

2025 Measure Set Review (MSR): 00673-01-C-IPFQR Preliminary Assessment

I. Measure Overview¹

CMIT ID	Title
Link to CMIT measure record: 00673-01-C-IPFQR	Screening for Metabolic Disorders
Measure Steward	CMS Program
Centers for Medicare & Medicaid Services (CMS)	Inpatient Psychiatric Facility Quality Reporting Link: Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

CBE Endorsement Status	CBE Endorsement History
Not Endorsed	Never Submitted

¹ The information in this PA is sourced from the [CMS Measures Inventory Tool \(CMIT\)](#) and the [PQM Submission Tool and Repository \(STAR\) Measure Database](#). This document reflects the content available as of September 2025. Version 1.0 | September 2025 | *The analyses upon which this publication (or document) is based were performed under Contract Number 75FCMC23C0010, entitled, "National Consensus Development and Strategic Planning for Health Care Quality Measurement," sponsored by the Department of Health and Human Services, Centers for Medicare & Medicaid Services. Restricted: Use, duplication, or disclosure is subject to the restrictions as stated in Contract Number 75FCMC23C0010 between the Government and Battelle.*

Measure Overview

Rationale for Use: 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 with antipsychotics from an inpatient psychiatric facility (IPF) for which a structured metabolic screening for four elements was completed in the past year.

CMS-Provided Rationale for Use in Program: The Screening for Metabolic Disorders measure was added to the IPFQR Program to address the risk of metabolic syndromes such as diabetes and obesity as a result of taking all routinely scheduled antipsychotics. Recent research strongly supports the need for ongoing metabolic monitoring in patients treated with antipsychotic medications, highlighting significant associations with obesity and, to a lesser extent, diabetes and metabolic syndrome.^{2,3,4,5,6}

A 2011 study found high obesity rates and moderate diabetes prevalence among remitted schizophrenia patients on long-term antipsychotics, while hypertension rates remained low.⁵ Other studies emphasize that medications such as olanzapine and clozapine carry higher metabolic risks and recommend regular screening and lifestyle interventions.³ Additional findings reveal that patients with severe mental illness have poorer cardiometabolic health compared to the general population, and adherence to monitoring guidelines, especially in pediatric settings, is often low.⁶ Overall, the literature underscores the importance of this measure to prevent serious health outcomes through early detection and management of metabolic side effects.

Description: Percentage of patients discharged from an Inpatient Psychiatric Facility (IPF) with a prescription for one or more routinely scheduled antipsychotic medications for which a structured metabolic screening for four elements was completed in the 12 months prior to discharge, either prior to or during the index IPF stay.

Numerator: The total number of patients who received a metabolic screening in the 12 months prior to discharge - either prior to or during the index IPF stay.

Exclusions: None

Denominator: Discharges from an IPF during the measurement period with a prescription for one or

² Lavagnino, L., Gurguis, C., & Lane, S. (2021). Risk factors for metabolic and cardiovascular disease in inpatients with severe mental illness. *Psychiatry Research*, 304, 114148. <https://doi.org/10.1016/j.psychres.2021.114148>

³ New York State Medicaid Office of Health Insurance Programs (2024). Metabolic Health as an Essential Consideration When Using Antipsychotic Medications. <https://nysep.nysdoh.suny.edu/wp-content/uploads/2024/05/Metabolic-Monitoring-of-Antipsychotic-Medications-NYSMPEP-Article-v5.2024.pdf>

⁴ Sabé M, Pallis K, Solmi M, Crippa A, Sentissi O, Kaiser S. Comparative Effects of 11 Antipsychotics on Weight Gain and Metabolic Function in Patients With Acute Schizophrenia: A Dose-Response Meta-Analysis. *J Clin Psychiatry*. 2023 Feb 8;84(2):22r14490. doi: 10.4088/JCP.22r14490. PMID: 36752753.

⁵ Saddichha S, Vishnuvardhan G, Akhtar S. Obesity, diabetes and hypertension associated with antipsychotic use in remitted schizophrenia. *Int J Risk Saf Med*. 2011;23(3):181-5. doi: 10.3233/JRS-2011-0536. PMID: 22020398.

⁶ Singhal, S., Billian, J., Kloosterman, C., Bailey, T., & Soares, N. (2021). Low rates of clinician monitoring for second generation antipsychotic medications in community pediatric practice. *Community Mental Health Journal*, 10.1007/s10597-021-00852-3. Advance online publication. <https://doi.org/10.1007/s10597-021-00852-3>

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Measure Overview	
more routinely scheduled antipsychotic medications. Exclusions: Patients for whom a screening could not be completed due to the patient's enduring unstable medical or psychological condition. Patients with a length of stay equal to or greater than 365 days, or equal to or less than three days. Patients who expired during the admission (Discharge Disposition = 6).	
CMS Program History: Active in Inpatient Psychiatric Facility Quality Reporting since 2017.	Cascade of Meaningful Measures Priority: Wellness and Prevention
Measure Type: Process	Is the Measure Digital/an Electronic Clinical Quality Measure (eCQM)? No
Level(s) of Analysis/Measured Entity: Facility, Hospital, Agency	Care Setting(s): Behavioral Health: Inpatient Psychiatric Facility (IPF)
Does the Measure Fill a Statutorily Required Category for the Program? No	Is the Measure Included in Upcoming Rulemaking? No

II. Measure Performance in Program

For this measure, the MSR evaluation and analysis team reviewed the publicly available datasets:

- [hospitals_04_2025.zip](#) (which contains data from January 2023-December 2023 and is referred to as PY2023 in this assessment)
- [hospitals_10_2024.zip](#) (which contains data from January 2022-December 2022 and is referred to as PY2022 in this assessment)
- [hospitals_11_2023.zip](#) (which contains data from January 2021-December 2021 and is referred to as PY2021 in this assessment)

About Figure 1: Figure 1 uses boxplots to show how scores have changed over the most recent 3 years of available data. For each year, the boxplot displays a box with lines and dots to help visualize the range and distribution of scores. The dots represent the points where the lowest 5% and highest 5% of scores fall, and the line connecting them shows where 90% of the scores are located. The box itself covers the middle half of the scores, from the 25th to the 75th percentile. Inside the box, a horizontal line marks the median score, which is the middle value, while a “+” sign shows the average score. This type of graph makes it easier to understand overall trends in scores over time as well as the consistency and spread of the results.

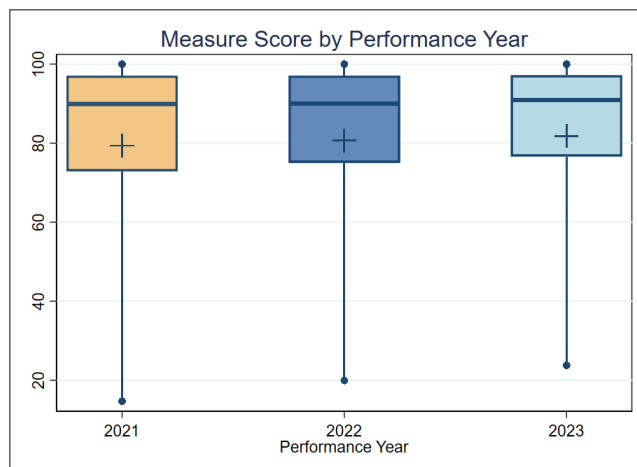


Figure 1. Boxplot of Measure Score by Year

Figure 1 Interpretation: In the boxplot above, the median score has a slight increasing trend from 89.9% in PY2021 to 90% in PY2022 and to 90.9% in PY2023. For this measure, a higher score indicates better quality of care. The narrowing of the box across the 3 years suggests that facilities below the median are improving while those above the median are staying the same.

About Table 1: Table 1 illustrates the distribution of scores and the number of patients represented within each group. Note: the groups with the lowest or highest scores (referred to as deciles, each comprising 10% of the organizations) may contain more or fewer patients than other groups. For example, if the lowest-scoring decile includes only 5% of the total patient population, this smaller group size may be associated with lower performance scores.

For this measure, Decile 1 represents a grouping of organizations who have the lowest measure scores and Decile 10 shows those with the highest measure scores. The arrow denotes improving performance on the measure.

Table 1. Importance (Decile by Measure Score, PY2023)


Lowest Performers  Highest Performers											
	Overall	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Score	81.8 (23.51)	21.9	62.6	76.4	84	89.2	92.4	95.2	97.3	99.2	100.0
Organizations	1,380	138	138	138	138	138	138	138	138	138	138
Patients	451,661	51,443	45,328	51,342	49,466	42,665	43,695	49,298	39,207	37,965	41,252

Table 1 Interpretation: To estimate the number of positive outcomes (appropriate screening for metabolic disorders for eligible patients), the number of patients is multiplied by the average score for each decile. Right now, the total estimated number of positive outcomes across all deciles is about 363,000. If the average performance of Decile 8 (97.3%) is considered a plausible, achievable score, and the entities in Deciles 1 through 7 improved to reach that benchmark, the estimated number of eligible patients screened for metabolic disorders would go up by about 17%, which translates to a potential total of about 440,000 positive outcomes. This means that improving performance on this measure could help ensure that tens of thousands more patients receive the appropriate screening for metabolic disorders, potentially leading to better health outcomes.

About Figure 2: Figure 2 is a bar graph displaying average change in performance by performance decile on this measure. Battelle developed this graph by first assigning each entity's year 1 performance score to a decile (1-10). For each entity, the change in performance score from year 1 was then calculated for both year 2 and year 3. The resulting changes in performance for year 2 and year 3 were plotted against the year 1 decile assignments, allowing for visualization of performance trends over time by initial performance level.

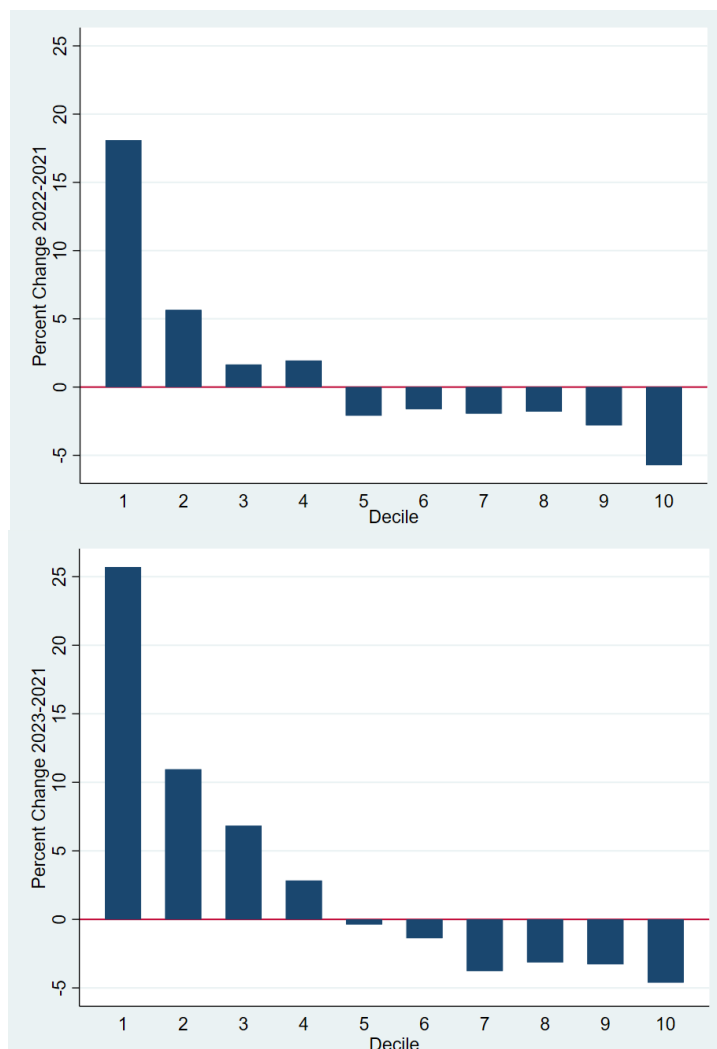


Figure 2. Mean Change in Performance by Decile

Figure 2 Interpretation: The upper graph shows that the improvement in average performance from PY2021 to PY2022 is inversely proportional to the performance score in PY2021. Deciles with lower scores in PY2021 showed an average increase in performance while deciles with high scores in PY2021 showed an average decrease in performance. The lower graph looks very similar, indicating that there was little change on average between PY2022 and PY2023 with the exception of the first three deciles, the 30% lowest scores in PY2021, which had an additional average increase in performance between PY2022 and PY2023, showing there is still room for improvement in performance among those who scored lower initially.

III. Evaluation Criteria

Meaningfulness

Importance
Guiding Questions: Does the evidence show that the focus of the measure is linked to meaningful outcomes for patients and health care organizations? Do the data demonstrate that using this measure within the quality program results in benefits that outweigh any associated burdens or costs?
Recent data summarized above show that both second-generation antipsychotics (SGAs) and antipsychotics increase the risk of metabolic syndrome. Performance on this measure is improving, and further gains could reduce the risk of preventable adverse events and improve the physical health status of the patient.
Committee Member Considerations: Based on reviewing measure performance and professional and personal experiences, committee members should consider the balance of implementation costs or burdens with the benefit of measure use within the program. Committee members will have a chance to share these thoughts with the broader committee via Pre-Meeting Initial Evaluation (PIE) Forms and group discussion.
Staff Rating: Met

Conformance
Guiding Question: Do measure components and specifications align with the measure intent and target population?
The intent of this measure is to screen patients who are receiving antipsychotics for metabolic syndrome before they are discharged to reduce the risk of preventable adverse events and improve physical health status. The specifications align with this intent: the numerator includes patients who received a metabolic screening in the 12 months prior to discharge. The denominator includes patients discharged from an IPF during the measurement period with a prescription for one or more routinely scheduled antipsychotic medications. This measure supports IPFQR objective to improve consumers' quality of care information to help them make more informed decisions about their healthcare options.
Committee Member Considerations: Committee members should review the list of active measures within this CMS program in the appendix and consider this measure's alignment with the group.
Staff Rating: Met

Feasibility
Guiding Question: Are the tools, processes, and people necessary to implement and report on the measure reasonably available for measured entities in the CMS program?
The measure relies on data elements that are not fully captured electronically and require manual chart abstraction. While feasible, this process increases staff workload and may impact reporting timeliness.
Committee Member Considerations: Committee members with experience implementing this or similar measures in inpatient psychiatric settings should reflect on potential challenges to feasibility of data collection and reporting.
Staff Rating: Met

Validity
Guiding Question: Do the data and/or logic support the idea that the measured entity can improve their performance on the measure?
Most entities are already performing at or near the maximum score, with little variation observed. The measure may have limited validity for driving further improvement in its current form. Committee Member Considerations: Committee members with experience implementing this or similar measures in inpatient psychiatric settings should reflect on potential methods to screen for metabolic disorders for patients using antipsychotics prior to discharge.
Staff Rating: Met

Reliability

The two tables below summarize reliability. Tables 2 and 3 sort entities by the number of patients, and the tables report average reliability along with the number of entities and average number and total patients for each decile. These tables can be used to assess the impact of population size on the reliability of an entity's measure score. Population size can impact reliability estimates because larger populations generally provide more stable and consistent measure scores, while smaller populations can lead to greater variation. In cases where reliability has a strong relationship to population size, reliability will be the lowest at Decile 1 and progressively increase up to Decile 10.

Table 3 sorts entities by reliability and reports the average reliability by decile. The table also includes the mean, standard deviation,⁷ minimum and maximum reliability, and interquartile range (IQR).⁸ This table can be used to see the distribution of the reliability of the entities. A measure is generally considered reliable when the reliability for at least 70% of the individual entities is above 60%.

Table 2. Reliability (Decile by Denominator – Target Population Size)

	Overall	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Mean Target Population Size	327	64	126	181	235	284	329	372	420	482	780
Mean Reliability	99.1	96.6	98.6	99.0	99.3	99.4	99.5	99.5	99.6	99.6	99.8
Entities	1,380	138	138	138	138	138	138	138	138	138	138
Total Patients	451,661	8,843	17,351	24,988	32,472	39,255	45,356	51,284	57,944	66,543	107,625

Table 3. Mean Reliability (By Reliability Decile)

Mean	SD	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	IQR
99.1	1.17	96.6	98.6	99.0	99.3	99.4	99.5	99.5	99.6	99.6	99.8	0.5

⁷ Standard deviation is a number that shows how spread out the values in a group of numbers are. If the standard deviation is small, most values are close to the average; if it's large, the values are more spread out and indicate greater variation in performance.

⁸ IQR, or interquartile range, is a number that shows how spread out the middle half of a group of numbers is. It measures the range between the value at the 25th percentile and the value at the 75th percentile, indicating how tightly or loosely the middle values are grouped.

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Tables 2 and 3 Interpretation: Reliability was estimated using a modification of the Adams⁹ signal-to-noise method where the reliability for each entity i is estimated by¹⁰

$100 * \frac{n_i}{\hat{\alpha} + \hat{\beta} + n_i}$ where n_i is the total number of patients for entity i , and $\hat{\alpha}$ and $\hat{\beta}$ are estimates of the beta binomial parameters. This method helps show how much the difference in scores between groups is due to real differences in quality rather than just random chance. In this case, all entities had a reliability score higher than 60%. This means that, for most entities, the measure can reliably tell the difference between those who are performing better or worse, making it a useful tool for comparing quality of care.

Reliability
Guiding Question: Does the evidence show that changes in measure performance are due to improvements in quality of care? In other words, do the data demonstrate that variation in measure performance is linked to changes made to processes or behaviors to improve care?
All entities have reliability scores above the accepted threshold, indicating that the measure consistently reflects true differences in care quality and can be used confidently for quality improvement.
Committee Member Considerations: Committee members should reflect on implications of the measure's reliability on program use and what the reliability may mean for individual measured entities.
Staff Rating: Met

Usability
Guiding Questions: Are there any known barriers or facilitators that determine whether the person or entity could improve the measure focus? Are these barriers addressable?
Based on the limited information available, the measure appears to be integrated into existing reporting processes and is generally understood by participating entities. No significant barriers to use or improvement have been identified, although unreported challenges may exist.
Committee Member Considerations: Based on professional/personal experiences, committee members should consider any barriers to using this measure for certain measured entities as well as any potential facilitators that might promote usability within the program.
Staff Rating: Met

Data Stream Parsimony

Data Stream Parsimony
Guiding Question: Does the data flow required for the measure promote non-burdensome data

⁹ Adams, John L., *The Reliability of Provider Profiling: A Tutorial*. Santa Monica, CA: RAND Corporation, 2009.

¹⁰ Nieser, K.J. and Harris, H.S. *Comparing methods for assessing the reliability of health care quality measures*. Statistics in Medicine: 43(23), 2024.

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Data Stream Parsimony

collection and reporting?

Some required data elements are not routinely captured electronically and must be collected manually. This increases staff workload and may introduce inefficiencies in the reporting process.

Committee Member Considerations: Based on professional/personal experiences, committee members should reflect on any additional barriers to the clinical data flow that collection may add as well as potential mitigation strategies.

Patient Journey

Patient Health Journey

Guiding Question: Does the measure address the appropriate aspects of care to align with the patient health care journey?

By focusing on the screening for metabolic disorders, the measure ensures patients who are at increased risk for developing metabolic syndromes because of the use of prescribed antipsychotic medicine are properly screened within an appropriate timeframe, supporting safer and more effective long-term outcomes.

Committee Member Considerations: Based on professional/personal experiences, committee members should consider if the measure identifies an appropriate and critical time to assess metabolic screening. Reflect on if this timepoint is meaningful to patients and any potential barriers or burdens associated with this timepoint in the care journey.

Appendix: Active Measures in the Inpatient Psychiatric Facility Quality Reporting Program

Measures Included in the Inpatient Psychiatric Facility Quality Reporting Program	
CMIT ID	Measure Title
01799-01-C-IPFQR	30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge Measure
00002-01-C-IPFQR	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Disorder Treatment at Discharge
00003-01-C-IPFQR	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility
00269-01-C-IPFQR	Follow-Up After Psychiatric Hospitalization
00042-01-C-IPFQR	Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
00673-01-C-IPFQR	<i>Screening for Metabolic Disorders</i>
00358-01-C-IPFQR	Hours of Seclusion Use
00357-01-C-IPFQR	Hours of Physical Restraint Use
00438-02-C-IPFQR	Medication Continuation Following Inpatient Psychiatric Discharge
00721-02-C-IPFQR	Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge
00727-02-C-IPFQR	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
00386-03-C-IPFQR	Influenza Immunization
01660-01-C-IPFQR	Facility Commitment to Health Equity
00180-02-C-IPFQR	Modified COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP)