

**Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
Online Data Entry Tool Content for Structural Measures
FY 2019 and Subsequent Years**

IPFs should complete the form in a fillable PDF format and submit via email to:

IPFQualityReporting@hcqis.org.

CCN

Facility Name

Measure: Assessment of Patient Experience of Care

Does the facility complete a detailed assessment of patient experience of care using a standardized collection protocol and structural instrument?

If yes, please specify the name of the survey administered.

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Measure: Use of an Electronic Health Record

Please select which of the following statements best describes the facility's highest level typical use of an Electronic Health Record 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:

- a. The facility most commonly used paper documents and other forms of information exchange (e.g. email) NOT involving transfer of health information using EHR technology at times of transition in care.
- b. The facility most commonly exchanged health information using non-certified EHR technology (i.e. not certified under the ONC HIT Certification Program) at times of transition in care.
- c. The facility most commonly exchanged health information using certified EHR technology (certified under ONC HIT Certification Program) at times of transition in care.

Please indicate whether transfers of health information at times of transition in care include the exchange of interoperable health information with a health information service provider (HISP):

Yes No

PRA DISCLOSURE STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1171**. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Expiration Date: xx/xx/xxxx