value reflects the value for the subset TOB-3a and should include the 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 a reason for not receiving a prescription for medication. The denominator value should include the number of hospitalized patients 18 years of age or older identified as current tobacco users.

The Non-Measure Data/Population Counts data entry page collects data at the total annual aggregate discharge level, as well as the number of discharges by age strata, by diagnostic category, and by payer source.

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Further down on the data entry screen, it asks whether global sampling methodology was applied to the data. As a reminder, IPFs are not required to sample.

Here are a couple of images to show you what will appear if your facility used the global sampling methodology versus if you did not. If you select Yes, then a prompt will appear for you to enter the annual aggregate sample size used. If your facility did not use global sampling, then select No, and that portion of the data entry screen will be complete.

Upon completion of your data submission, the web-based Measures Summary page will show a status of “Completed” under the hyperlink of each data entry page. We recommend that you retain printouts of each data entry page, as well as the Measures Summary page for your records. When you are satisfied that you have submitted all of the requirements indicated on the Measures Summary screen, you can proceed to the Data Accuracy and Correctness Acknowledgement form, also known as DACA, which leads us to the sixth and final key to successful reporting.

It is important that IPFs review all measure data for accuracy and completeness before and after it is submitted into the web-based data collection tool and only then complete and submit the DACA. IPFs can submit or edit previously-submitted measure data and complete the DACA any time prior to the submission deadline of August 15, 2018. Please note that a third-party vendor may submit data on an IPF’s behalf as long as that vendor has been previously authorized. However, the facility must complete the online DACA form prior to the August 15 deadline.

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. Therefore, we highly recommend that IPFs enter the data as far in advance of the deadline as possible.

When all of the data entered for the measures and non-measures have been reviewed, verified, and confirmed to be accurate, then it is time to

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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.

Let’s review the six keys to successful reporting. First and foremost, you must ensure that you have access to and are able to log into the *QualityNet Secure Portal*. 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. Third, be sure to manage the IPFQR Program Notice of Participation for your facility. The fourth key is to prepare and verify the accuracy of data prior to submitting it into the web-based data collection tool. The fifth key is to enter the data and verify the accuracy of that data that is submitted to CMS via the web-based data collection tool. Finally, make sure to review your submissions before signing the DACA form. Again, remember that IPFs cannot change their data nor complete 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 updates of this nature is to send a completed Hospital Contact Change Form via fax. The Hospital Contact Change Form is located on the *QualityReportingCenter.com* website, where you will click on **[Inpatient]**, then **[Hospital IQR Program - Resources and Tools]**, and the form is the first item listed on the page. You can also access the form by clicking on the link on this slide. This concludes my portion of today’s webinar. I will turn the presentation over to Louisa.

Louisa Heath:

Thank you, Evette. The next several slides include links to helpful resources.

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. IPFs 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

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located in the Fiscal Year 2016 IPF PPS (Inpatient Psychiatric Facility Prospective Payment System) Final Rule. Remember, sampling is not allowed for the HBIPS-2, HBIPS-3, and the Influenza Vaccination Coverage Among Healthcare Personnel measures. For additional guidance on sampling options, please refer to the IPFQR Program Manual.

CMS recommends that IPFs refer to the program manual for information pertaining to the IPFQR Program. This document is available for download along with various optional paper tools on the *QualityNet* and *Quality Reporting Center* websites at the links on this slide.

You can click on the title of the table on this slide to access the IPFQR Program resources page on the *QualityNet* website. Additional active links on this slide are available for you 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 it also delivers our responses to your e-mail inbox.

Additionally, this is 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 recommend that you sign up for the IPFQR Program ListServe, if you have not already, so 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 drop-down menu to ensure appropriate knowledge of the IPFQR Program requirements and deadlines.

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

On this slide, we have a couple of upcoming educational webinar events that are planned through the third quarter of 2018. Again, please monitor your e-mails to ensure that you receive information regarding these webinars by the IPFQR Program ListServe at a later date. This concludes the content portion of the webinar, entitled *IPFQR Program: Keys to*

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Successful Fiscal Year 2019 Reporting. I will now turn the presentation over to Doctor Deb Price, who will describe the continuing education process for this event.

Debra Price:

Thank you. This event has been approved for one continuing education credit. You must report your own credit to your respective boards.

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 e-mail and phone number. If you are a New User or have had problems getting your credits, use the 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* website at a later day. Enjoy the rest of your day. Goodbye.