



# **Inpatient Psychiatric Facility Quality Reporting Program Manual**

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

**January 06, 2016**

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# Section 1: CMS Inpatient Psychiatric Facility Quality Reporting Program

## Overview

The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program was developed as mandated by section 1886(s)(4) of the Social Security Act, and amended by Sections 3401(f) and 10322(a) of the Affordable Care Act (Pub.L.111-148). It was implemented on October 1, 2012 as a Centers for Medicare & Medicaid Services (CMS) pay-for-reporting program.

The IPFQR pay-for-reporting program is intended to equip consumers with quality of care information to make more informed decisions about healthcare options. It is also intended to encourage psychiatric facilities and clinicians to improve the quality of inpatient care provided to patients by ensuring that providers are aware of and reporting on best practices for their respective facilities and type of care. To meet the IPFQR Program requirements, Inpatient Psychiatric Facilities (IPFs) are required to collect and submit all quality measures in the form, manner, and time as specified by the Secretary, to CMS, which began with the Fiscal Year (FY) 2014 annual payment update (APU) and continues in subsequent fiscal years.

This Program Manual is intended for use as a quick reference to assist in the implementation of the program. Links to the websites that display the measure specifications are provided, as this manual does not contain the specifications for the individual measures. Each section of the manual provides detailed instructions for completing the steps necessary for successful implementation of the IPFQR Program:

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

## QualityNet

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

## Eligibility

All IPFs paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) are subject to the IPFQR program requirements. The IPF PPS applies to inpatient psychiatric services furnished by Medicare participating entities in the United States that are classified as

psychiatric hospitals or psychiatric units in acute care or critical access hospitals (CAHs). This includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

## **Additional Program Information**

Additional information about the IPFQR Program can be found on *QualityNet* by selecting the Inpatient Psychiatric Facilities tab (direct link):

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

National Provider Webinars are provided by CMS and by the IPFQR Support Contractor on a routine basis. The slides from each of the education sessions are published to the *QualityNet* website and are available for review under the Inpatient Psychiatric Facilities tab, by selecting the Webinars/Calls link from the drop-down menu.

## **Glossary of Terms**

**Acute Care Hospital (ACH)** – A hospital providing inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).

**Aggregate (data)** – Aggregate data elements derived for a specific hospital from the results of each measures algorithm over a given period of time period (e.g. quarterly).

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

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

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

**Data Accuracy and Completeness Acknowledgement (DACA)** – A requirement for IPFQR Program participating facilities, the DACA is an electronic acknowledgement indicating that the data provided to meet the APU data submission requirements are accurate and complete to the best of the facility's knowledge at the time of data submission.

**Data Collection** – The act or process of capturing raw or primary data from a single or number of sources, also called “data gathering.”

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

**Excluded Populations** – Detailed information describing the populations that should not be included in the indicator. For example, specific age groups, ICD-9-CM procedure or diagnostic codes, or certain time periods could be excluded from the general population drawn upon by the indicator.

**Initial Patient Populations** – Detailed information describing the population(s) that the indicator intends to measure. Details could include such information as specific age groups,

diagnoses, ICD-9-CM diagnostic and procedure codes, CPT codes, revenue codes, enrollment periods, insurance and health plan groups, etc.

**Format** – Specifies the character length of a specific data element; the type of information the data element contains: numeric, decimal, number, date, time, character, or alphanumeric; and the frequency with which the data element occurs.

**Hospital Based Inpatient Psychiatric Services (HBIPS) Core Measure Set** – A specific set of measures developed and maintained by The Joint Commission for the inpatient psychiatric population, some of which are used by CMS in the IPFQR Program. In 2007, The Joint Commission, the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the NASMHPD Research Institute, Inc. (NRI) collaborated on the development of performance measures specific to hospital-based inpatient psychiatric services.

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

**Measure Information Form** – This tool provides specific clinical and technical information on a measure. The information contained includes: measure set, performance measure name, description, rationale, type of measure, improvement noted as, numerator/denominator/continuous variable statements, included populations, excluded populations, data elements, risk adjustment, data collection approach, data accuracy, measure analysis suggestions, sampling, data reported as, and selected references.

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

**Notice of Participation (NOP)** – A requirement for IPFQR Program participating facilities, the NOP indicates a facility’s agreement to participate in the program and to allow public reporting of its measure rates. The NOP has three options: agree to participate, do not agree to participate, and request to be withdrawn from participation.

**Numerator** – The upper portion of a fraction used to calculate a rate, proportion, or ratio.

**Patient Level Data** – Collection of data elements that depict the healthcare services provided to an individual (patient). Patient-level data are aggregated to generate data at the setting level (e.g., hospital) and/or comparison group data.

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

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

**Sampling Method** – Describes the process used to select a sample. Sampling approaches for the IPFQR Program are simple random sampling and systematic random sampling. Refer to the “Sampling Approaches” discussion in the Population and Sampling Specifications section of the respective manuals for further information.

**Sampling Size** – The number of individuals or particular patients included.

**Simple Random Sample** – A process in which a sample is selected from the total population in such a way that every case has a similar chance of being selected.

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

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

**Strata** – See stratified measure.

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

**Systematic Random Sampling** – A process in which the starting case is selected randomly and the next cases are selected according to a fixed interval based upon the number of cases in the population. Refer to the “Sampling Approaches” discussion in the Population and Sampling Specifications section of the respective manuals for further information.



## **Proposed Rule and Final Rule Publication Site**

Every year, CMS publishes proposed program and policy changes to the IPFQR Program in April. The proposed changes are published to the *Federal Register* and are open to the public for review and comment for 60 days. CMS also provides notices through the *QualityNet* website to ensure broad awareness. Following the comment period, CMS summarizes the comments and responds to them in the final rule. The final rule is published in August.

The IPFQR Program was implemented with the FY 2013 IPPS Final Rule, published August 31, 2012. Information for the IPFQR Program begins on page 53644 of the FY 2013 IPPS Final Rule (direct download, 15.16 MB): <http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/FR-2012-08-31.pdf>.

The FY 2014 IPPS Final Rule was published August 19, 2013. The rule contained updated information applicable for FY 2015 and beyond. Information for the IPFQR Program begins on page 50887 (direct download, 15.16 MB): <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf>.

The FY 2015 IPF PPS Final Rule was published on August 6, 2014. The rule contained changes to the IPFQR Program applicable for FY 2016 and beyond (direct download, 15.16 MB): <http://www.gpo.gov/fdsys/pkg/FR-2014-08-06/pdf/2014-18329.pdf>.

The FY 2016 IPF PPS Final Rule was published on August 5, 2015. The rule contained changes to the IPFQR Program applicable for FY 2016 and beyond (direct download, 790 KB): <http://www.gpo.gov/fdsys/pkg/FR-2015-08-05/pdf/2015-18903.pdf>.

## IPFQR Program Requirements

The FY 2017 IPFQR requirements are listed below. Click on the hyperlink imbedded within the text to be directed to detailed instructions for each step, as necessary.

1. Complete the [QualityNet Registration](#).
  - This step must be accomplished for each [QualityNet Security Administrator \(SA\)](#) and user who will access the *QualityNet Secure Portal*.
  - Once registered, it is important that the SA(s) and user(s) maintain an active account by periodically logging into the system. CMS recommends that each IPF have at least two SAs, so that one can serve as a backup.
2. Complete the IPFQR Program [Notice of Participation](#) (NOP), indicating participation status.
  - Newly eligible facilities have 180 days from the Medicare Accept date to submit an NOP for the IPFQR Program.
  - An IPF NOP status of “Participating” must be on file in the *QualityNet Secure Portal* by the annual August 15 deadline in order to meet the NOP requirement. Once a participation status is selected, the status automatically carries over year after year.
  - Any eligible IPF that chooses not to participate in the program should contact the IPFQR Program VIQR Project Lead by emailing [IPFQualityReporting@hcqis.org](mailto:IPFQualityReporting@hcqis.org).
3. Collect measure data during the measure reporting period.
  - The measure reporting period is January 1, 2015 through December 31, 2015 (1Q 2015 through 4Q 2015) for 9 chart-abstracted IPF quality measures.
  - IPFs are to report the status of the facility for the two structural measures as of December 31, 2015.
  - For the IMM-2 and the Influenza Vaccination Coverage Among Healthcare Personnel measures, the reporting period is October 1, 2015 through March 31, 2016.
4. Submit measure data before the annual data submission deadlines.
  - The Influenza Vaccination Coverage Among Healthcare Personnel measure data is due to the National Healthcare Safety Network (NHSN) by May 15, 2016.
  - The chart-abstracted IPF quality measures and two structural measures are due July 1, 2016 through August 15, 2016.
  - The claims-based measure is calculated by CMS using Medicare fee-for-service Parts A and B claims data; therefore, no action is required by IPFs for this measure.
5. Complete the Data Accuracy and Completeness Acknowledgement (DACA) by the August 15, 2016 submission deadline.

## Section 2: Measure Specifications

Information for this program manual was developed for use by facilities participating in the CMS IPFQR Program. Measures adopted by CMS for the IPFQR program are from a variety of sources, and unless otherwise indicated, the specifications are generally the same as those of the original measure steward. **They are not intended to provide direction for reporting to The Joint Commission, the National Committee for Quality Assurance (NCQA), or NHSN.** For detailed measure specifications, please refer to: The *Specifications Manual for Joint Commission National Quality Core Measures*, The *Specifications Manual for National Hospital Inpatient Quality Measures*, the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) Measures Technical Specifications, and the NHSN specifications.

The measure specifications are periodically updated by the measure stewards. IPFs and vendors must update their documentation and software when applicable, based on the published manuals.

Vendors supporting the IPFQR Program must be aware that the reporting and submission requirements for CMS may differ from those of The Joint Commission. Generally, measure specifications are released on a bi-annual basis, spanning two calendar quarters, in January and July of each year. When abstracting data for a particular quarter, it is important for the facility to use the specifications applicable to that quarter. For example, for IPFQR reporting applicable to the FY 2017 annual payment update, the quarters being collected are first quarter 2015 through fourth quarter 2015. This requires the facility to reference one *Specifications Manual* for collection of the first three quarters of 2015 and a different version of the *Specifications Manual* for the fourth quarter of 2015.

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

### **Inpatient Psychiatric Facility Quality Measures**

#### ***FY 2017***

Effective for the FY 2017 payment determination and subsequent years, CMS added four new measures to the IPFQR Program. Three are chart-abstracted measures: Tobacco Use Screening (TOB-1); Tobacco Use Treatment Provided or Offered (TOB-2) and the subset Tobacco Use Treatment (TOB-2a); and Influenza Immunization (IMM-2).

The fourth new measure is Influenza Vaccination Coverage Among Healthcare Personnel. The facility will report data for this measure through the NHSN website.

CMS removed one measure from the IPFQR Program for the FY 2017 payment determination and subsequent years: Patients Discharged on Multiple Antipsychotic Medications (HBIPS-4).

**NOTE:** Data collection for all new measures begins with first quarter 2015 discharges, except for the IMM-2 and Influenza Coverage Among Healthcare Personnel measures, which begin with fourth quarter 2015. The measures are shown in the following table:

**TABLE 1: FY 2017 Measures**

Measure ID	Measure Description
<b>HBIPS-2</b>	Hours of Physical Restraint Use
<b>HBIPS-3</b>	Hours of Seclusion Use
<b>HBIPS-5</b>	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
<b>HBIPS-6</b>	Post-Discharge Continuing Care Plan
<b>HBIPS-7</b>	Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge
<b>SUB-1</b>	Alcohol Use Screening
<b>FUH</b>	Follow-Up After Hospitalization for Mental Illness
<b>TOB-1</b>	Tobacco Use Screening*
<b>TOB-2/-2a</b>	Tobacco Use Treatment Provided or Offered* and the subset Tobacco Use Treatment*
<b>N/A</b>	Assessment of Patient Experience of Care
<b>N/A</b>	Use of an Electronic Health Record
<b>IMM-2</b>	Influenza Immunization*
<b>N/A</b>	Influenza Vaccination Coverage Among Healthcare Personnel*

\* New quality measures for the FY 2017 payment determination and subsequent years

## ***FY 2018***

Effective for FY 2018 payment determination and subsequent years, CMS added five new measures to the IPFQR program. All five are chart-abstracted measures:

- Tobacco Use Treatment Provided or Offered at Discharge (TOB-3) and the subset Tobacco Use Treatment at Discharge (TOB-3a)
- Alcohol Use Brief Intervention Provided or Offered (SUB-2) and the subset Alcohol Use Brief Intervention (SUB-2a)
- Transition Record with Specified Elements Received by Discharged Patients
- Timely Transmission of Transition Record
- Screening for Metabolic Disorders

CMS removed two measures from the IPFQR Program for the FY 2018 payment determination and subsequent years: Post Discharge Continuing Care Plan Created (HBIPS-6) and Post Discharge Continuing Care Plan Transmitted to Next Level of Care at Discharge (HBIPS-7).

**NOTE:** Data collection for all new measures begins with first quarter 2016 discharges, except for the Transition Record with Specified Elements Received by Discharged Patients, Timely Transmission of Transition Record, and Screening for Metabolic Disorders measures, which begin with third quarter 2016 discharges. The measures are shown in the table below:

**Table 2: FY 2018 Measure**

<b>Measure ID</b>	<b>Measure Description</b>
<b>HBIPS-2</b>	Hours of Physical Restraint Use
<b>HBIPS-3</b>	Hours of Seclusion Use
<b>HBIPS-5</b>	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
<b>SUB-1</b>	Alcohol Use Screening
<b>SUB-2/-2a</b>	Alcohol Use Brief Intervention Provided or Offered and the subset Alcohol Use Brief Intervention
<b>FUH</b>	Follow-Up After Hospitalization for Mental Illness
<b>TOB-1</b>	Tobacco Use Screening
<b>TOB-2/-2a</b>	Tobacco Use Treatment Provided or Offered and the subset Tobacco Use Treatment
<b>TOB-3/-3a</b>	Tobacco Use Treatment Provided or Offered at Discharge and the subset Tobacco Use Treatment at Discharge*
<b>Transition Record with Specified Elements Received by Discharge Patients</b>	Transition Record with Specified Elements Received by Discharge Patients*
<b>Timely Transmission of Transition Record</b>	Timely Transmission of Transition Record*
<b>Screening for Metabolic Disorders</b>	Screening for Metabolic Disorders*
<b>N/A</b>	Assessment of Patient Experience of Care
<b>N/A</b>	Use of an Electronic Health Record
<b>IMM-2</b>	Influenza Immunization
<b>N/A</b>	Influenza Vaccination Coverage Among Healthcare Personnel

\* New quality measures for the FY 2018 payment determination and subsequent years.

## **Identifying the Initial Patient Population**

The initial selection of cases (i.e., patient medical records) intended for data abstraction under the IPFQR Program must meet the following criteria:

- The cases must be patients (Medicare and non-Medicare) receiving care in a psychiatric hospital or psychiatric unit paid under IPF PPS.

For specific details regarding the Initial Patient Population, refer to the corresponding Measure Information Form (MIF) published within the applicable *Specifications Manual*:

- HBIPS - [Specifications Manual for Joint Commission National Quality Measures](#)
- SUB, TOB, IMM - [Specifications Manual for National Hospital Inpatient Quality Measures](#) (Section 2 – Measure Information, Section 2.10 – Prevention)

### ***HBIPS Population***

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

### ***Event Measures (HBIPS-2 and HBIPS-3)***

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

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

### ***Discharge Measure (HBIPS-5)***

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

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

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

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

## **Sampling**

IPFs are *not* required to sample. IPFs submit data for either a complete population of cases or a random sample for each of the measure sets covered by the quality measures. Per the FY 2016 IPF PPS Final Rule, IPFs are no longer required to report measure data by quarter and age strata. If the initial patient population size does not exceed the minimum number of cases per year for the measure set, the facility must submit 100% of the initial patient population.

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

### ***FY 2017 Payment Determination***

The following two options are available for measure data collected by IPFs during the 2015 calendar year and reported to CMS in 2016, impacting the FY 2017 payment determination:

- No sampling
- Use existing sampling methodologies:
  - HBIPS sampling
  - Global sampling where this method is already built into the measure specifications

IPFs will continue referencing the population and sampling guidelines described in the following manuals:

- [\*Specifications Manual for Joint Commission National Quality Measures\*](#): HBIPS-5 through HBIPS-7.
- [\*Specifications Manual for National Hospital Inpatient Quality Measures \(Section 4 – Population and Sampling Specifications\)\*](#): SUB-1, TOB-1, TOB-2/-2a; IMM-2.

### ***FY 2018 Payment Determination and Subsequent Years***

Data collected by IPFs during the 2016 calendar year will be reported to CMS in 2017 and impact the FY 2018 payment determination. IPFs will have two options from which to choose with respect to population and sampling of measure data.

**Option 1** – IPFs may choose not to sample.

**Option 2** – IPFs may choose to continue referencing the population and sampling guidelines described in the following manuals:

- [\*Specifications Manual for Joint Commission National Quality Measures\*](#): HBIPS-5 only
- [\*Specifications Manual for National Hospital Inpatient Quality Measures \(Section 4 – Population and Sampling Specifications\)\*](#): SUB-1, SUB-2/-2a, TOB-1, TOB-2/-2a, TOB-3/-3a, IMM-2.

**NOTE:** The Transition Record with Specified Elements Received by Discharged Patients, Timely Transmission of Transition Record, and Screening for Metabolic Disorders measures will use the same population and sampling guidelines as the SUB, TOB, and IMM measures.

**Option 3** – The table below lists the global population and sampling guidelines for measures that allow sampling. This option was adopted in the FY 2016 IPF PPS Final Rule and goes into effect for the FY 2018 payment determination year.

**TABLE 3: 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

The guidelines listed in the table above can be applied to the following measures: HBIPS-5, SUB-1, SUB-2/-2a, TOB-1, TOB-2/-2a, TOB-3/-3a, IMM-2, Transition Record with Specified Elements Received by Discharged Patients, Timely Transmission of Transition Record, and Screening for Metabolic Disorders.



## Chart Abstraction

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

### ***Chart-Based Measures: HBIPS-2, -3, and -5***

The HBIPS measure set was developed by The Joint Commission as part of a group of global measure sets. Although CMS is collecting the aggregate numerators and denominators for each HBIPS measure, it is necessary to collect the patient level data for each measure as defined in the applicable *Specifications Manual*. The data dictionary provides important details about each of the data elements needed to determine the numerators and denominators of each measure.

#### ***HBIPS-2: Hours of Physical Restraint Use***

The use of physical restraints increases a patient's risk of physical and psychological harm. This intervention is intended for use only if a patient is in imminent danger to him/herself or others and if less restrictive interventions have failed. It is not intended to address staff shortages or to be used as a form of discipline or coercion. This measure evaluates the total number of hours that all patients admitted to the IPF were maintained in physical restraints.

The **numerator** is defined as the total number of hours that all psychiatric inpatients were maintained in physical restraint. The **denominator** is defined as the number of psychiatric inpatient hours overall. Total leave days are excluded from the denominator.

#### ***HBIPS-3: Hours of Seclusion Use***

The use of seclusion increases a patient's risk of physical and psychological harm. This intervention is intended for use only if a patient is in imminent danger to him/herself or others and if less restrictive interventions have failed. It is not intended to address staff shortages or to be used as a form of discipline or coercion. This measure is reported as the total number of hours of seclusion use for all patients admitted to an IPF.

The **numerator** is defined as the total number of hours all psychiatric inpatients were held in seclusion. The **denominator** is defined as the number of psychiatric inpatient hours overall. Total leave days are excluded from the denominator.

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

This measure is collected on those patients discharged on multiple antipsychotics and is reported as the rate of patients discharged on multiple antipsychotics with appropriate justification. The Joint Commission has identified the following justifications as appropriate reasons for discharging a patient on multiple antipsychotics:

- The medical record contains a documented minimum of three failed trials with monotherapy.
- The medical record contains documentation of either a plan that tapers to monotherapy or one that decreases the dosage of one or more antipsychotic medications while increasing the dosage of another to a level that manages the patient's symptoms with one antipsychotic medication (i.e., cross-tapering).
- The medical record contains documentation of augmentation of Clozapine.

Higher rates on HBIPS-5 indicate higher quality of care because documenting the reasons for assigning two or more antipsychotics suggests that careful consideration of the benefits of this course of treatment were weighed against the potential patient side effects.

The **numerator** statement is defined as psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification. The **denominator** is defined as psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications, with or without justification. The measure excludes patients who died, patients with an unplanned departure resulting in discharge due to elopement, patients with an unplanned departure resulting in discharge due to failing to return from leave, and patients with a length of stay less than or equal to three days.

For detailed HBIPS measure information, including specific data element definitions, please refer to the *Specifications Manual for Joint Commission National Quality Measures* - <https://manual.jointcommission.org/>. The measure information is contained in Section 1 under the Measure Information Forms Section. The HBIPS data elements are located under Section 2-Data Dictionary. The Paper Abstraction Tools are located under the IPFQR Measures Resource section:

<https://www.QualityNet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228773653066>

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

As with the HBIPS measures, it is necessary to collect patient-level data, as defined in the applicable Specifications Manual. Facilities are required to submit aggregate data (one numerator and one denominator) for the entire reporting period.

### ***SUB-1: Alcohol Use Screening***

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

The **numerator** is defined as the number of patients who were screened for alcohol use using a validated screening questionnaire within the first three days of admission. The **denominator** is defined as the number of psychiatric inpatients 18 years of age and older. The measure excludes patients who: are less than 18 years of age; are cognitively impaired; have a duration of stay less than or equal to three days, or greater than 120 days; or have Comfort Measures Only documented.

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

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

The SUB-2 **numerator** is defined as the number of patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The SUB-2a **numerator** is defined as the number of patients who received a brief intervention. The **denominator** for both measures is the number of patients 18 years of age and older who screen positive for unhealthy alcohol use or an alcohol use disorder (alcohol abuse or alcohol dependence). The measure excludes patients who are less than 18 years of age, are cognitively impaired, patients who refused or were not screened for alcohol use during the hospital stay, have a duration of stay less than or equal to three days or greater than 120 days, or have Comfort Measures Only documented.

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

### **TOB-1: Tobacco Use Screening**

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

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

### **TOB-2 (Tobacco Use Treatment Provided or Offered) and TOB-2a (Tobacco Use Treatment)**

The Tobacco Use Treatment Provided or Offered (TOB-2) chart-abstracted measure is reported as an overall rate that includes all patients to whom tobacco use treatment was provided or offered and refused. A second rate (Tobacco Use Treatment TOB-2a), a subset of the first, includes only those patients who received tobacco use treatment.

The overall rate, TOB-2, assesses patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit and receive or refuse Food and Drug Administration (FDA)-approved cessation medications. The **numerator** includes the number of patients who received or refused practical counseling to quit and received or refused FDA-approved cessation medications or had a reason for not receiving the medication.

The second rate, TOB-2a, assesses patients who received counseling and medication, as well as those who received counseling and had a reason for not receiving the medication. The **numerator** includes the number of patients who received practical counseling to quit and received FDA-approved cessation medications or had a reason for not receiving the medication.

The **denominator** for both TOB-2 and TOB-2a includes the number of hospitalized patients 18 years of age and older identified as current tobacco users. The measure excludes patients who are less than 18 years of age, are cognitively impaired, are not current tobacco users, refused or were not screened for tobacco use during the hospital stay or have Comfort Measures Only documented. Exclusions based on LOS are determined using the current *Specifications Manual*.

### **TOB-3 (Tobacco Use Treatment Provided or Offered at Discharge) and TOB-3a (Tobacco Use Treatment at Discharge)**

The overall rate, TOB-3, assesses patients identified as tobacco product users within the past 30 days who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication upon discharge. The **numerator** includes patients who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge.

The second rate, TOB-3a, assesses patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication upon discharge as well as those who were referred to outpatient counseling and had a reason for not receiving a prescription for medication. The **numerator** includes patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication at discharge.

The **denominator** for both TOB-3 and TOB-3a includes the number of hospitalized patients 18 years of age and older identified as current tobacco users. The measure excludes patients who are less than 18 years of age, are cognitively impaired, are not current tobacco users, refused or were not screened for tobacco use during the hospital stay, have Comfort Measures Only documented, patients who expired, patients who left against medical advice, patients discharged to another hospital, patients discharged to another health care facility, patients discharged to home for hospice care, or patients who do not reside in the United States. Exclusions based on LOS are determined using the current *Specifications Manual*.

For TOB measure information, please refer to the [Specifications Manual for National Hospital Inpatient Quality Measures](#).

### **IMM-2: Influenza Immunization**

Increasing influenza (flu) vaccination can reduce unnecessary hospitalizations and secondary complications, particularly among high risk populations such as the elderly. Each year, approximately 226,000 people in the U.S. are hospitalized with complications from influenza, and between 3,000 and 49,000 die from the disease and its complications. Vaccination is the most effective method for preventing influenza virus infection and its potentially severe complications, and vaccination is associated with reductions in influenza among all age groups.

This prevention measure addresses hospitalized inpatients age 6 months and older who were screened for seasonal influenza immunization status and were vaccinated prior to discharge if indicated. The **numerator** captures two activities: screening and the intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to the vaccine, patients who were offered and declined the vaccine, and patients who received the vaccine during the current year's influenza season (but prior to the current hospitalization) are captured as numerator events. The **denominator** is the number of inpatients age 6 months and older discharged during October, November, December, January, February or March.

For IMM-2 measure information, including a list of exclusions, please refer to the [Specifications Manual for National Hospital Inpatient Quality Measures](#).

## ***Transition Record with Specified Elements Received by Discharged Patients***

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

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

The **numerator** is comprised of patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all 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

### **Advance Care Plan**

- Advance directives or surrogate decision maker documented OR Documented reason for not providing advance care plan

### **Contact Information/Plan for Follow-up Care**

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

All eleven elements must be captured to satisfy the measure numerator. Please refer to the data element definitions listed on pages 20–22 of this manual for additional guidance pertaining to the required elements for this measure.

The **denominator** includes all patients, regardless of age, discharged from the inpatient facility to home/self-care or any other site of care. The measure excludes patients who died or left against medical advice (AMA) or discontinued care.

### ***Timely Transmission of Transition Record***

The availability of the patient's discharge information at the first post-discharge physician visit improves the continuity of care and may be associated with a decreased risk of re-hospitalization.

The measure assesses the percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

The **numerator** includes patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. All eleven elements must be captured and transmitted within 24 hours to satisfy the measure numerator.

The **denominator** includes all patients, regardless of age, discharged from an IPF to home/self-care or any other site of care. The measure excludes patients who died or left against medical advice (AMA) or discontinued care.

Please refer to the data element definitions listed on pages 20–22 of this manual for additional guidance pertaining to the required elements for this measure.

## **Definitions for Transition Record Measures**

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

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

**Advance directives** - 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. The statement 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. Additionally, it identifies a person 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. More information on advance directives for non-psychiatric care can be found at: <http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289>. Information on psychiatric advance directives can be found at: <http://www.nrc-pad.org/>.

**Contact information for obtaining results of studies pending at discharge** - Health care professional or facility contact number at which patient can receive information on studies that were not concluded at discharge. Patient preference should be considered in sharing results of studies, including whether results should be provided on paper.

**Contact information / plan for follow-up care** - For patients discharged to home, the listed elements 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, AND
- Contact information for obtaining results of studies pending at discharge, AND
- Plan for follow-up care, AND
- Primary physician, other health care professional, or site designated for follow-up care

**Current medication list** - The current medication list should include prescription 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 AND 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, AND medications with which current prescriptions may react.



**Documented reason for not providing advance care plan** - Documentation that advance directive or surrogate decision maker was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance directive, OR documentation as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning or a surrogate decision maker as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship.

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

**Major procedures and tests performed during inpatient stay and summary of results** - All procedures and tests noteworthy in supporting patients' diagnosis, treatment, or discharge plan as determined by provider or facility. Examples may include: complete blood count and metabolic panel, urinalysis, or radiological imaging.

**Patient instructions** - Directions for patient and/or caregiver to follow upon discharge from facility. Examples include: medication information, activity restrictions, warning signs and symptoms associated with the condition, information regarding what to do if symptoms occur, etc. Patient instructions should be appropriate for the patient, including the use of language services as appropriate.

**Plan for follow-up care** - A plan for follow-up care that describes treatment and other supportive services to maintain or optimize health in alignment with patient's goals. The plan should include dates/times and contact information for appointments for follow-up care, 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.

**Primary physician, other health care professional, or site designated for follow-up care** - The primary care physician (PCP), medical specialist, psychiatrist or psychologist, or other physician or health care professional who will be responsible for appointments after inpatient visit. A site of care may include a group practice specific to psychiatric care. A hotline or general contact does not suffice for follow-up care.

**Studies pending at discharge** - Medical tests not concluded at discharge. Examples include: complete blood count and metabolic panel, urinalysis, radiological imaging.

**Surrogate decision maker** - Health care proxy available as patient advocate when a patient is legally incapacitated and unable to make decisions for him/herself about personal health care. A surrogate decision maker must be designated by the patient in a way that complies with the state's laws for the state in which the patient receives care.

**Transition record** - A core, standardized set of data elements related to patient's demographics, diagnosis, 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.

**Transmitted** - 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 (EHR). The time and method of transmission should be documented.

**Within 24 hours of discharge** - Calculated as 24 consecutive hours from the time the facility ordinarily records the patient discharge.

For measure information, please refer to the Physician Consortium for Performance Improvement<sup>®</sup> (PCPI<sup>®</sup>) approved Quality Measures Manual:

<http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI>

## **Screening for Metabolic Disorders**

Studies show that both second generation antipsychotics (SGAs) and antipsychotics increase the risk of metabolic syndrome. Metabolic syndrome is a cluster of conditions that occur together, including excess body fat around the waist, high blood sugar, high cholesterol, and high blood pressure, and increases the risk of coronary artery disease, stroke, and type 2 diabetes.

In 2004, a consensus statement was released by the American Diabetes Association (ADA), the American Psychiatric Association (APA), the American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity regarding an association between the use of specific SGAs and diabetes and obesity. This group recommended that providers obtain baseline screening for metabolic syndrome prior to or immediately after the initiation of antipsychotics to reduce the risk of preventable adverse events and improve the physical health status of the patient.

The Screening for Metabolic Disorders measure was developed to assess the percentage of patients discharged from an IPF for which a structured metabolic screening for four elements was completed in the past year. 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>.

The **numerator** is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) BMI; (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel – which includes total cholesterol (TC), triglycerides (TG), high density lipoprotein (HDL), and low density lipoprotein (LDL-C) levels. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or another facility for which records are available to the reporting facility.

The **denominator** includes IPF patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period. The measure excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical or psychological condition and patients with a length of stay equal to or greater than 365 days or less than 3 days.

Additional specifications for the Screening for Metabolic Disorders measure, including a data dictionary and algorithm, are in development and will be included as appendices in the next release of the IPFQR Program Manual. The next release is tentatively scheduled for early summer of 2016.

## **Claims Based Measure: Follow-Up After Hospitalization for Mental Illness (FUH)**

The FUH measure was developed and is maintained by the NCQA. Mental illness accounts for a very large disease burden, and it is estimated that half of first-time psychiatric patients are readmitted within two years of hospital discharge. Continuity of treatment and appropriate follow-up care and management of chronic diseases, such as mental illnesses, are known to reduce the risk of repeated hospitalizations. Proper follow-up treatment for psychiatric hospitalization can lead to improved quality of life for patients, families, and society as a whole.

The Follow-Up After Hospitalization for Mental Illness measure assesses the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who subsequently had an outpatient visit or an intensive outpatient encounter with a mental health practitioner, or received partial hospitalization services. Two rates are reported

- The percentage of discharges for which the patient received follow-up within 30 days of discharge
- The percentage of discharges for which the patient received follow-up within seven days of discharge

As this is a claims-based measure, CMS will calculate the measure outcome using Part A and Part B claims data that are received by Medicare for payment purposes. CMS will calculate this measure by linking Medicare fee-for-service (FFS) claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges. This approach requires no additional data collection or reporting by IPFs. Completion of this measure does not affect an IPF's payment determination.

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

### ***Definitions***

The definition of **outpatient follow-up care** is a mental health procedure (identified by CPT<sup>®</sup> / Healthcare Common Procedure Coding System (HCPCS) / Uniform Bill (UB) Revenue codes) provided by a mental health practitioner - a psychiatrist, psychologist, or social worker according to the HEDIS<sup>®</sup> definition. Health plan records are used to determine whether a provider is a mental health practitioner. CMS uses provider taxonomy and specialty codes in Medicare claims to make this determination. Specifically, the National Provider Identifier (NPI) numbers of providers are used to determine the exact taxonomy code and specialty. Diagnosis codes are not used to identify follow-up mental health visits.

A **mental health practitioner** is a practitioner who provides mental health services and meets any of the following criteria:

- An MD or Doctor of Osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed

to practice patient care psychiatry or child psychiatry, if required by the state of practice.

- An individual who is licensed as a psychologist in his/her state of practice.
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.
- A neurologist with a specialty in neuropsychiatry or a psychiatric nurse will be considered to be a mental health practitioner for purposes of the measure.

The **eligible population** includes IPF discharges for Medicare patients 6 years and older as of the date of discharge with a selected principal mental health diagnosis included in Table A in Appendix B, during the first 11 months of the measurement year.

The **denominator** includes IPF discharges remaining in the eligible population after denominator exclusions. Denominator exclusions include:

- Both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after the first 11 months of the measurement year (e.g., after December 1)
- Discharges followed by readmission or direct transfer to a non-acute facility for any mental health principal diagnosis within the 30-day follow-up period
- Discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or non-acute facility for a non-mental health principal diagnosis

The **numerator** includes an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 or 7 days of discharge, for patients receiving care in a psychiatric hospital or psychiatric unit paid under IPF PPS.

## **Attestations**

### ***Assessment of Patient Experience of Care***

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

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

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

## ***Use of Electronic Health Record***

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

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

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

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

After selecting an attestation, an IPF must then respond to the following question with a Yes or No answer:

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

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

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

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

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

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

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

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

**NOTE:** IPFs will use the Centers for Disease Control and Prevention (CDC) NHSN infrastructure and protocol to report the measure for IPFQR Program purposes. If the IPF has not reported to NHSN in the past, it will be necessary to perform setup prior to reporting. Step by step instructions are available at <http://www.cdc.gov/nhsn/acute-care-hospital/setup.html>.

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

## **Data Submission**

The following tables list information pertinent to data submission for the FY 2017 and FY 2018 measures.

<b>IPFQR FY 2017 Measures</b>					
<b>Measure</b>	<b>Reporting Period</b>	<b>Submission Period</b>	<b>Measure Type</b>	<b>Sampling Allowed</b>	<b>Public Display<sup>1</sup></b>
<b>HBIPS-2: Hours of Physical Restraint Use</b>	January 1– December 31, 2015	July 1– August 15, 2016	Chart-Abstracted	No	April 2017
<b>HBIPS-3: Hours of Seclusion Use</b>	January 1– December 31, 2015	July 1– August 15, 2016	Chart-Abstracted	No	April 2017
<b>HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification</b>	January 1– December 31, 2015	July 1– August 15, 2016	Chart-Abstracted	Yes	April 2017
<b>HBIPS-6: Post-Discharge Continuing Care Plan Created</b>	January 1– December 31, 2015	July 1– August 15, 2016	Chart-Abstracted	Yes	April 2017
<b>HBIPS-7: Post-Discharge Continuing Care Plan Transmitted to Next Level of Care at Discharge</b>	January 1– December 31, 2015	July 1– August 15, 2016	Chart-Abstracted	Yes	April 2017
<b>SUB-1: Alcohol Use Screening</b>	January 1– December 31, 2015	July 1– August 15, 2016	Chart-Abstracted	Yes	April 2017



## IPFQR FY 2017 Measures

Measure	Reporting Period	Submission Period	Measure Type	Sampling Allowed	Public Display <sup>1</sup>
<b>FUH: Follow-Up After Hospitalization for Mental Illness</b>	July 1, 2014– June 30, 2015	Calculated by CMS	Claims-Based	N/A	April 2017
<b>Use of Electronic Health Record</b>	As of December 31, 2015	July 1– August 15, 2016	Structural Web-Based	N/A	April 2017
<b>Assessment of Patient Experience of Care</b>	As of December 31, 2015	July 1– August 15, 2016	Structural Web-Based	N/A	April 2017
<b>IMM-2: Influenza Immunization</b>	October 1, 2015– March 31, 2016	July 1– August 15, 2016	Chart-Abstracted	Yes	April 2017
<b>Influenza Vaccination Coverage among Healthcare Personnel</b>	October 1, 2015– March 31, 2016	October 1, 2015– May 15, 2016	Web-Based reported on NHSN website <sup>2</sup>	No	April 2017
<b>TOB-1: Tobacco Use Screening</b>	January 1– December 31, 2015	July 1– August 15, 2016	Chart-Abstracted	Yes	April 2017
<b>TOB-2: Tobacco Use Treatment Provided or Offered and TOB-2a: Tobacco Use Treatment</b>	January 1– December 31, 2015	July 1– August 15, 2016	Chart-Abstracted	Yes	April 2017

## IPFQR FY 2018 Measures

Measure	Reporting Period	Submission Period	Measure Type	Sampling Allowed	Public Display <sup>1</sup>
<b>HBIPS-2: Hours of Physical Restraint Use</b>	January 1– December 31, 2016	July 1– August 15, 2017	Chart-Abstracted	No	April 2018
<b>HBIPS-3: Hours of Seclusion Use</b>	January 1– December 31, 2016	July 1– August 15, 2017	Chart-Abstracted	No	April 2018
<b>HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification</b>	January 1– December 31, 2016	July 1– August 15, 2017	Chart-Abstracted	Yes	April 2018
<b>Transition Record with Specified Elements Received by Discharged Patients</b>	July 1– December 31, 2016	July 1– August 15, 2017	Chart-Abstracted	Yes	April 2018
<b>Timely Transmission of Transition Record</b>	July 1– December 31, 2016	July 1– August 15, 2017	Chart-Abstracted	Yes	April 2018
<b>Screening for Metabolic Disorders</b>	July 1– December 31, 2016	July 1– August 15, 2017	Chart-Abstracted	Yes	April 2018
<b>FUH: Follow-Up After Hospitalization for Mental Illness</b>	July 1, 2015– June 30, 2016	Calculated by CMS	Claims-Based	N/A	April 2018
<b>SUB-1: Alcohol Use Screening</b>	January 1–December 31, 2016	July 1– August 15, 2017	Chart-Abstracted	Yes	April 2018
<b>SUB-2: Alcohol Use Brief Intervention Provided or Offered and SUB-2a: Alcohol Use Brief Intervention</b>	January 1–December 31, 2016	July 1– August 15, 2017	Chart-Abstracted	Yes	April 2018

## IPFQR FY 2018 Measures

Measure	Reporting Period	Submission Period	Measure Type	Sampling Allowed	Public Display <sup>1</sup>
<b>TOB-1: Tobacco Use Screening</b>	January 1–December 31, 2016	July 1–August 15, 2017	Chart-Abstracted	Yes	April 2018
<b>TOB-2: Tobacco Use Treatment Provided or Offered and TOB-2a Tobacco Use Treatment</b>	January 1–December 31, 2016	July 1–August 15, 2017	Chart-Abstracted	Yes	April 2018
<b>TOB-3: Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a: Tobacco Use Treatment at Discharge</b>	January 1–December 31, 2016	July 1–August 15, 2017	Chart-Abstracted	Yes	April 2018
<b>IMM-2: Influenza Immunization</b>	October 1, 2016–March 31, 2017	July 1–August 15, 2017	Chart-Abstracted	Yes	April 2018
<b>Influenza Vaccination Coverage among Healthcare Personnel</b>	October 1, 2016–March 31, 2017	October 1, 2016–May 15, 2017	Web-Based reported on NHSN website <sup>2</sup>	No	April 2018
<b>Use of Electronic Health Record</b>	As of December 31, 2016	July 1–August 15, 2017	Structural Web-Based	N/A	April 2018
<b>Assessment of Patient Experience of Care</b>	As of December 31, 2016	July 1–August 15, 2017	Structural Web-Based	N/A	April 2018

<sup>1</sup> Timing of data refresh in *Hospital Compare* subject to change

<sup>2</sup> Each new entry overwrites previous entry

**NOTE:** The reporting period for IMM-2 and Influenza Vaccination Coverage Among HCP cross over 2 calendar years, from October 1, 2015, through to March 31, 2016, for the FY 2017 payment determination and from October 1, 2016, through to March 31, 2017, for the FY 2018 payment determination. While the data submission timeframe for IMM-2 aligns with the other measures (July 1 through August 15 – annually), the Influenza Vaccination Coverage Among Healthcare Personnel will be from October 1, 2015, through to May 15, 2016, for the FY 2017 payment determination and October 1, 2016 through to May 15, 2017, for the FY 2018 payment determination.

## ***Submission Information***

Screenshots of the portal submission pages are unavailable at this time, as the secure portal is being updated for the next submission period. Generally, this information is available immediately prior to the submission period, and providers will be notified via ListServe when new tools displaying the updated collection and submission fields have been released. The tools with screenshots will be located on *QualityNet.org* under the IPFQR Resources tab as well as on the [www.QualityReportingCenter.com](http://www.QualityReportingCenter.com) website.

## ***Submission of Non-Measure Data***

Beginning with FY 2017 payment determination and subsequent years, CMS no longer requires non-measure data by quarter, but as an aggregate, yearly count. It is vital for IPFs to accurately determine and submit general population data for CMS to assess data reporting completeness for their total population, both Medicare and non-Medicare. This information is expected to improve CMS' ability to interpret measure results and assess the relevance and impact of potential future measures. Understanding that the size of subgroups of patients addressed by a particular measure varies over time could be helpful in assessing the stability of reported measure values and in subsequent decision-making concerning measure retention. Similarly, better understanding of the size of particular subgroups in the overall population will assist CMS in making choices among potential future measures specific to a particular subgroup (e.g., patients with depression).

## ***Diagnostic Categories***

- Diagnostic code grouping for the purpose of reporting non-measure data utilizes the categories developed for the Clinical Classifications Software (CCS) under the Healthcare Cost and Utilization Project (H-CUP) by the Agency for Healthcare Research and Quality (AHRQ). The CCS for ICD-10 is a diagnosis and procedure categorization scheme that collapses individual codes into a smaller number of clinically meaningful categories. Categorization should be based on the primary diagnosis at discharge.
- Analysis of Medicare claims indicate that six CCS categories account for more than 90% of patients treated by inpatient psychiatric facilities. The following CCS categories should be used for grouping and reporting diagnostic codes:
  - Anxiety disorders (651)
  - Delirium, dementia, and amnestic and other cognitive disorders (653)
  - Mood disorders (657)
  - Schizophrenia and other psychotic disorders (659)
  - Alcohol-related disorders (660)
  - Substance-related disorders (661)
  - Other diagnosis – all other diagnoses not falling into one of the above categories
- A list of individual codes for each clinical category can be found here: <https://www.hcup-us.ahrq.gov/toolssoftware/ccs10/ccs10.jsp#download>
- Facility data for non-measure data submission will be required as displayed in the tables below. CMS will use the population counts and measure denominator values to determine whether sampling guidelines are being followed for measures that allow sampling (HBIPS-5, HBIPS-6, HBIPS-7, SUB-1, SUB-2/-2a, TOB-1, TOB-2/-2a, TOB-3/-3a, IMM-2, Transition and Metabolic Screening). Refer to the Non-Measure Data

Collection Tool 01-01-15 (Q1 2015 through 12-31-15 (Q4 2015) document located under IPFQR Program Abstraction Tools on the following web page:  
<http://www.qualityreportingcenter.com/inpatient/ipf/tools/>.

**Non-Measure Data Annual Collection for FY 2017 Payment Determination**

Total Annual Discharges

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

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	

Payer	Total Annual Discharges
Medicare	
Non-Medicare	

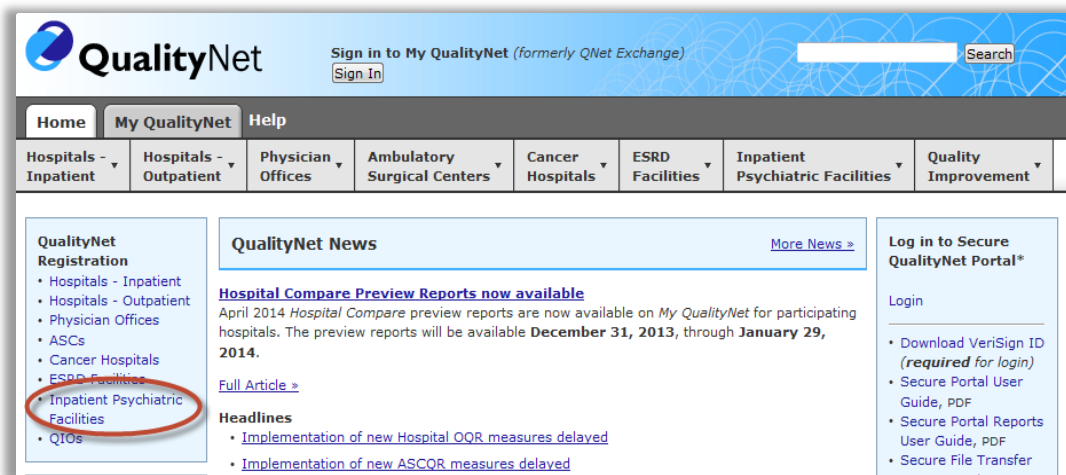
Measure	Sample Size
HBIPS-5, -6, -7	
SUB-1, IMM-2, TOB-1, TOB-2/-2a	

## Section 3: *QualityNet* Registration

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

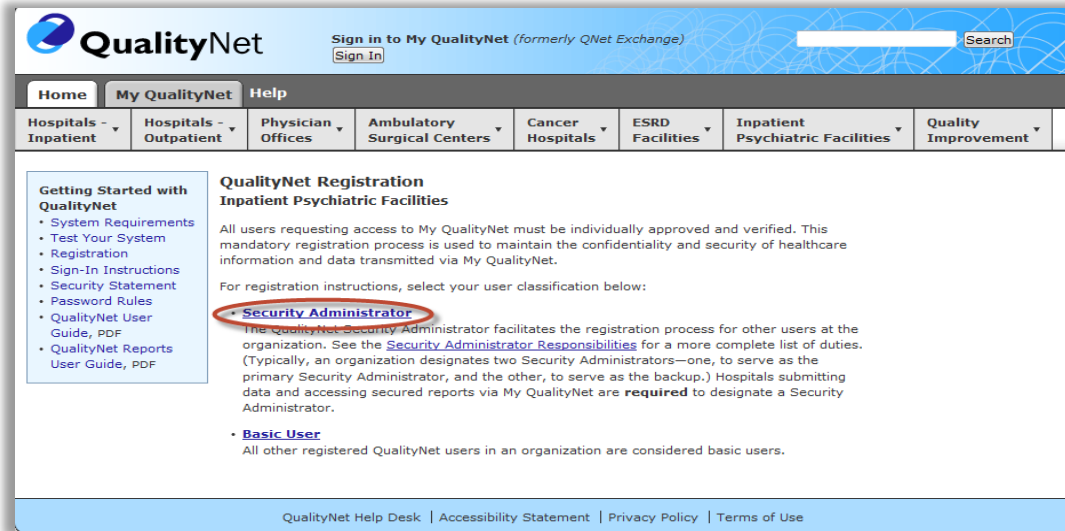
To begin *QualityNet* Registration:

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



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

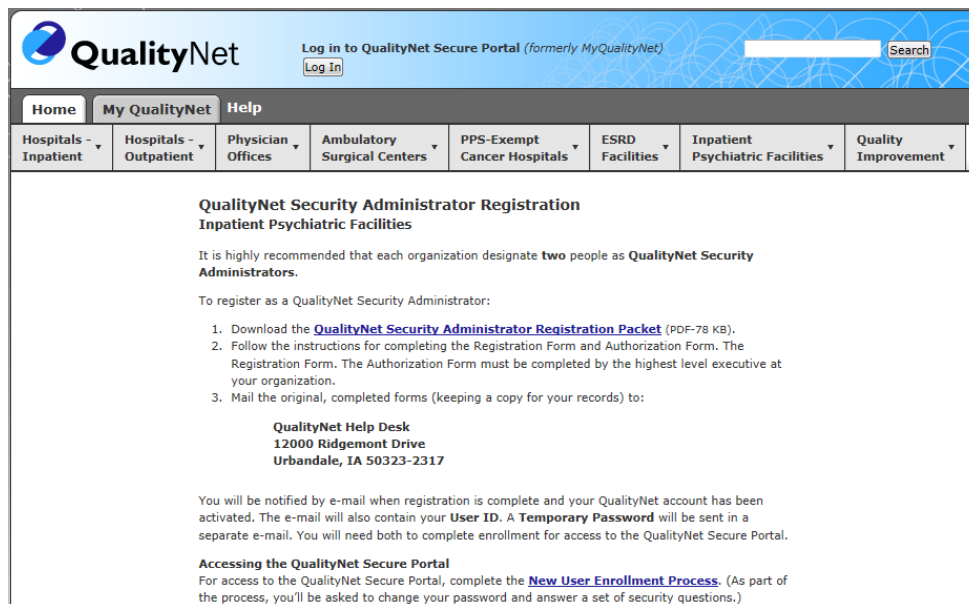
The Inpatient QualityNet Registration page appears.



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

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

The *QualityNet* Security Administrator Registration page appears.



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



## **QualityNet Security Administrator**

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

**Best Practice:** We recommend facilities designate a minimum of two QualityNet Security Administrators (SA) - one to serve as the primary QualityNet Security Administrator and the other to serve as the alternate SA. To keep the facility's account active, your SA should sign in at least once a month. If it becomes necessary to reactivate your account, call the QualityNet Help Desk at 866.288.8912.

## ***Security Administrator Responsibilities***

The security administrator has the following responsibilities:

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

## **Non-Administrative User**

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

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

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

## Completing the *QualityNet* Registration Form

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

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

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

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

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

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

*QualityNet* Help Desk  
 1401 50<sup>th</sup> St., Suite 200  
 West Des Moines, IA 50266

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

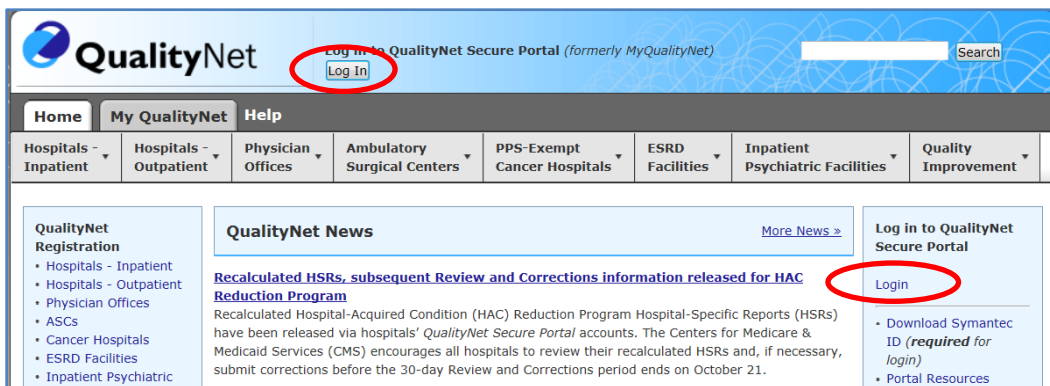
*QualityNet* Help Desk  
 Monday through Friday  
 7:00 a.m. to 7:00 p.m. Central Time  
 E-mail: qnetsupport@hcqis.org  
 Phone: 866.288.8912  
 TTY: 877.715.6222

## Activating the Security Administrator Account

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

To begin account activation:

1. Go to the [QualityNet.org](http://QualityNet.org) website.



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

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

## QualityNet Secure Portal Access

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

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

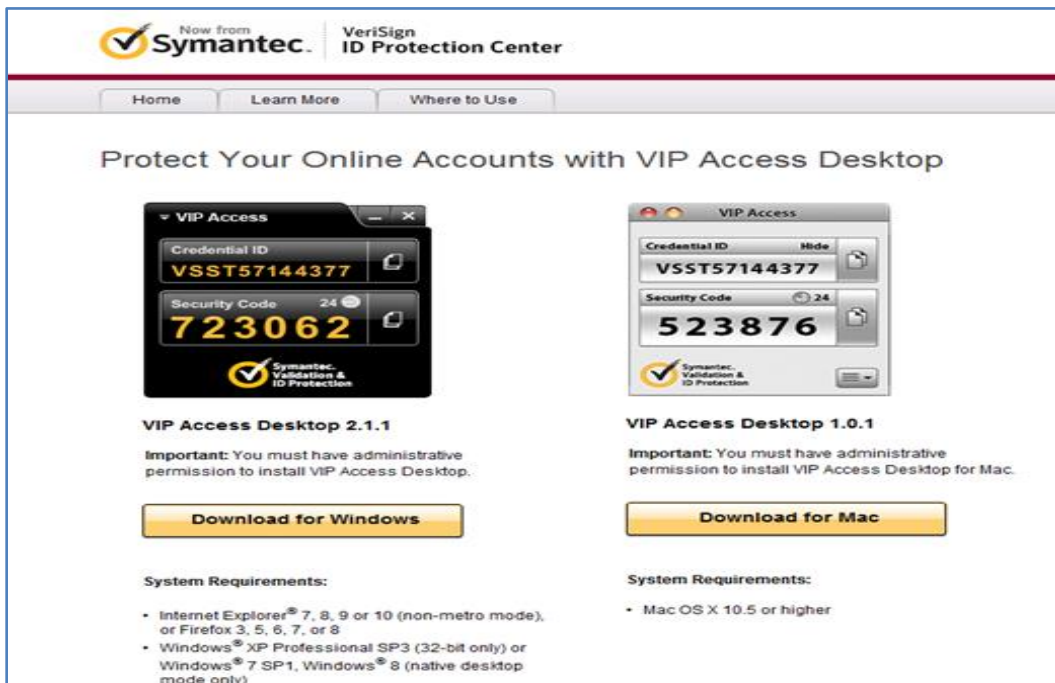
To download the multifactor authentication application to a PC or tablet:

1. Go to the [QualityNet.org](http://QualityNet.org) website.



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

The VeriSign ID Protection Center page will appear.

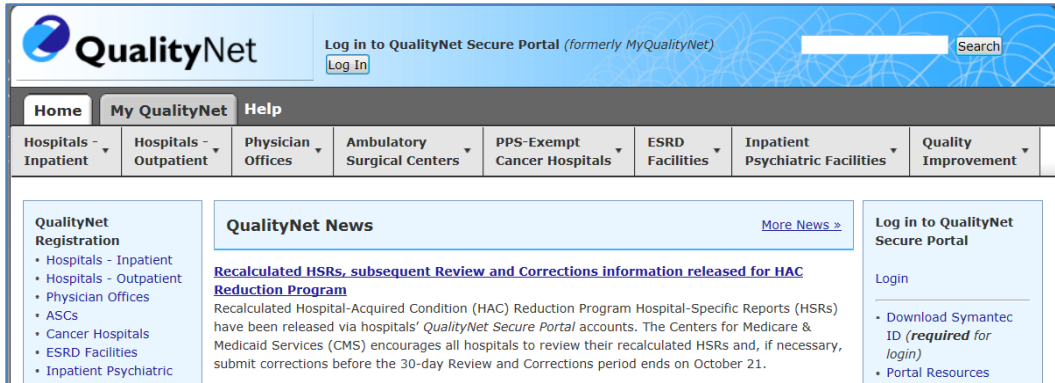


3. Select the download option that is appropriate to the device being used, either for Windows® or Mac®.

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

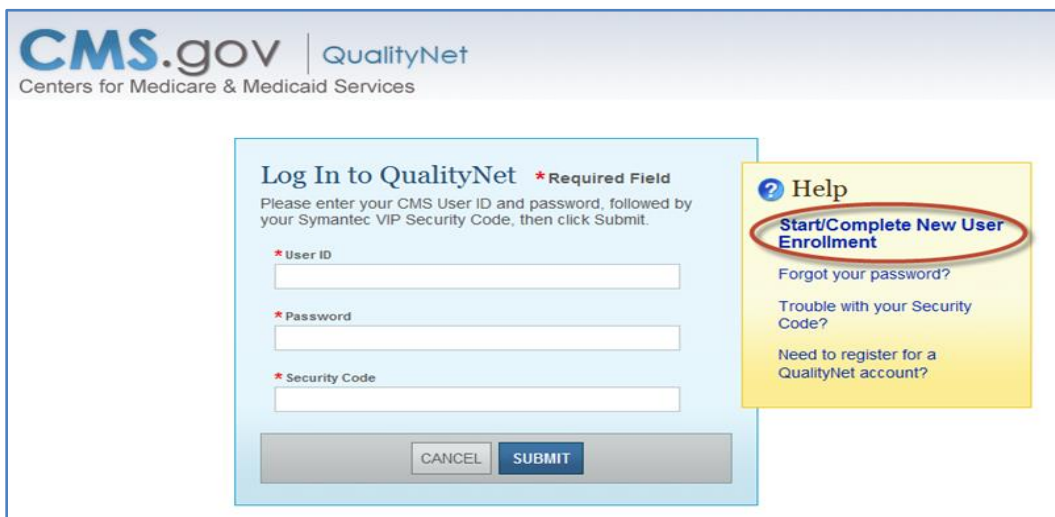
Once the Symantec multifactor authentication application download is on the computer, users are ready to access the *QualityNet Secure Portal*.

4. Access the *QualityNet Secure Portal* on the [QualityNet.org](http://QualityNet.org) website.



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

The *Log In to QualityNet* window appears.



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

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

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

**CMS.gov** | QualityNet  
Centers for Medicare & Medicaid Services

Progress bar: Login (active), Verify Identity, Identity Questions, Identity Confirmed, Enroll Credential, Enrollment Confirmed

### Starting and Completing New User Enrollment

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

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

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

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

**Log In to QualityNet** \* Required Field

\* User ID

\* Password

CANCEL SUBMIT

**Help**  
Forget your password?

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

## Verifying Identity

To verify a user's identity:

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

The screenshot shows the 'Verify Your Identity' page on CMS.gov. The page has a header with the CMS.gov logo and 'QualityNet' text. Below the header is a navigation bar with buttons for 'Login', 'Verify Identity', 'Identity Questions', 'Identity Confirmed', 'Enroll Credential', and 'Enrollment Confirmed'. The main content area is titled 'Verify Your Identity' and contains a form for personal information. The form fields are: First Name (Heather), Middle Name, Last Name (Fox), Suffix (-Select-), Street Address (213 East Bradford Ct.), Additional Address Information, City (Middletown), State/Province (Delaware), Country (United States), ZIP/Postal Code (19705), Personal Phone Number ((302) 287-0240), Full Social Security Number (circled in red with a note 'US users must enter a Social Security Number'), and Date of Birth (mm/dd/yyyy). There is a checkbox for a privacy notice: 'CMS is highly aware of the privacy concerns around disclosure of your personal data including your Social Security Number. CMS is collecting the Personally Identifiable Information (PII) on this screen and on the identity question screen to verify your identity only. Your information will be disclosed to Experian, an external authentication service provider to help us verify your identity. Your Social Security Number will be masked and encrypted during this transaction to assure it is secure. Other than your name, none of the PII data collected in this process is retained.' At the bottom of the form are 'CANCEL' and 'SUBMIT' buttons. On the left side of the form, there is a 'Verify Your Identity' section with instructions, a 'Remote Proofing FAQs' section, and an 'Experian' logo with a 'Click to verify' button.

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

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

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

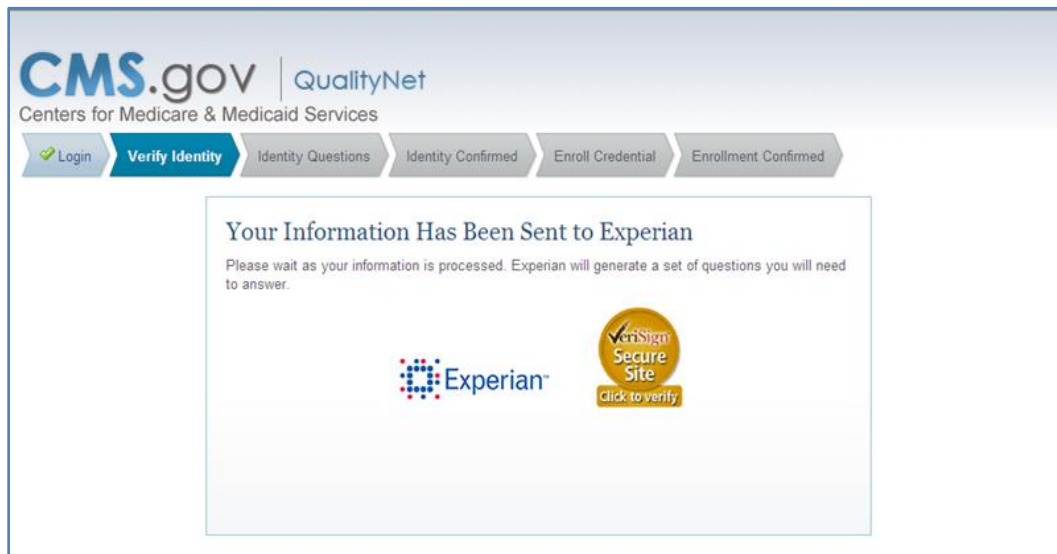
CMS is aware of the privacy concerns regarding disclosure of personal data, including social security numbers. CMS is collecting the Personally Identifiable Information (PII) on this screen and on the identity question screen to verify identity only. Verifying a user's identity meets the National Institute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

FISMA was passed as Title III of the E-Government Act (Public Law 107-347) in December 2002. FISMA requires each federal agency to develop, document, and implement an agency-wide program to provide information security for the information and information systems that support the operations and assets of the agency, including those provided or managed by another agency, contractor, or other source. This Act assigned NIST the responsibility to develop standards to be used by Federal agencies to categorize information and information systems based on the objectives of providing appropriate levels of information security according to a range of risk levels.

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

3. Once the required fields have been entered, check the privacy statement, and click **Submit**.

The screen will display a message stating that the information has been sent to Experian and will instruct the user to wait as the information is being processed.



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



**CMS.gov** | QualityNet  
Centers for Medicare & Medicaid Services

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

**Identity Challenge Questions from Experian**



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

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



Click to verify

**Identity Challenge Questions** \* Required Field

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

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

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

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

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

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

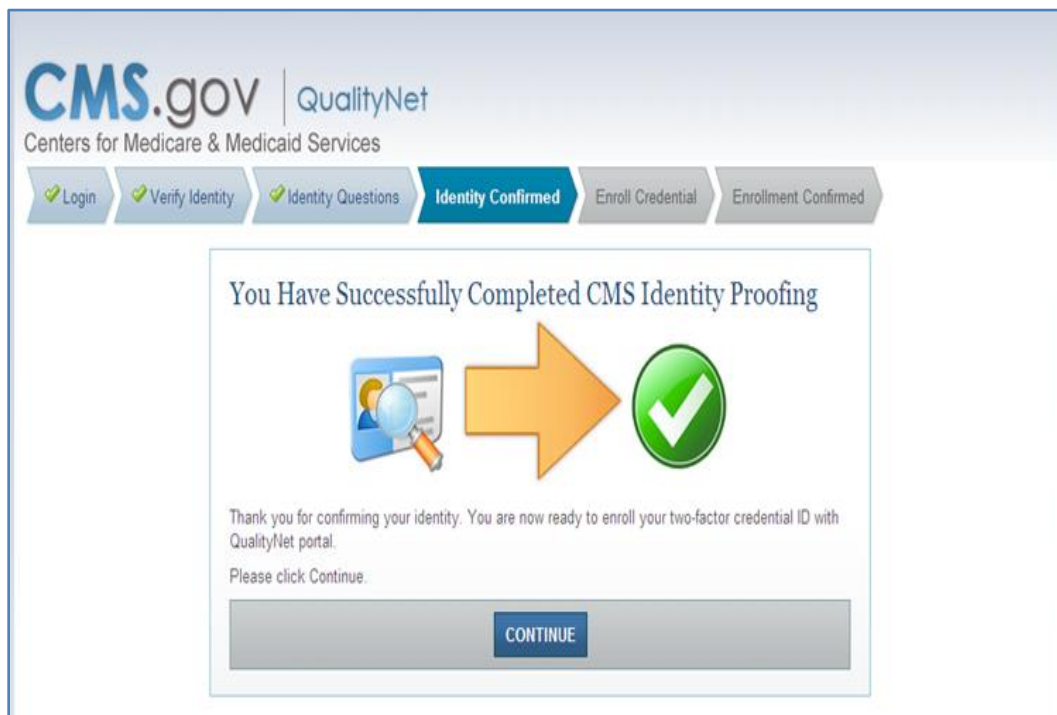
\* 4. Which of the following is a current or previous employer? If there is not a matched employer name, please select 'NONE OF THE ABOVE'.

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

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

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

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



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

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

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

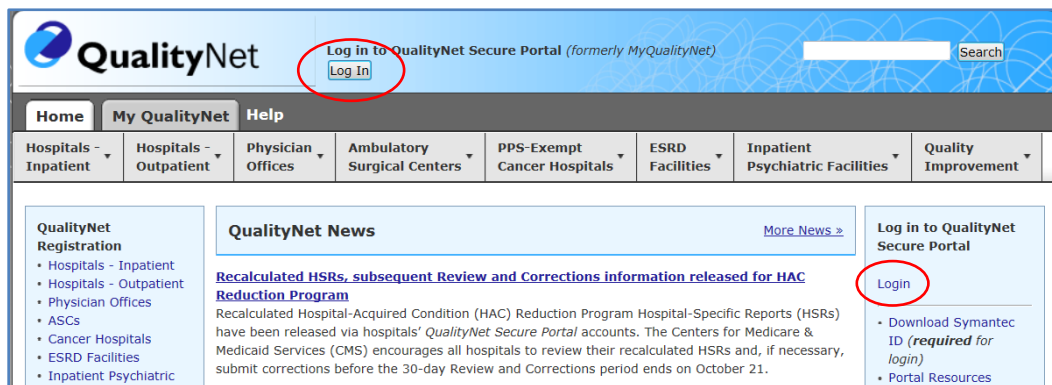


## Logging In to the QualityNet Secure Portal

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

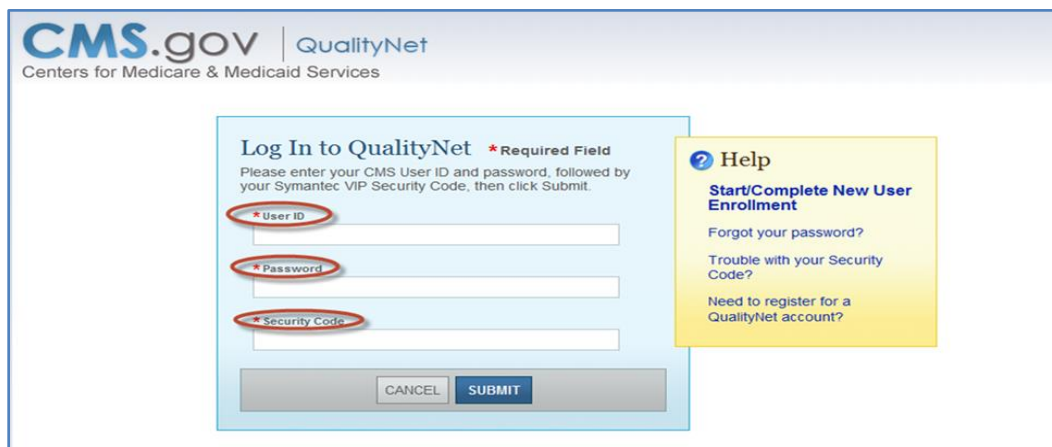
To access the *QualityNet Secure Portal*:

1. Go to the [QualityNet.org](http://QualityNet.org) website.



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

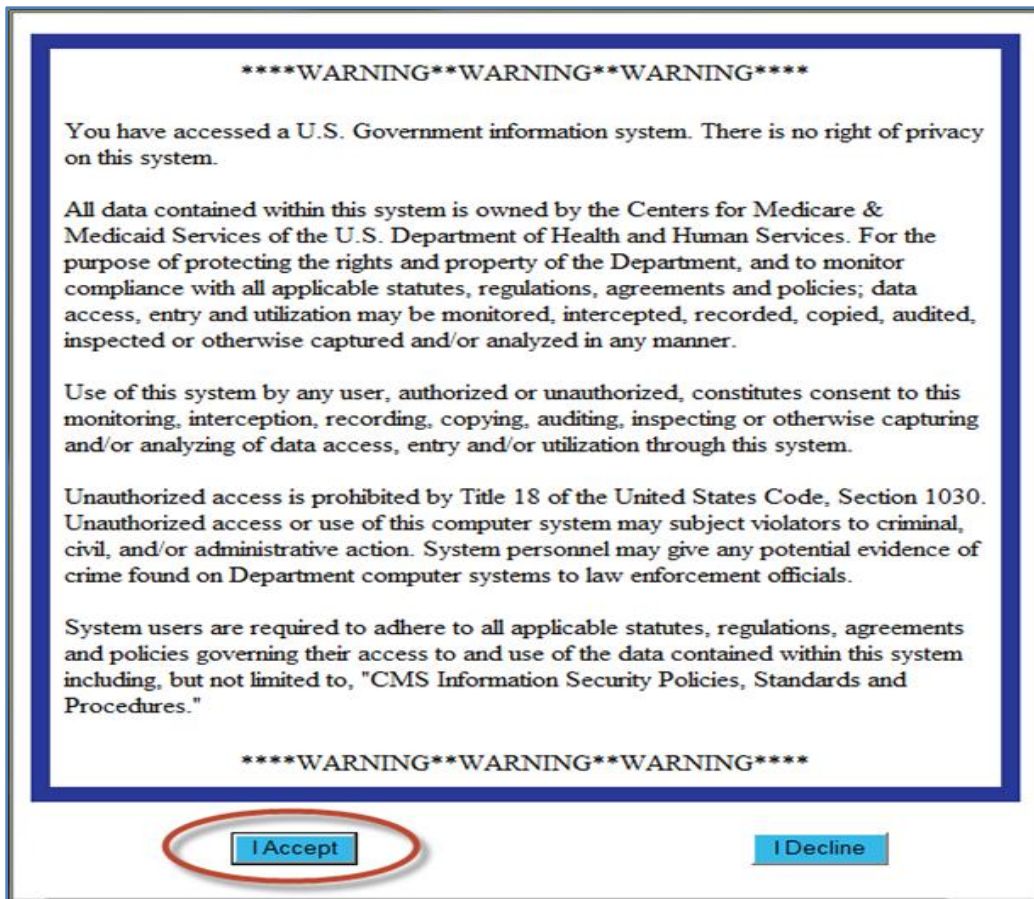
The *Log In to QualityNet* screen appears.



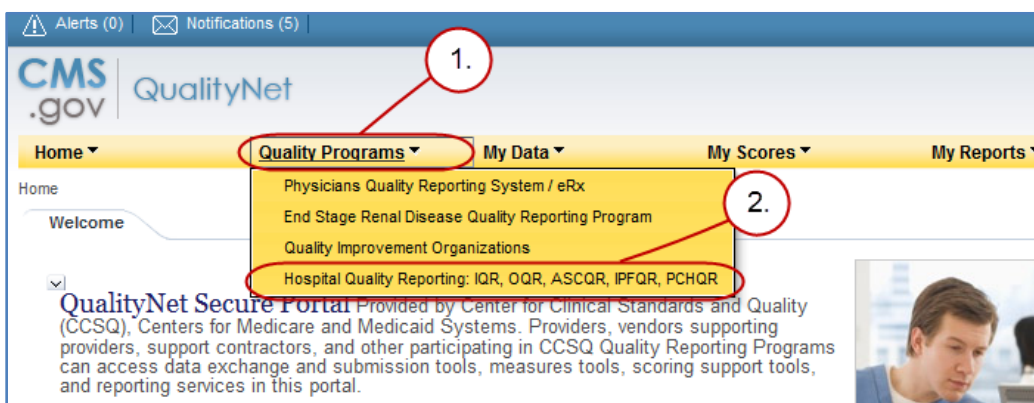
3. Open the previously downloaded Symantec VIP application for the time sensitive Security Code.
4. Enter the **User ID**, **Password**, and **Security Code**.
5. Select **Submit**.

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

6. Accept the terms to be granted access to the *QualityNet Secure Portal*.



7. To access the IPFQR Program, select **Quality Program** (1.) then the **Hospital Quality Reporting: IQR, OQR, ASC, IPFQR, PCHQR** option (2.) from the drop-down menu.



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

- Access reports
- Authorize vendors to submit data
- Manage measures

- Manage security
- Manage Notice of Participation
- View/edit online forms

## ***User Roles***

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

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

### **IPFQR Notice of Participation**

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

### **IPFQR Web-Based Measure/DACA Application**

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

### **IPFQR Reports**

- IPFQR Reports Read
- IPFQR Reports Update

### **IPFQR Vendor Authorization**

- IPF Vendor Authorization
- Hospital Reporting Feedback - IPFQR

### **Online Forms**

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

### **File Exchange**

- File Search and Exchange

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

The screenshot displays the CMS QualityNet interface. At the top, there is a navigation bar with 'Alerts (0)', 'Notifications (0)', 'Secure File Transfer', 'User Profile', and 'Log Out'. The user's name 'Nina Rose' and role 'IFMC - SDPS' are shown in the top right. Below the navigation bar is a search box and a menu with 'Home', 'Quality Programs', 'My Data', 'My Reports', and 'My Tools'. The main content area is titled 'Quality Reporting System: My Tasks' and contains six task cards:

- Vendor Authorization**: Authorize Vendors to Submit Data
- Hospital Reporting Inpatient / Outpatient**: View / Edit Population & Sampling
- Manage Notice of Participation**: View/Edit Notice of Participation, Contacts, Campuses
- Online Forms**: View/Edit Online Forms
- Manage Security**: My Account
- Manage Measures**: View/Edit Structural/Web-Based Measures/Data Acknowledgement (DACA)

## Section 4: Vendor Authorization

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

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

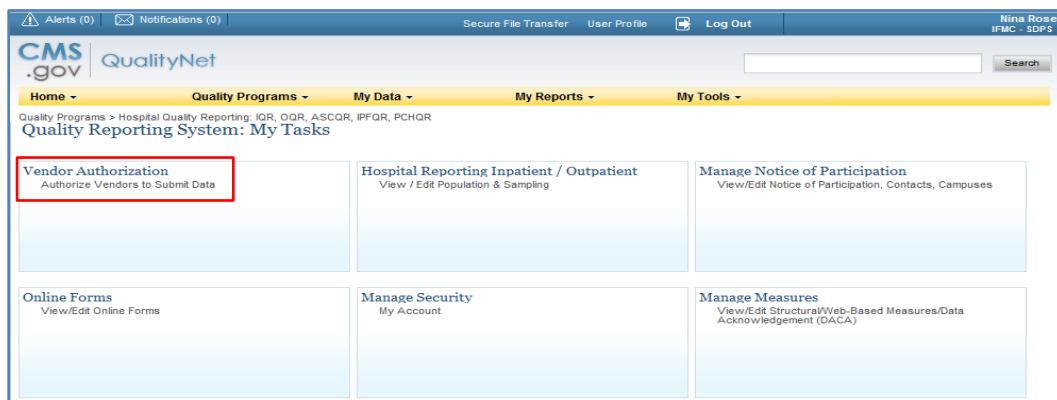
**NOTE:** IPFs may authorize a vendor to submit data on behalf of the facility. However, CMS maintains that **an IPF is responsible for ALL data submission, even when contracting with a vendor.**

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

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

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

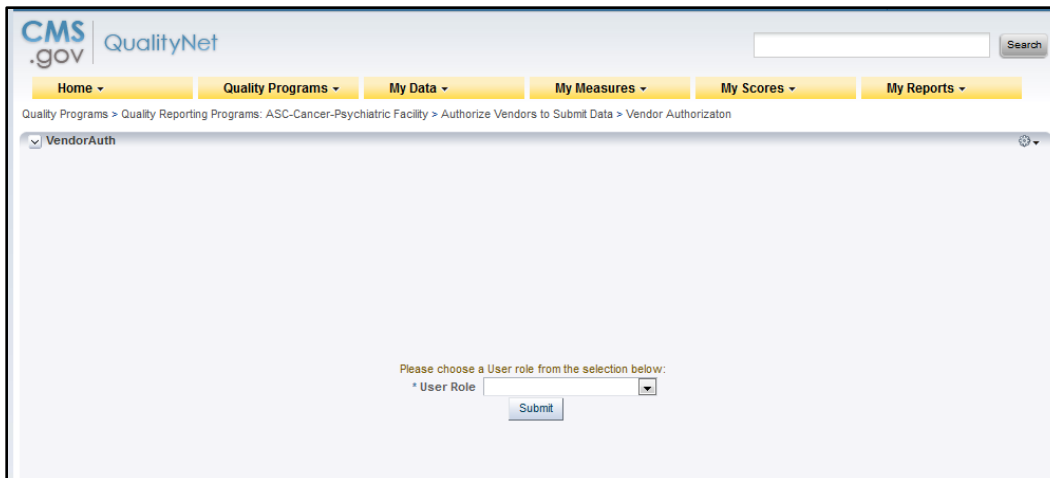
The *Quality Reporting System: My Tasks* page appears:



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

The *Vendor Authorization* screen appears.





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



4. Select either the **Add New Vendor Authorization** or the **Update Vendor Authorization** tab.  
All vendors that have been allowed to submit clinical data on the institution's behalf are automatically authorized to submit web-based measures for the data submission period beginning July 1.  
The *Authorized Vendors to Submit Data* page appears.
5. Select a vendor from the list and verify the correct vendor is displayed.  
**NOTE:** Use the **Cancel** button to return to the previous page to make a vendor change, if necessary.
6. Scroll to the measure.

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

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

### **Recommendations**

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

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

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

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

The Approve New or Changed Vendor Authorization page appears.

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

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

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

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

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

The screenshot shows the QualityNet website interface. At the top left is the QualityNet logo. To its right is a sign-in area with the text "Sign in to My QualityNet (formerly QNet Exchange)" and a "Sign In" button. A search bar is located to the right of the sign-in area. Below the header is a navigation menu with tabs for "Home" and "My QualityNet", and a "Help" link on the far right. The main navigation bar contains several categories: "Hospitals - Inpatient", "Hospitals - Outpatient", "Physician Offices", "Ambulatory Surgical Centers", "Cancer Hospitals", "ESRD Facilities", "Inpatient Psychiatric Facilities", and "Quality Improvement".

A yellow callout box contains the following text:

**QualityNet Secure Portal available**  
Enhancements to the QualityNet Secure Portal are complete, and registered QualityNet users may access the Portal for data submission and other functions.

**Resources**  
**QualityNet Secure Portal**

The QualityNet Secure Portal houses various applications for the Centers for Medicare & Medicaid Services (CMS') Ambulatory Surgical Centers, Inpatient Psychiatric Facilities, and PPS-Exempt Cancer Hospitals Quality Reporting programs.

The following links provide useful information for those users wishing to access the QualityNet Secure Portal:

**Secure Portal Enrollment and Identity Proofing Questions**

- [Identity Proofing Question Examples](#), PDF
- [Frequently Asked Questions](#), PDF-209 KB (02/11/14)

**Portal User Training**

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

**CMS E-mail Notifications**

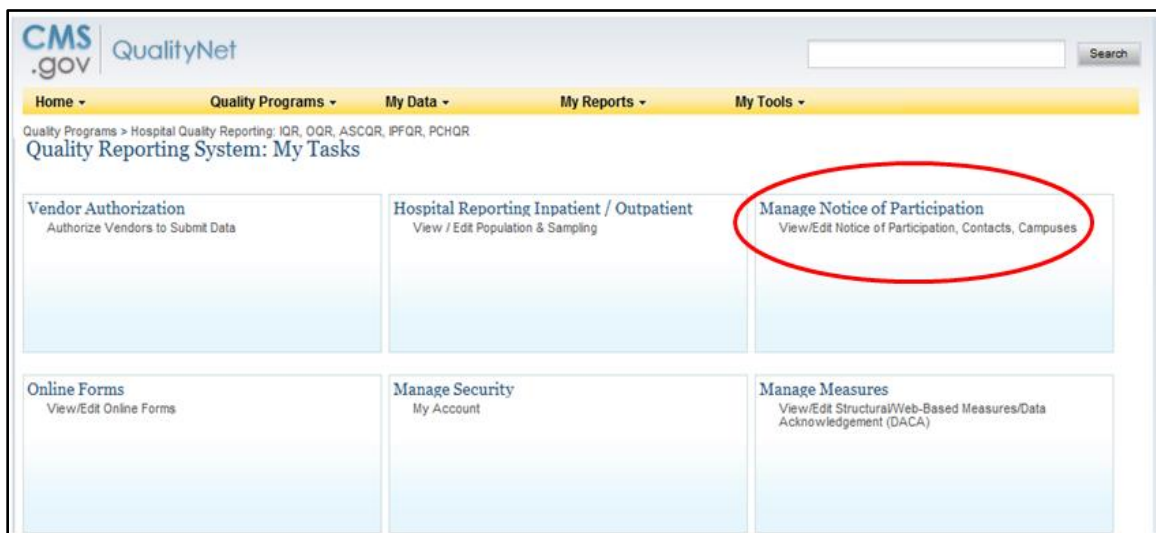
- [QualityNet Java Issue Resolution](#), PDF-16 KB (issued 07/18/13)
- [QualityNet Secure Portal Updates](#), PDF-44 KB (issued 07/16/13)
- [Clarification Regarding Portal Enrollment Process](#), PDF-38 KB (issued 06/25/13)

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

## Section 5: Notice of Participation

To participate in the IPFQR Program, each facility must complete a Notice of Participation (NOP). During the first year of the program, facilities had the option of submitting a paper NOP or completing the NOP online. Once completed, the NOP remains in effect until an IPF decides to withdraw from the program or there is a change in their eligibility status.

Facilities that completed a NOP for FY 2016 and plan to continue to participate in the IPFQR Program do not need to complete a NOP for FY 2017. The system will automatically update their NOP and populate the FY 2015 screen and annually thereafter. To verify the NOP was updated, it is recommended that the facility log in to the NOP application. It is also recommended that facilities log in to the NOP application to update their facility contacts, since this information was not available if a facility completed the paper NOP form.



Eligible facilities that did not participate in the IPFQR Program previously may complete an online NOP for FY 2017 by August 15, 2016.

New facilities must complete the NOP no more than 180 days from the Medicare Accept Date.

**NOTE:** Once an IPF has submitted an NOP, the IPF is considered an active IPFQR Program participant until the IPF submits a withdrawal of participation or until there is a change in the eligibility status of the IPF.

To access the NOP application:

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

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

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

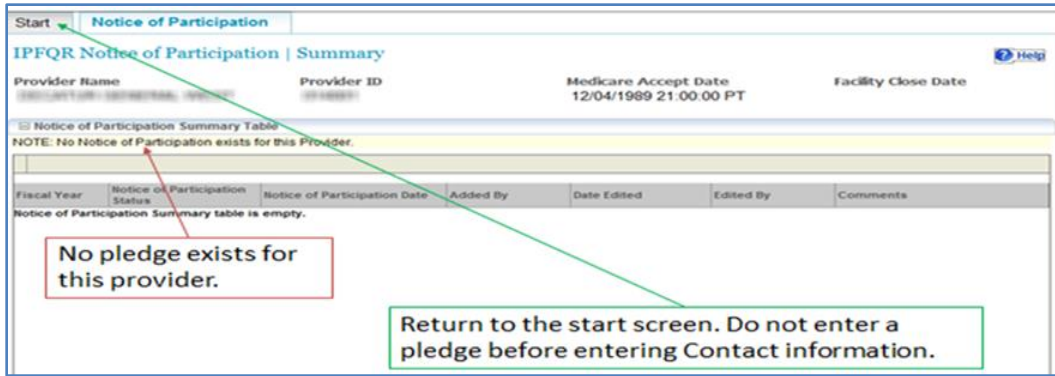
3. Select the action to be completed.

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

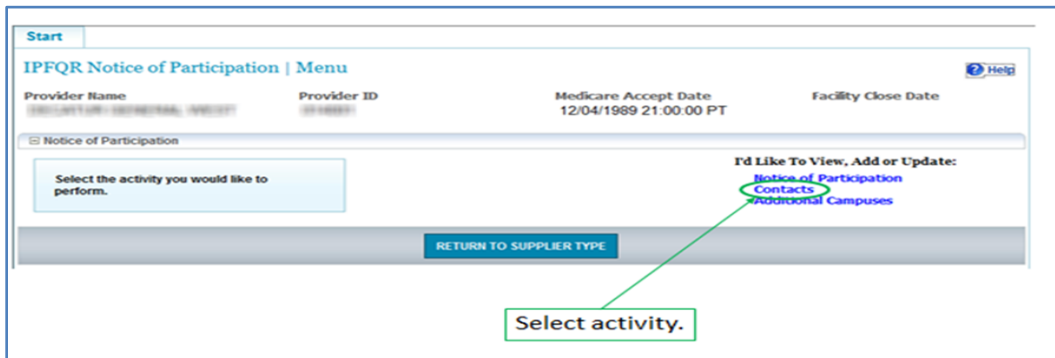
Additional campus information may not apply to all IPFs. It is applicable for facilities that have more than one physical location but are licensed and reimbursed under the same CCN.

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

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



5. Select Contacts from the list.



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

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

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

IPFQR Notice of Participation | Text Print

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

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

**Please review the Notice of Participation below.**

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

The Inpatient Psychiatric Facility (IPF) agrees to follow procedures for participating in the IPFQR Program as outlined in the federal regulations found in the Federal Register, or is indicating its decision to decline participation. The IPF understands that participation in the IPFQR Program is voluntary for the applicable fiscal year.

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

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

\* We entities operating under the submitted Provider ID:320001

Agree to participate

Do not agree to participate

Request to be withdrawn from participation.

**Rationale for Withdrawal.**

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

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

**By entering this pledge, I agree to:**

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

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

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

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

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

\* We entities operating under the submitted Provider ID:320001

Agree to participate

Do not agree to participate

Request to be withdrawn from participation.

**Rationale for Withdrawal.**

Wish to Change NOP Status

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

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

**By entering this pledge, I agree to:**

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

**Confirm SAVE?**

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

Once a facility has agreed to participate, they remain a program participant until they log in and select the option to withdraw.

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



## Section 6: Data Accuracy and Completeness Acknowledgement

IPFQR program participants enter NOP and measure data using the web-based applications on *QualityNet*. Following the submission of the measure data, each IPF must attest to the accuracy and completeness of the entered data via a Data Accuracy and Completeness Acknowledgement (DACA) statement. The DACA must be completed annually by the August 15 submission deadline, prior to the respective payment determination year.

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

As you complete submission of data for each measure, the status will change from “Incomplete” to “Completed,” indicated by #1 below.

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

Start | Structural/Web-Based Measures | 07/06/2015 12:30:47 PT

### Inpatient Psychiatric Facilities Web-Based Measures/DACA

Submission Period: 07/01/2015 - 08/15/2015 | With Respect to Reporting Period: 01/01/2014 - 12/31/2014

Web-Based Measures | PY 2016

Provider ID	HBIPS-2	HBIPS-3	HBIPS-4/HBIPS-5	HBIPS-6	HBIPS-7	SUB-1	Assessment of Patient Experience of Care	Use of an Electronic Health Record	DACA
	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed

Program Selection | Payment Year Selection

The following page appears:

**Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program  
Data Accuracy and Completeness Acknowledgement for FY 2016**

**(\*) indicates required for providers participating in the Inpatient Psychiatric Quality Reporting Program**

I acknowledge that to the best of my ability all of the information reported for this Inpatient Psychiatric Facility (IPF) Quality Reporting (IPFQR) Program, as required for the Fiscal Year 2016 IPFQR Program requirements, is accurate and complete. This information includes the following:

- *Aggregated data for all required measures*
- *Current Notice of Participation and QualityNet Security Administrator*

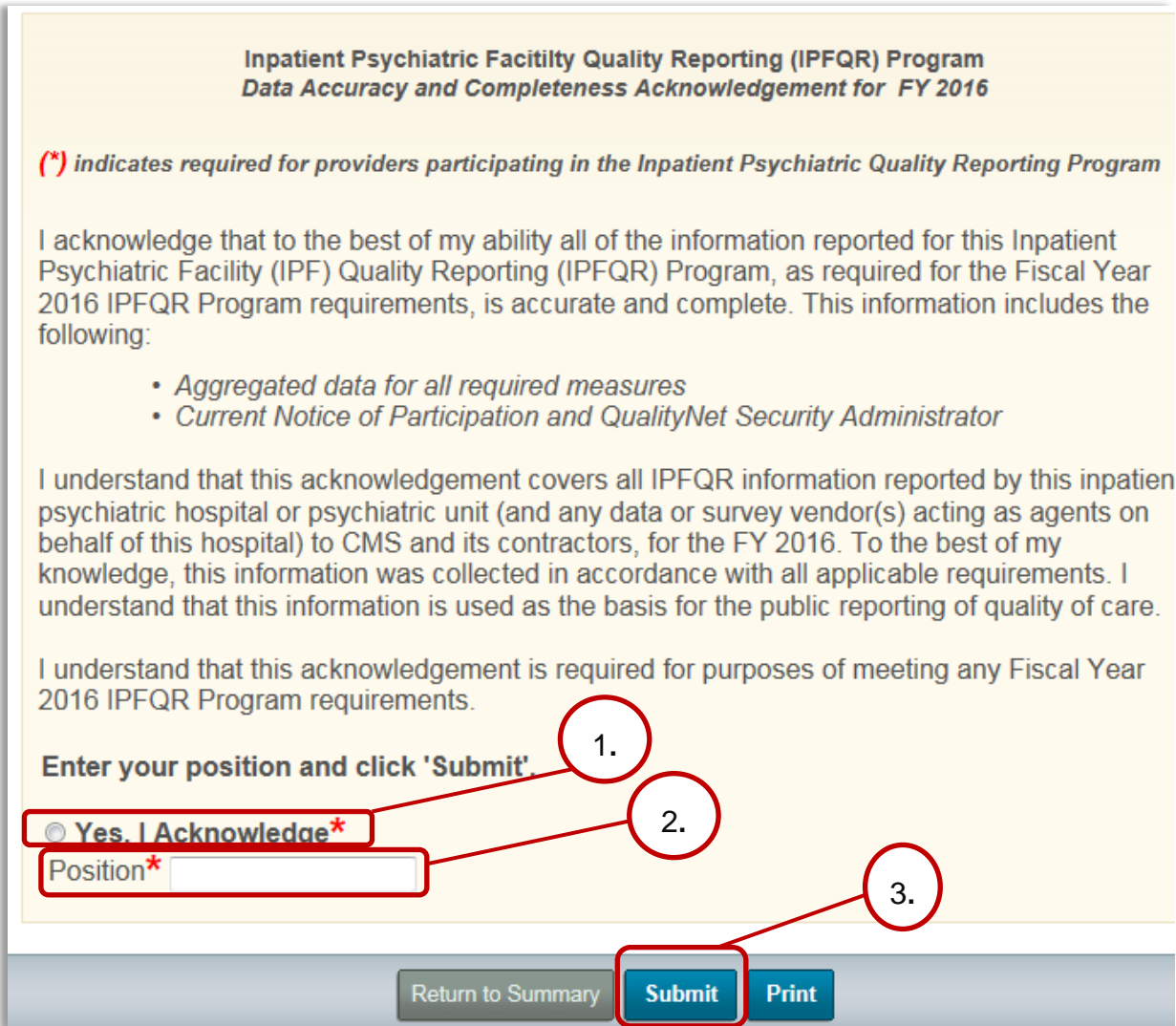
I understand that this acknowledgement covers all IPFQR information reported by this inpatient psychiatric hospital or psychiatric unit (and any data or survey vendor(s) acting as agents on behalf of this hospital) to CMS and its contractors, for the FY 2016. To the best of my knowledge, this information was collected in accordance with all applicable requirements. I understand that this information is used as the basis for the public reporting of quality of care.

I understand that this acknowledgement is required for purposes of meeting any Fiscal Year 2016 IPFQR Program requirements.

**Enter your position and click 'Submit'.**

**Yes, I Acknowledge\***

Position\*



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

## Section 7: Accessing and Reviewing Reports

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

### Facility, State, and National Report

The Facility, State and National Report provide information about the data that is submitted to the clinical warehouse, following entry into the web-based application. The facility rate is specific to the facility accessing the report.

The state and national rates are calculated approximately 30 days following the end of the submission period. This information is used for an individual facility to compare its facility-specific rates with state and national averages for each measure.

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

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

### Provider Participation Report

The Provider Participation Report will be available in the future. This report provides the facility with a summary of the requirements for participation in the IPFQR program. The report assists IPFs in determining their facility's status towards meeting the program requirements. However, the information provided does not guarantee the hospital will receive the full APU.

## Section 8: Public Reporting of IPFQR Data

### **Background**

Section 1886(s)(4)(E) of the Social Security Act requires the Secretary of Health and Human Services to establish procedures for making the data submitted under the IPFQR program available to the public.

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

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

### **Public Display Timeline**

The IPFQR program will have quality of care data publicly displayed on an annual basis.

### **Preview**

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

### **Preview Report Content**

The report contains Facility, State, and National level data listed by age category (stratum) and overall rate in an aggregate annualized format. The reporting quarters and measures included on the report are the same as those submitted for the specific program year. For example, for FY 2015, the HBIPS measures 2 through 7 were reported for the period from the second through the fourth quarters of 2013.

An example of the IPFQR Program Review Report is described below:

- Starting at the top of the report, the report header includes the report title, the name of the program, and the reporting period for the IPFQR measures. Note that there is also a Report Run date and Page numbering in the top section.
- The Facility CMS Certification Number is followed by the Facility Name at the top of the table and this information will appear on subsequent pages of the report. Note that there are a few instances where your facility name may have changed; however, if the

information has not been updated by the state survey and certification department, then it may still display as the previous name.

- Just below the facility name, there is a section containing facility demographic information such as the City, State, Zip, Phone Number, County where the facility is located, the type of facility (such as an acute, critical access or psychiatric hospital), the type of ownership, and whether your facility provides emergency services.
- The report is separated into three columns. The first column on the left is the facility specific data. The column in the middle contains the data for all facilities within your individual state. The far right column contains the national data.
- The data are displayed in measure order, starting with HBIPS-2. The data is displayed by stratum or age group. There is a column for the numerator and one for the denominator. Note for the HBIPS-2 and HBIPS-3 event measures, the rates are calculated per 1000 patient hours. For this report, the measure results are rounded to two decimals.

An example of page 1 of the Preview Report is displayed below:

Page 1 of 5

Report Run Date: 11/19/2015

**Hospital Compare Preview Report: Improving Care Through Information**  
*Inpatient Psychiatric Facility Quality Reporting Program*  
**Reporting Period for IPFQR Measures: First Quarter 2014 through Fourth Quarter 2014 Discharges**

000000-NAME OF IPF											
Address:						Type of Facility: Short-term					
City, State, ZIP:						Type of Ownership: Proprietary					
Phone Number:						Emergency Service Provided: No					
County Name:											

Web-Based Measures Set IPFQR-HBIPS					Facility			State			National		
Measure Description	Age Group	Numerator	Denominator	Rate Per 1000 Patient Hours	Numerator	Denominator	Rate Per 1000 Patient Hours	Numerator	Denominator	Rate Per 1000 Patient Hours	Numerator	Denominator	Rate Per 1000 Patient Hours
HBIPS-2: Hours Of Physical-Restraint Use													
	1 - 12 years	0	0	N/A(3,7)	400	1280	13.02	1832	3608	21.16			
	13 - 17 years	0	0	N/A(3,7)	400	1280	13.02	1744	3608	20.14			
	18 - 64 years	53.44	94	23.69(3)	400	1280	13.02	1744	3608	20.14			
	65 and over	0	0	N/A(3,7)	400	1280	13.02	1744	3608	20.14			
	Overall	53.44	94	23.69	1600	5120	13.02	7064	14432	20.39			

Web-Based Measures Set IPFQR-HBIPS					Facility			State			National		
Measure Description	Age Group	Numerator	Denominator	Rate Per 1000 Patient Hours	Numerator	Denominator	Rate Per 1000 Patient Hours	Numerator	Denominator	Rate Per 1000 Patient Hours	Numerator	Denominator	Rate Per 1000 Patient Hours
HBIPS-3: Hours Of Seclusion													
	1 - 12 years	0	0	N/A(3,7)	48	144	13.89	250	942	11.06			
	13 - 17 years	0	0	N/A(3,7)	48	144	13.89	450	934	20.07			
	18 - 64 years	5.17	64	3.37(3)	48	144	13.89	250	934	11.15			
	65 and over	0	0	N/A(3,7)	48	144	13.89	250	934	11.15			
	Overall	5.17	64	3.37	192	576	13.89	1200	3744	13.35			

**Footnote Legend**

- 1 . The number of cases/patients is too few to report.
- 3 . Results are based on a shorter time period than required.
- 4 . Data suppressed by CMS for one or more quarters.
- 5 . Results are not available for this reporting period.
- 7 . No cases met the criteria for this measure.

The discharge measures are displayed the same way as the event measures with the exception that the rate is displayed as a percentage of the total. In the example below, footnote four is

displayed for the HBIPS-4 and HBIPS-5 measures. Footnote four is used when CMS suppresses the display of data for a measure(s) for public reporting. The results for a measure(s) may be excluded for various reasons, such as data inaccuracies. More information about footnotes can be found on page 69.

An example of page 2 of the Preview Report is displayed below:

Page 2 of 5

Report Run Date: 12/21/2015

**Hospital Compare Preview Report: Improving Care Through Information**  
*Inpatient Psychiatric Facility Quality Reporting Program*  
 Reporting Period for IPFQR Measures: First Quarter 2014 through Fourth Quarter 2014 Discharges

000000-NAME OF IPF											
Web-Based Measures Set IPFQR-HBIPS			Facility			State			National		
Web-Based Measure Description	Age Group	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total	
HBIPS-4: Patients Discharged On Multiple Antipsychotic Medications											
	1 - 12 years	0	0	0.00(4)	12	24	50.00%	48	108	44.44%	
	13 - 17 years	0	0	0.00(4)	12	24	50.00%	48	108	44.44%	
	18 - 64 years	2	33	6.06(4)	12	24	50.00%	48	108	44.44%	
	65 and over	6	71	8.45(4)	12	24	50.00%	48	108	44.44%	
	Overall	8	104	7.69(4)	48	96	50.00%	192	432	44.44%	
HBIPS-5: Patients Discharged On Multiple Antipsychotic Medications With Appropriate Justification											
	1 - 12 years	0	0	0.00(4)	12	24	50.00%	192	296	64.86%	
	13 - 17 years	0	0	0.00(4)	12	24	50.00%	192	296	64.86%	
	18 - 64 years	1	N/A(1)	50.00(4)	12	24	50.00%	192	296	64.86%	
	65 and over	6	N/A(1)	100.00(4)	12	24	50.00%	192	296	64.86%	
	Overall	7	N/A(1)	87.50(4)	48	96	50.00%	768	1184	64.86%	

**Footnote Legend**

1. The number of cases/patients is too few to report.
3. Results are based on a shorter time period than required.
4. Data suppressed by CMS for one or more quarters.
5. Results are not available for this reporting period.
7. No cases met the criteria for this measure.

Page 3 of the sample report shows the HBIPS-6, and HBIPS-7 measures. The rate is displayed as a percentage of the total, as shown below:

Page 3 of 5

Report Run Date: 12/21/2015

**Hospital Compare Preview Report: Improving Care Through Information**  
*Inpatient Psychiatric Facility Quality Reporting Program*  
 Reporting Period for IPFQR Measures: First Quarter 2014 through Fourth Quarter 2014 Discharges

000000-NAME OF IPF										
Web-Based Measures Set IPFQR-HBIPS					State			National		
Web-Based Measure Description	Age Group	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total
HBIPS-6: Post-Discharge Continuing Care Plan Created										
	1 - 12 years	0	0	N/A(3.7)	8	16	50.00%	376	616	61.04%
	13 - 17 years	0	0	N/A(3.7)	8	16	50.00%	376	616	61.04%
	18 - 64 years	42	42	100.00(3)	8	16	50.00%	376	616	61.04%
	65 and over	111	112	99.11(3)	8	16	50.00%	376	616	61.04%
	Overall	153	154	99.35%	32	64	50.00%	1504	2464	61.04%

Web-Based Measures Set IPFQR-HBIPS					State			National		
Web-Based Measure Description	Age Group	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total	Numerator	Denominator	% of Total
HBIPS-7: Post-Discharge Continuing Care Plan Transmitted To The Next Level Of Care Provider Upon Discharge										
	1 - 12 years	0	0	N/A(3.7)	4	8	50.00%	4	8	50.00%
	13 - 17 years	0	0	N/A(3.7)	4	8	50.00%	4	8	50.00%
	18 - 64 years	42	42	100.00(3)	4	8	50.00%	4	8	50.00%
	65 and over	111	112	99.11(3)	4	8	50.00%	4	8	50.00%
	Overall	153	154	99.35%	16	32	50.00%	16	32	50.00%

**Footnote Legend**

1. The number of cases/patients is too few to report.
3. Results are based on a shorter time period than required.
4. Data suppressed by CMS for one or more quarters.
5. Results are not available for this reporting period.
7. No cases met the criteria for this measure.

On page 4 of the sample Preview Report data for the SUB-1, Assessment of Patient Experience of Care, and the Use of an Electronic Health Record (EHR) measures are displayed.

Report Run Date: 12/21/2015

Page 4 of 5

**Hospital Compare Preview Report: Improving Care Through Information**  
*Inpatient Psychiatric Facility Quality Reporting Program*  
 Reporting Period for IPFQR Measures (Except FUH Measure): First Quarter 2014 through Fourth Quarter 2014 Discharges

000000-NAME OF IPF											
Substance Use		Facility			State			National			
Measure ID	Measure Description	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	
SUB-1	Alcohol Use Screening	N/A(5)	N/A(5)	N/A(5)	53340	81984	65.06%	9405339	1525978	256.81%	

Assessment of Patient Experience of Care		Facility	State			National		
Measure ID	Measure Description	Response	Response	Facility Count	Percentage	Response	Facility Count	Percentage
IPFQR-PEoC	Did Your Facility Routinely Assess Patient Experience Of Care Using A Standardized Collection Protocol And A Structured Instrument?	Yes	Yes	2	100.00%	Yes	6	85.71%
			No	0	0.00%	No	1	14.29%

Use of an Electronic Health Record (EHR)		Facility	State			National		
Measure ID	Measure Description	Response	Response	Facility Count	Percentage	Response	Facility Count	Percentage
IPFQR-EHR	Please Select Which Of The Following Statements Best Describes Your Facility'S Highest Level Typical Use Of An Ehr System (Excluding The Billing System) During The Reporting Period:	N/A(5)	Paper or Other Form	1	50.00%	Paper or Other Form	3	50.00%
			Non-Certified EHR Technology	1	50.00%	Non-Certified EHR Technology	1	16.67%
			Certified EHR Technology	0	0.00%	Certified EHR Technology	2	33.33%
	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 (Hispanic)?	N/A(5)	Yes	1	50.00%	Yes	4	66.67%
			No	1	50.00%	No	2	33.33%

**Footnote Legend**

1. The number of cases/patients is too few to report.
3. Results are based on a shorter time period than required.
4. Data suppressed by CMS for one or more quarters.
5. Results are not available for this reporting period.
7. No cases met the criteria for this measure.



The last page of the sample Preview Report displays the Follow-Up After Hospitalization (FUH) for Mental Illness measure. Note that the 7-day and 30-day FUH measure results will be suppressed for FY 2016 reporting and N/A(4) will be displayed on the Preview Report and on *Hospital Compare*.

Page 5 of 5

Report Run Date: 12/21/2015

**Hospital Compare Preview Report: Improving Care Through Information**  
*Inpatient Psychiatric Facility Quality Reporting Program*  
 Reporting Period for FUH Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

000000-NAME OF IPF										
Follow-Up After Hospitalization for Mental Illness		Facility			State			National		
Measure ID	Measure Description	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage
FUH-30	Follow-up after Hospitalization for Mental Illness 30-Days	N/A(4)	N/A(4)	N/A(4)	N/A(4)	N/A(4)	N/A(4)	N/A(4)	N/A(4)	N/A(4)
FUH-7	Follow-up after Hospitalization for Mental Illness 7-Days	N/A(4)	N/A(4)	N/A(4)	N/A(4)	N/A(4)	N/A(4)	N/A(4)	N/A(4)	N/A(4)

**Footnote Legend**

1. The number of cases/patients is too few to report.
3. Results are based on a shorter time period than required.
4. Data suppressed by CMS for one or more quarters.
5. Results are not available for this reporting period.
7. No cases met the criteria for this measure.

## Footnotes

There are times when footnotes are necessary to further explain the data displayed in the report. There are five footnotes that may be applicable for the IPFQR program preview report. At the bottom of every page of the report, there is a footnote legend that lists the footnotes that may appear on the report.

The footnotes applied are particular to the facility based on their data, so not every footnote may be used. For example, Footnote 4 is used at the discretion of CMS and reserved for issues where the data may not be accurate due to an issue with data collection or submission. A complete list of footnotes and footnote details is located on the *Hospital Compare* website:

<https://www.medicare.gov/hospitalcompare/data/Footnotes.html>.

# Medicare.gov Website

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

## Medicare.gov Home Page

The IPFQR announcement is located under the Spotlight section on the lower left portion of the page.

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

Select the link for inpatient psychiatric facility data to navigate to the IPFQR program’s information page.

**Medicare.gov | Hospital Compare**  
The Official U.S. Government Site for Medicare

Hospital Compare Home | About Hospital Compare | About the data | Resources | Help

Home Share

### Find a hospital

A field with an asterisk (\*) is required.

\* **Location**  
Example: 45802 or Lima, OH or Ohio

ZIP code or City, State or State

**Hospital name (optional)**  
Full or Partial Hospital Name

**Search**

**Spotlight**

- ◆ **NEW** Healthcare-associated infections data have been expanded to include adult and pediatric medical, surgical, as well as combined medical and surgical wards. [Learn more.](#)
- ◆ We've reorganized the data categories. [Learn more.](#)
- ◆ Compare hospital star ratings on the Survey of Patients' Experiences Tab. [Learn more.](#)
- ◆ Get PPS-exempt cancer hospital data.
- ◆ Review hospital survey reports.
- ◆ **Check inpatient psychiatric facility data.**

**Additional information**

- ◆ **Hospital Compare data last updated:** December 10, 2015. [Go to updates.](#)
- ◆ [Download the Hospital Compare database](#)
- ◆ [Get Hospital Compare data archives.](#)
- ◆ [Linking quality to payment:](#)
  - ◆ [Hospital Value-Based Purchasing Program \(Hospital VBP\):](#)
    - ◆ [Fiscal Year 2016 data and scoring](#)  
Data updated Dec. 2015
    - ◆ [Fiscal Year 2014 incentive payment adjustments](#)

**Tools and Tips**

- ◆ [Learn how Medicare covers inpatient and outpatient hospital services.](#)
- ◆ [Use The Guide to Choosing a Hospital when comparing hospitals.](#)
- ◆ [Get tips for printing hospital information](#)
- ◆ [Compare other providers and plans](#)
  - ◆ [Visit Physician Compare to learn what hospitals your physicians and other healthcare professionals are affiliated with.](#)
  - ◆ [Nursing Home Compare](#)
  - ◆ [Home Health Compare](#)
  - ◆ [Dialysis Facility Compare](#)

The IPFQR program page includes a brief description of the program and the measures. It includes public access to performance measure data provided by IPFs; however, it does not generate a report equivalent to the Facility, State, and National report available to a facility through the secure portal. The data is in an aggregate annualized format of the quarters for the reporting period. This data may be calculated from the Facility, State, and National report.

**Medicare.gov | Hospital Compare**  
The Official U.S. Government Site for Medicare

**Inpatient Psychiatric Facility Quality Reporting Program**

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

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

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

- Hours of physical restraint use (HBIPS 2) – *lower numbers are better*
- Hours of seclusion use (HBIPS 3) – *lower numbers are better*
- Post discharge continuing care plan created (HBIPS 6) – *higher numbers are better*
- Post discharge continuing care plan transmitted to next level of care provider upon discharge (HBIPS 7) – *higher numbers are better*

CMS has suppressed data for the following measures for the April 2014 display:

- Patients discharged on multiple antipsychotic medications (HBIPS 4)
- Patients discharged on multiple antipsychotic medications with appropriate justification (HBIPS 5)

[Get more details about these measures.](#)

**Inpatient Psychiatric Facility Quality Measure Data – by Facility**  
Data Reporting Period: October 1, 2012 - March 31, 2013

If you would like to sort or filter these data, click the three-line menu icon ☰ for that particular column header.

**Data.Medicare.gov** MENU

Inpatient Psychiatric Facility Quality Measure Data – by Facility

Type in your search term and press enter.

Scroll down the page to see the next section - Data by Facility. The upper left corner of the data table is labeled as Data.Medicare.gov. This is where the data resides. A drop down “Menu” with options to sort and filter data is located in the top right corner.

**Inpatient Psychiatric Facility Quality Measure Data – by Facility**  
Data Reporting Period: October 1, 2012 - March 31, 2013

If you would like to sort or filter these data, click the three-line menu icon ☰ for that particular column header.

**Data.Medicare.gov** MENU

	Provider_Number	Hospital_Name	Address
1	010001	SOUTHEAST ALABAMA MEDICAL CENTER	1108 ROSS CLARK
2	010007	MIZELL MEMORIAL HOSPITAL	702 N MAIN ST
3	010008	CRENSHAW COMMUNITY HOSPITAL	101 HOSPITAL CIR
4	010011	ST VINCENT'S EAST	50 MEDICAL PARK
5	010016	SHELBY BAPTIST MEDICAL CENTER	1000 FIRST STREE
6	010021	DALE MEDICAL CENTER	126 HOSPITAL AVE
7	010023	BAPTIST MEDICAL CENTER SOUTH	2105 EAST SOUTH
8	010033	UNIVERSITY OF ALABAMA HOSPITAL	619 SOUTH 19TH S
9	010034	COMMUNITY HOSPITAL INC	805 FRIENDSHIP R
10	010039	HUNTSVILLE HOSPITAL	101 SIVLEY RD
11	010040	GADSDEN REGIONAL MEDICAL CENTER	1007 GOODYEAR /
12	010062	WIREGRASS MEDICAL CENTER	1200 W MAPLE AV
13	010069	MEDICAL CENTER BARBOUR	820 W WASHINGTC
14	010078	NORTHEAST ALABAMA REGIONAL MED CEN	400 EAST 10TH STI
15	010085	DECATUR MORGAN HOSPITAL-DECATUR CA	1201 7TH STREET :
16	010086	NORTHWEST MEDICAL CENTER	1530 U S HIGHWAY
17	010091	GROVE HILL MEMORIAL HOSPITAL	295 JACKSON HW^
18	010092	D C H REGIONAL MEDICAL CENTER	809 UNIVERSITY B
19	010101	CITIZENS BAPTIST MEDICAL CENTER	604 STONE AVENU
20	010103	BAPTIST MEDICAL CENTER-PRINCETON	701 PRINCETON AL

After selecting the menu list, you may access the download option. Once the download is complete, filtering and other types of data manipulation are available depending on the file format selected.

**Inpatient Psychiatric Facility Quality Measure Data – by Facility**  
Data Reporting Period: October 1, 2012 - March 31, 2013  
If you would like to sort or filter these data, click the three-line menu icon ☰ for that particular column header.

**Data.Medicare.gov** MENU

	Provider_Number	Hospital_Name
1	010001	SOUTHEAST ALABAMA M
2	010007	MIZELL MEMORIAL HOSP
3	010008	CRENSHAW COMMUNITY
4	010011	ST VINCENT'S EAST
5	010016	SHELBY BAPTIST MEDIC
6	010021	DALE MEDICAL CENTER
7	010023	BAPTIST MEDICAL CENTE
8	010033	UNIVERSITY OF ALABAM
9	010034	COMMUNITY HOSPITAL IN
10	010039	HUNTSVILLE HOSPITAL
11	010040	GADSDEN REGIONAL ME
12	010062	WIREGRASS MEDICAL C
13	010069	MEDICAL CENTER BARB
14	010078	NORTHEAST ALABAMA R
15	010085	DECATUR MORGAN HOSPITAL-DECATUR CA 1201 7TH STREET S
16	010086	NORTHWEST MEDICAL CENTER 1530 U S HIGHWAY

**More Views**  
Filters, Charts, and Maps

- Download**  
Download in various formats
- Discuss**  
Discuss this Dataset
- Embed**  
Embed this player on your site
- API**  
Access this Dataset via SODA
- OData**  
Access this Dataset via OData
- Print**  
Print this dataset

Help with file formats & plug-ins  
About the Socrata Open Data Platform

Continue to scroll down the IPFQR Program page to locate the next section, Data by State. The menu list provides access to the download function.

**Inpatient Psychiatric Facility Quality Measure Data – by State**  
Data Reporting Period: October 1, 2012 - March 31, 2013  
If you would like to sort or filter these data, click the three-line menu icon ☰ for that particular column header.

**Data.Medicare.gov** MENU

	State	S_HBIPS-2_Measure_Description	S_HBIPS-2_Overall
1	HI	Hours of Physical Restraint Use	
2	KS	Hours of Physical Restraint Use	
3	RI	Hours of Physical Restraint Use	
4	IA	Hours of Physical Restraint Use	
5	FL	Hours of Physical Restraint Use	
6	WA	Hours of Physical Restraint Use	
7	NM	Hours of Physical Restraint Use	
8	WI	Hours of Physical Restraint Use	
9	WY	Hours of Physical Restraint Use	
10	AR	Hours of Physical Restraint Use	
11	ND	Hours of Physical Restraint Use	
12	VA	Hours of Physical Restraint Use	

Continue to scroll down the IPFQR Program page to locate the final section, Data by Nation. The menu list provides access to the download function. Hospital Compare Archives are available for historical data.

An alternate method to access the data is to access the Data.Medicare.gov website at the direct link: <http://data.medicare.gov>

## Section 9: Resources

The following information contains additional resources available for IPFs participating in the CMS IPFQR Program.

For resources and tools from the IPFQR Support Contractor, users can access the website <http://www.QualityReportingCenter.com>. Data collection tools, timelines, and calendars, as well as other valuable resources, can be located on this website. In the dropdown menu for the Inpatient tab, select the IPFQR Program.

National Provider Webinars are provided by CMS and by the IPFQR Support Contractor on a routine basis. The slides from each of the education sessions are published to the *QualityNet* website and are available for review under the Inpatient Psychiatric Facilities tab by selecting the Webinars/Calls link from the drop down menu.

### **IPFQR ListServe**

To receive important IPFQR program updates and notifications, please subscribe to the ListServe on the *QualityNet* website. On the left side of the page, navigate to the “Join ListServes” box and select the “Notifications and Discussions” link. Check the box next to Inpatient Psychiatric Facility Quality Reporting Program, enter your User Information, and click Submit.

### **Questions & Answers**

The CMS Q&A tool is also a good resource for program information. The tool is intended to help users quickly find program answers when they are needed. The Q&A tool can be accessed from *QualityNet* by selecting the “Inpatient Psychiatric Facilities” link from the Questions & Answers section on the right side of the page and then choosing the “Inpatient Psychiatric Facility Quality Reporting” link (direct link): <https://cms-ip.custhelp.com/app/home4>.

If needed information is not in the Q&A Tool, select the “Ask a Question” link to submit a question to the IPFQR Support Contractor.

IPFQR Support Contractor

Toll-Free Telephone: 844.472.4477 or 866.800.8765

Email: [IPFQualityReporting@hcqis.org](mailto:IPFQualityReporting@hcqis.org)

Hours of Operation: 8:00 a.m. – 8:00 p.m. Eastern Time

### **Help Desk - QualityNet**

For technical issues contact the *QualityNet* Help Desk at:

Toll-Free Telephone: 866.288.8912

Email: [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org)

Hours of Operation: 7:00 a.m. – 7:00 p.m. Central Time

## **QualityNet Website**

The IPFQR program uses *QualityNet* to publish information including requirements, announcements about educational offerings, and news stories. The IPFQR Program home page is located at the following link:

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

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

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

## **Paper Abstraction Tools**

Paper Abstraction Tools have been developed for IPFs to use as an **optional** mechanism to aid in the collection of the HBIPS measure data for the CMS IPFQR Program. The Paper Abstraction Tools are located under the IPFQR Measures Resource section:

<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772864255>.

## **Specification Manuals**

### ***Specifications Manual for Joint Commission National Quality Core Measures Manual***

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

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

### ***Specifications Manual for National Hospital Inpatient Quality Measures***

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

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

## **National Committee for Quality Assurance (NCQA)**

The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality (<http://www.ncqa.org/>).

## **Other Resources**

### ***National Institute on Alcohol Abuse and Alcoholism (NIAAA)***

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is one of the 27 institutes and centers that comprise the National Institutes of Health (NIH). NIAAA supports and conducts research on the impact of alcohol use on human health and well-being. It is the largest funder of alcohol research in the world. The NIAAA has published a list of validated screening tools that may be used by facilities in conducting their Alcohol Screening for the SUB-1 Measure (<http://www.niaaa.nih.gov/>).

# Appendix A: Components of the Specifications Manual for National Hospital Inpatient Quality Measures and the Specifications Manual for Joint Commission National Quality Core Measures

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

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

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

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

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

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

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

A comprehensive list of each of the data elements is provided along with the page number and a list of specific measures in which the data element is used. Many data elements are used for more than one measure or measure set.

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

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



## Data Element Sections (continued)

- **Format** - Identifies the criteria (length, type, occurs) of data that is being collected for transmission purposes.
  - Length - Number of characters or digits allowed for the element.
  - Type - Identifies the allowed data value: numeric, alphanumeric, date or time.
  - Occurs - Number of times the data element occurs in a single episode of care record.
- **Allowable Value** - A list of acceptable responses for the element. In some data elements, the response may be limited to one while others may allow for multiple values.
- **Notes for Abstraction** - Provided to assist the abstractor in the selection of the correct Appropriate Value for the data element. The Notes section may include examples of documentation encountered in the medical record.
- **Suggested Data Sources** - Provides a list of source documents from which data can be identified, such as an administrative or medical record. The sources are usually listed alphabetically for guidance locating the information within records. The information listed is for suggested sources only; however, other sources may be used, unless otherwise noted.
- **Guideline for Abstraction** - Designed to assist abstractors in determining how a data element should be answered. The instructions can reference inclusions abstracted as a positive finding. Unless specified within the data element, the inclusions listed are **not** considered all inclusive. The data element can contain specific exclusions or unacceptable terms abstracted as negative findings. Also, the instructions can reference an appendix in the *Specifications Manual*, such as a medication table. Element specific notes and guidelines take precedence over the “General Abstraction Guidelines” found in the “Introduction to the Data Dictionary.”

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

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

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

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

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

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

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

**Measure Information Algorithms** - Algorithms illustrate the calculation steps needed for a measure. Each algorithm provides the logical steps, data element evaluation, arithmetic calculations and data manipulation information required to calculate a measure. The algorithms are used by vendors to design software applications and are helpful as a visual aid. For example, “Appendix E” of the manual provides more details and the definition of each field contained within the MIF. Data elements used in the calculation of the measure are italicized within the algorithm.

A narrative description of the algorithm immediately follows the algorithm diagram. The information is supplemental and explains the flow in less technical terms. It is not intended to be used for programming purposes; however, the narrative steps may be of assistance for abstractors in understanding how the algorithm functions.

## Appendix B: Follow-Up After Hospitalization for Mental Illness (FUH) Data Tables

<b>Eligible Population</b>	
Data Sources	<p><b>Eligible Population</b> is comprised of fee-for-service Medicare claims for IPF discharges with a principal mental health diagnosis (Table B).</p> <p><b>Denominator</b> is the eligible population minus exclusions. The denominator is based on discharges, not individuals.</p> <p><b>Denominator exclusions</b> are defined using fee-for-service Medicare claims.</p> <p><b>Numerator</b> is populated using Medicare fee-for-service claims.</p>
Ages	6 years and older
Continuous Enrollment	Includes discharges for Medicare beneficiaries having continuous coverage (no gaps) for Part A and Part B as of the date of discharge through the 30 days following discharge date.
Event/Diagnosis	IPF discharges occurring within the reporting period (July 1 through June 30). If individuals have more than one discharge in the reporting period, then include all discharges in the eligible population.

<b>Denominator Exclusions</b>	
IPF Readmission or Direct Transfer	<p>A 30-day follow-up period is used for all exclusions related to the 7-day and 30-day measures.</p> <p>If the initial IPF discharge is followed by readmission or direct transfer to an IPF for a principal mental health diagnosis on Table B within the 30-day follow-up period, count only the readmission discharge or the discharge from the IPF to which the individual was transferred.</p> <p>Exclude both the initial IPF discharge and the IPF readmission/direct transfer discharge if the IPF readmission/direct transfer discharge occurs after June 30 of the reporting period.</p> <p>If the initial IPF discharge is followed by readmission/direct transfer to an IPF for a principal mental health diagnosis not on Table B within the 30 day follow-up period, then exclude the initial IPF discharge.</p>
Non-IPF Readmission or Direct Transfer	<p>Exclude IPF discharges that are followed by admission or direct transfer to an acute care (non-IPF) facility within the 30-day follow-up period. These discharges are excluded from the measure because the admission or transfer to the hospital may prevent an outpatient follow-up visit from taking place. Refer to Table C for rules to identify acute care facilities.</p> <p>Exclude IPF discharges followed by admission or direct transfer to a non-acute (non-IPF) facility within the 30-day follow-up period. These discharges are excluded from the measure because the admission or transfer to the non-acute facility may prevent an outpatient follow-up visit from taking place. Refer to Table D for rules to identify admission to non-acute care facilities.</p>
Exclusions Related to Discharge Status or Death	<p>Exclude IPF discharges followed by discharge/transfer to other institutions, including direct transfer to a prison, within the 30-day follow-up period. Refer to Table E for rules to identify these transfers.</p> <p>Exclude individuals who died during the stay and discharges followed by patient death within the 30-day follow-up period. Refer to Table E for relevant codes related to patient death.</p>

**Table A. Codes to identify IPF discharges**

<b>Facility codes</b> (Medicare inpatient file)
• Last 4 digits of 4000–4499 (Psychiatric Hospital excluded from PPS)
• 3rd digit of ‘S’ (distinct part Psychiatric Unit in an acute care hospital)
• 3rd digit of ‘M’ (Psychiatric Unit in a CAH)
<b>NOTE:</b> A stay in any facility that meets one of the three criteria above constitutes an IPF stay.

**Table B. Codes to identify principal mental health diagnosis ICD-9**

<b>Diagnosis codes</b>
295–299, 300.3, 300.4, 301, 308, 309, 311–314

**Table C. Codes to identify acute care facilities**

<b>Description (Medicare inpatient file)</b>	<b>Provider Number</b>
Provider number corresponding to acute care facilities	Fifth through Eighth digit (0001-0899)
<b>Notes:</b> Medicare files are used to identify all exclusions. Any acute care stay during the 30-day period following IPF discharge constitutes an exclusion.	

**Table D. Codes to identify admission to non-acute care**

<b>Description</b>	<b>HCPCS (Medicare carrier file)</b>	<b>UB Revenue (Medicare SNF, hospice, outpatient, and HHA files)</b>	<b>UB type of bill (Medicare SNF, hospice, outpatient, and HHA files)</b>	<b>POS (Medicare carrier files)</b>
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Comprehensive inpatient rehabilitation facility		0118, 0128, 0138, 0148, 0158		61
Respite		0655		
Intermediate care facility (ICF)				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017- H0019	1001		56
<b>Notes:</b> Medicare files are used to identify all exclusions. Any code corresponding to the 30-day period following IPF discharge constitutes an exclusion.				

**Table E. Codes to identify patient deaths and transfer/discharge to another institution (exclusion)**

<b>Description</b>	<b>Discharge Code (Medicare inpatient file)</b>
Discharged/transferred to other short term general hospital for inpatient care	02
Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care - for hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non- certified SNF, the hospital must use Code 04 - ICF.	03
Discharged/transferred to intermediate care facility (ICF)	04
Discharged/transferred to another type of institution for inpatient care	05
Expired	20
Discharged/transferred to a federal hospital	43
Hospice – Home	50
Hospice - medical facility	51
Discharged/transferred within this institution to a hospital-based Medicare approved swing bed 61 swing bed	61
Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital 62 units of a hospital	62
Discharged/transferred to a long term care hospital	63
Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	64
Discharged/transferred to a psychiatric hospital or psychiatric distinct unit of a hospital 65 hospital	65
Discharged/transferred to a Critical Access Hospital	66
Discharged/transferred to another type of health care institution not defined 70 elsewhere in code list	70
Died during the 30-day follow-up period	Medicare enrollment file
<b>NOTE:</b> Medicare files are used to identify all exclusions. Any code corresponding to the 30-day period following IPF discharge constitutes an exclusion.	

**Table F. Codes to identify outpatient visits, intensive outpatient encounters, and partial hospitalizations**

CPT		HCPCS
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510		G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485
<b>CPT with POS</b>		
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	with	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	with	52, 53
<b>CPT with TYP SVC/FACTYP</b>		
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876 99221-99223, 99231-99233, 99238, 99239, 99251-99255	with	TYP SVC of 2 or 3 if FACTYP = 1-6 or 9 FACTYP = 7 FACTYP = 8
<b>UB Revenue</b>		
0513, 0900-0905, 0907, 0911-0917, 0919 – does not have to be with mental health practitioner		
0510, 0515-0517, 0519-0523, 0526-0529, 077x, 0982, 0983 - must be with either a principal mental health diagnosis or practitioner		
<b>ER visits cannot count toward numerator (Medicare carrier/outpatient)</b>		
No line-level claim information related to ER services can count as a numerator hit. These are defined as [revenue center code values of 0450-0459 (Emergency room) or 0981 (Professional fees-Emergency room) or HCPCS codes associated with ER use (99281, 99282, 99283, 99284, 99285) in the OP file] OR [Place of Service code (23=Emergency room-hospital) or BETOS code (M3 = Emergency Room visit) in the carrier file]		
<b>NOTE:</b> A claim meeting any of the requirements above constitutes an outpatient visit.		



**Table G: Codes to identify mental health practitioners in Medicare**

<b>HEDIS definition of mental health practitioner</b>	<b>Specialty code</b>	<b>Taxonomy (linked to NPI)</b>
An MD or DO who is certified as a psychiatrist or child psychiatrist	26	2084P0800X 2084P0804X
Neurologist (not in original HEDIS specification)	13	2084V0102X; 2084N0400X 2084N0402X
An MD or DO who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry	86	2084A0401X; 2084P0802X 2084B0002X; 2084N0600X 2084D0003X ; 2084F0202X 2084P0805X ; 2084H0002X 2084P0005X ; 2084N0008X 2084P2900X ; 2084P0015X 2084S0012X; 2084S0010X
Licensed Psychologist	62	103T00000X; 103TA0400X 103TA0700X; 103TC0700X 103TC2200X; 103TB0200X 103TC1900X; 103TE1000X 103TE1100X; 103TF0000X 103TF0200X; 103TP2701X 103TH0004X; 103TH0100X 103TM1700X; 103TM1800X 103TP0016X; 103TP0814X 103TP2700X; 103TR0400X 103TS0200X; 103TW0100X
Certified in Clinical Social Work	80	1041C0700X
Psych Nurse, PA, or Occupational Therapist	89; 50; 67	364SP0808X 364SP0809X 364SP0807X 364SP0810X 364SP0811X 364SP0812X 364SN0800X 364SP0813X 363LP0808X 225XM0800X
<p><b>Notes:</b> All codes are found in Medicare outpatient/carrier files. Either a Medicare specialty code OR taxonomy code qualifies as a numerator hit.</p> <p>Specialty codes and Taxonomy codes are the best match with mental health practitioners defined in HEDIS specifications. NPI codes and specialty codes in Medicare claims can be used to determine provider taxonomy and type, respectively.</p>		