



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 0552

Corresponding Measures:

De.2. Measure Title: HBIPS-4: Patients discharged on multiple antipsychotic medications.

Co.1.1. Measure Steward: The Joint Commission

De.3. Brief Description of Measure: The proportion of patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-5 (Patients discharged on multiple antipsychotic medications with appropriate justification).

1b.1. Developer Rationale: As stated above, recent literature supports antipsychotic monotherapy as the optimal treatment choice. The reduction in prescribing more than one antipsychotic medication will in turn decrease the likelihood of developing serious side effects which will ultimately reduce the ongoing costs of health care. And finally, a review of the justifications for prescribing more than one antipsychotic medication will help hospitals determine if their practice is supported by the evidence-base. The measure will assist health care organizations (HCOs) to track the number of patients prescribed two or more antipsychotic medications at the time of discharge.

S.4. Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications.

S.7. Denominator Statement: Psychiatric inpatient discharges

- Included populations: Patients with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders as defined in Appendix A, Table 10.01 discharged on one or more routinely scheduled antipsychotic medications (refer to Appendix B, Table 10.0-Antipsychotic Medications) available at: <http://manual.jointcommission.org>

S.10. Denominator Exclusions: • Patients who expired

- 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

De.1. Measure Type: Process

S.23. Data Source: Electronic Health Record (Only), Paper Records

S.26. Level of Analysis: Facility, Other

IF Endorsement Maintenance – Original Endorsement Date: Aug 05, 2009 **Most Recent Endorsement Date:** Aug 05, 2009

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Not applicable

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[0552_Evidence_MSF5.0_Data.doc](#)

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)

As stated above, recent literature supports antipsychotic monotherapy as the optimal treatment choice. The reduction in prescribing more than one antipsychotic medication will in turn decrease the likelihood of developing serious side effects which will ultimately reduce the ongoing costs of health care. And finally, a review of the justifications for prescribing more than one antipsychotic medication will help hospitals determine if their practice is supported by the evidence-base.

The measure will assist health care organizations (HCOs) to track the number of patients prescribed two or more antipsychotic medications at the time of discharge.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received two or more antipsychotic medications (Covell, et al., 2002; Ganguly, et al., 2004; Gilmer, et al., 2007; Kreyenbuhl, et al., 2006; Stahl & Grady, 2004). Recent studies indicate clinicians frequently resort to antipsychotic polypharmacy for refractory patients without first trying an adequate number of trials of monotherapy or exploring the suitable dose range for the individual antipsychotic medications first (Tandon, 2012). A number of health care systems have implemented intervention programs which led to a reduction in antipsychotic polypharmacy.

The New York State Office of Mental Health (NYSOMH) network of psychiatric hospitals implemented the Psychiatric Services Clinical Knowledge Enhancement System (PSYCKES) which is a web-based tool providing clinical decision making support used concurrently with a policy requiring approval by NYSOMH's medical director to prescribe two or more antipsychotic medications. The program comprised three phases beginning with a polypharmacy rate of 16.9 inpatients per 1,000 which decreased to 3.1 inpatients per 1,000 by the end of phase three. Following the end of state-level oversight, the rate leveled out at 9.2 inpatients per 1,000, which was well below baseline levels (Finnerty, et al., 2011).

Goren, et al. (2010) examined a regional academic health care system to determine the rate of antipsychotic monotherapy and polypharmacy during three periods consisting of a three month baseline, after delivery of educational luncheon seminars and following provision of monthly prescriber-specific audit feedback over a period of one year. The educational presentations were provided to both medical and nursing staff about the safety and efficacy of polypharmacy, medical risks of antipsychotic medications, specific versus non-specific effects of antipsychotic medications and the effectiveness of first- versus second-generation antipsychotic medications. The baseline rate of patients prescribed two or more antipsychotic medications at discharge declined from 33.9% at baseline to 21.8% after educational seminars and then to 12.2% after audit feedback.

In a RCT conducted by Thompson, et al. (2008) at 19 adult psychiatric units a multi-faceted intervention comprising an educational workbook, an educational visit to clinicians and a reminder on medical records was used to reduce antipsychotic polypharmacy. The odds of being prescribed antipsychotic polypharmacy was significantly lower than the control group when adjusted for confounders (OR 0.43, 95% CI 0.21-0.90, p=0.028)

Based on 13 quarters of data reported to The Joint Commission, HBIPS-4 has an aggregate performance rate of 11.2%, indicating a potential performance gap of 11.2 % as well, when the optimal rate is 0%. Since data collection on this measure began nationally in the fourth quarter of 2008, aggregate performance has improved from 15.8%.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

- Covell, N.H., Jackson, C.T., Evans, A.C., & Essock, S.M. (2002). Antipsychotic prescribing practices in Connecticut's public mental health system: rates of changing medication prescribing styles. *Schiz Bull.* 28(1):17-29.
- Finnerty, M.T., Kealey, E., Leckman-Westin, E., Gupta, N., White, G.M., Engel, G.M. & Opler, L.A. (2011). Best practices: long-term impact of web-based tools, leadership feedback, and policies on inpatient antipsychotic polypharmacy. *Psychiatric Services.* 62(10):1124-6.
- Ganguly, R., Kotzan, J.A., Miller, L.S., Kennedy, K., & Martin, B.C. (2004). Prevalence, trends, and factors associated with antipsychotic polypharmacy among Medicaid-eligible schizophrenia patients, 1998-2000. *J Clin Psychiatry.* 65(10):1377-88.
- Gilmer, T.P., Dolder, C.R., Folsom, D.P., Mastin, W., & Jeste, D.V. (2007). Antipsychotic polypharmacy trends among Medicaid beneficiaries with schizophrenia in San Diego County, 1999 - 2004. *Psychiatric Serv.* 59(7):1007-1010.
- Goren, J.L., Beck, S.E., Mills, B.J., Shtasel, D.L. & Dufresne, R.L. (2010). Development and delivery of a quality improvement program to reduce polytherapy. *J Manag Care Pharm.* 16(6):393-401.
- Kreyenbuhl, J., Valenstein, M., McCarthy, J.F., Ganocy, D., & Blow, F.C. (2006). Long-term combination antipsychotic treatment in VA patients with schizophrenia. *Schiz Res.* 84:90-99.
- Stahl, S.M. & Grady, M.M. (2004). A critical review of atypical antipsychotic utilization: comparing monotherapy with polypharmacy augmentation. *Curr Med Chem.* 11:313-327.
- Tandon, R. (2012). Antipsychotic polypharmacy: update and guidelines for practice. Retrieved on March 27, 2012 at: <http://medicaidmentalhealth.org>
- Thompson, A., Sullivan, S.A., Barley, M., Strange, S.O., Moore, L., Rogers, P., Sipos, A. & Harrison, G. (2008). The DEBIT trial: an intervention to reduce antipsychotic polypharmacy prescribing in adult psychiatry wards- a randomized controlled trial. *Psychological Medicine.* 38(5):705-15.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

In an observational study examining Medicaid claims for multiple antipsychotic prescribing conducted by Busch, et al. (2009), the greatest disparities were noted for patients with co-occurring substance use disorders, and those patients of the black race. Older adults admitted to a geriatric psychiatric ward were commonly prescribed more than one antipsychotic medication in a retrospective study conducted by Dolder & McKinsey (2011) examining 416 patients between 2006 and 2010. Ogburu, et al. (2009) found similar findings based on reviews of the National Ambulatory Medical Care Survey (NAMCS) from 2002 through 2004. Based on chi-square test, patients who were non-white and/or whose method of payment was either Medicare or Medicaid were more likely to be prescribed antipsychotic polypharmacy.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

- Busch, A.B., Lehman, A.F., Goldman, H. & Frank, R.G. (2009). Changes over time and disparities in schizophrenia treatment quality. *Med Care.* 47(2):199-207.
- Dolder, C.R. & McKinsey, J. (2010). Antipsychotic polypharmacy among patients admitted to a geriatric psychiatry unit. *J Psychiatr Pract.* 17(5):368-74.
- Ogburu, E.O. (2009). Patient provider and payer characteristics associated with antipsychotic drug polypharmacy in ambulatory care. *Dissertation Abstracts International: section B: The Sciences and Engineering.* 70(6-B):3359.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, A leading cause of morbidity/mortality, Patient/societal consequences of poor quality

1c.2. If Other:**1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.****List citations in 1c.4.**

The practice of prescribing more than one antipsychotic medication is a major contributor to high-dose prescribing which increases the potential of adverse side effects. This practice is also of limited value in helping to establish the optimum medication maintenance regime for the patient (Barnes & Paton, 2011). Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received two or more antipsychotic medications (Covell, et al., 2002; Ganguly, et al., 2004; Gilmer, et al., 2007; Kreyenbuhl, et al., 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received three or more antipsychotic medications (Jaffe & Levine, 2003). Pandurangi & Dalkilic (2008) noted that polypharmacy with second generation antipsychotic medications varies from 3.9% to 50% depending on the patient population and setting of care despite the lack of randomized controlled trials (RCTs) supporting this practice. These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care.

Prevalent antipsychotic polypharmacy is also associated with significantly higher total health care costs compared to monotherapy (Baandrup, et al., 2010; Zhu, et al., 2008). Baandrup, et al. (2010) determined that costs were 25% higher in 2007 and 17% in 2008 after reviewing a sample of 736 outpatients diagnosed with schizophrenia who were prescribed more than one antipsychotic medication.

Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). The increased risk of sudden cardiac death has been noted with increased doses of antipsychotic medications. Joukamaa, et al. (2006) found patients prescribed three antipsychotic medications simultaneously were twice as likely to die as those prescribed monotherapy. Pediatric exposure to multiple antipsychotic medications increased the odds of developing obesity/excessive weight gain (odds ratio [OR], 2.28), Type II diabetes (OR, 2.36) and dyslipidemia (OR, 5.26), cardiovascular conditions (OR, 2.70), digestive/urogenital problems and neurological/sensory symptoms (Jerrell & McIntyre, 2008). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, et al., 2004; Gilmer, et al., 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004).

One pharmacological justification for combining antipsychotic medications is to achieve greater therapeutic potential by optimizing dopamine D2 receptors; however, there are few sources of evidence to support this (Barnes & Paton, 2011). RCTs provide some evidence to support augmentation with a second antipsychotic in treatment resistant patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic medication (Tranulis, et al., 2008). Among patients without a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, et al., 2004; Potkin, et al., 2002; Shim et al., 2007; Stahl, & Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. Cross-tapering to monotherapy should generally be completed within 8 weeks; therefore, effective communication of the cross-tapering plan between the inpatient and aftercare clinician is an essential element of care (Tandon, 2012).

1c.4. Citations for data demonstrating high priority provided in 1a.3

- American Psychiatric Association (APA). (2004). Steering Committee on Practice Guidelines. Practice guideline for the treatment of patients with schizophrenia, second edition. *Am J Psychiatry*. 161(2 Suppl):1-56
- Ananth, J., Parameswaran, S., & Gunatilake, S. (2004). Antipsychotic polypharmacy comparing monotherapy with polypharmacy and augmentation. *Curr Med Chem*. 11(3):313-327 *Curr Pharm Des*. 10(18):2231-2238.
- Baandrup, L., Sorensen, J., Lublin, H., Nordentoft, M. & Glenthøj, B. (2011). Association of antipsychotic polypharmacy with health service cost: a register-based cost analysis. *Eur J Health Econ*. Retrieved March 27, 2012 at: <http://www.ncbi.nlm.nih.gov/pubmed>.
- Barnes, R.E. & Paton, C. (2011). Antipsychotic polypharmacy in schizophrenia. *CNS Drugs*. 25(5):383-399.
- Centorrino, F., Gören, J.L., Hennen, J., Salvatore, P., Kelleher, J.P., & Baldessarini, R.J. (2004) Multiple versus single antipsychotic agents for hospitalized psychiatric patients: a case control study of risk versus benefit. *Am J Psychiatry*. 161 (4):700-706.
- Covell, N.H., Jackson, C.T., Evans, A.C., & Essock, S.M. (2002). Antipsychotic prescribing practices in Connecticut's public mental health system: rates of changing medication prescribing styles. *Schiz Bull*. 28(1):17-29.
- Ganguly, R., Kotzan, J.A., Miller, L.S., Kennedy, K., & Martin, B.C. (2004). Prevalence, trends, and factors associated with antipsychotic polypharmacy among Medicaid-eligible schizophrenia patients, 1998-2000. *J Clin Psychiatry*. 65(10):1377-88.
- Gilmer, T.P., Dolder, C.R., Folsom, D.P., Mastin, W., & Jeste, D.V. (2007), Antipsychotic polypharmacy trends among

Medicaid beneficiaries with schizophrenia in San Diego County, 1999 - 2004. Psychiatric Serv. 59(7):1007-1010.

- Jaffe, A.B. & Levine, J. (2003). Antipsychotic medication co-prescribing in a large state hospital system. Pharmacoeconomol Drug Saf.12:41-48.
 - Jerrell, J.M. & McIntyre, R.S. (2008). Metabolic and cardiovascular adverse events associated with antipsychotic treatment in children and adolescents. Pediatr Adolesc Med. 162(10):929-35.
 - Joukamaa, M., Heliövaara, M., Knekt, P., Aromaa, A., Raitasalo, R. & Lehtinen, V. (2006). Schizophrenia, neuroleptic medication and mortality. Br J Psychiatry. 188:122-7.
 - Kreyenbuhl, J., Valenstein, M., McCarthy, J.F., Ganocy, D., & Blow, F.C. (2006). Long-term combination antipsychotic treatment in VA patients with schizophrenia. Schiz Res.84:90-99.
 - National Association of State Mental Health Program Directors (NASMHPD). (2001). Technical report on psychiatric polypharmacy. Alexandria, VA.
 - Pandurangi, A.K. & Dalkilic, A. (2008). Polypharmacy with second-generation antipsychotics: a review of evidence. J Psychiatr Pract. 14(6):345-67.
 - Potkin, S.G., Thyrum, P.T., Alva, G., Bera, R., Yeh, C., & Arvanitis, L.A. (2002). The safety and pharmacokinetics of quetiapine when coadministered with haloperidol, risperidone or thioridazine. J Clin Psychopharmacol. 22:121-130.
 - Shim, J.C., Shin, J.G., Kelly, D.L., Jung, D.U., Seo, Y.S., Liu, K.H., et al. (2007). Adjunctive treatment with a dopamine partial agonist aripiprazole, for treatment of antipsychotic-induced hyperprolactinemia: A placebo controlled trial. Am J Psych.164:1404-1410.
 - Stahl, S.M. & Grady, M.M. (2004). A critical review of atypical antipsychotic utilization: comparing monotherapy with polypharmacy augmentation. Curr Med Chem.11:313-327.
 - Tandon, R. (2012). Antipsychotic polypharmacy: update and guidelines for practice. Retrieved on March 27, 2012 at: <http://medicaidmentalhealth.org>
 - Tranulis, C., Skalli, L., Lalonde, P., & Nicole, L. (2008). Benefits and risks of antipsychotic polypharmacy. An evidence based review of the literature. _Drug Saf. 31_(1):7-20
 - University HealthSystem Consortium. (2006). Mental health performance measures field brief. Oakbrook, IL.
 - Zhu, B., Ascher-Svanum, H., Faries, D.E., Correll, C.U., Kane, & J.M. (2008). Cost of antipsychotic polypharmacy in the treatment of schizophrenia. BMC Psychiatry. 8, ArtID 19.
- Opportunity for Improvement (Measure evaluation criterion 1b)

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Non-Condition Specific (check all the areas that apply):

Safety, Safety : Medication, Safety : Overuse

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

<http://manual.jointcommission.org/releases/TJC2013A/MIF0119.html>

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool

(MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

URL Attachment:

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications.

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

Episode of care which is the entire hospitalization from admission to discharge.

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

One data element is used to calculate the numerator:

1. Number of Antipsychotic Medications Prescribed at Discharge - Documentation in the medical record of the number of antipsychotic medications prescribed for the patient at discharge. Allowable values: 0-99, UTD (Unable to determine)
Patients are eligible for the numerator population when they are prescribed two or more antipsychotic medications at the time of discharge.

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

Psychiatric inpatient discharges

- Included populations: Patients with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders as defined in Appendix A, Table 10.01 discharged on one or more routinely scheduled antipsychotic medications (refer to Appendix B, Table 10.0- Antipsychotic Medications) available at: <http://manual.jointcommission.org>

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

Eight data elements are used to calculate the denominator:

1. Birthdate - The month, day and year the patient was born.
2. Discharge Date – The month day and year the patient was discharged from acute care, left against medical advice or expired during the stay.
3. Discharge Disposition- The patient's discharge disposition. Allowable values: 1. Home, 2. Hospice – Home, 3. Hospice – Health Care Facility, 4. Acute Care Facility, 5. Other Health Care Facility, 6. Expired, 7. Left Against Medical Advice/AMA, 8 Not Documented or Unable to Determine (UTD).

4. ICD-9-CM Other Diagnosis Codes - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the secondary diagnoses for this hospitalization.
5. ICD-9-CM Principal Diagnosis Code - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization.
6. Number of Antipsychotic Medications Prescribed at Discharge- Documentation in the medical record of the number of antipsychotic medications prescribed for the patient at discharge. Allowable values: 0-99, UTD (Unable to determine)
7. Patient Referral to Next Level of Care Provider - Documentation in the medical record that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting. Allowable values: 1. The medical record contains documentation that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting. 2. The medical record contains documentation that the patient or guardian refused the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting OR refused to authorize release of information. 3. The medical record contains documentation that the patient eloped OR failed to return from leave and was discharged OR that the patient has not yet been discharged from the hospital OR discharged from the hospital to another level of care outside of the hospital system from a setting other than a Psychiatric Care Setting. 4. The medical record contains documentation that the patient was not referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting for a reason other than above. 5. The medical record does not contain documentation that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting OR unable to determine from medical record documentation.
8. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No.

Populations: Discharges with Table 10.01 Mental Disorders in the Psychiatric Care Setting who were discharged on one or more routinely scheduled antipsychotic medications on Table 10.0.

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

- Patients who expired
- 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

S.11. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

- Patients who expired are identified by the data element Discharge Disposition.
- Patients with an unplanned departure resulting in discharge due to elopement and failing to return from leave are identified by the data element Patient Referral to Next Level of Care Provider

S.12. Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*

The measure is stratified by the following age groups:

- Children (1 through 12 years)
- Adolescent (13 through 17 years)
- Adult (18 through 64 years)
- Older Adult (≥65 years)

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*

Not applicable

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

S.16. Type of score:

Rate/proportion

If other:

S.17. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Lower score

S.18. Calculation Algorithm/Measure Logic (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

1. Run all cases that are included in the Initial Patient Population for HBIPS-1,4,5,6,7 and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.
2. Check Discharge Disposition
 - a. If Discharge Disposition equals 6, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-4a) and will not be in the measure population. Continue processing and proceed to step 7 and initialize the Measure Category Assignment for each strata measure.
 - b. If Discharge Disposition equals 1, 2, 3, 4, 5, 7 or 8, continue processing and proceed to Psychiatric Care Setting.
3. Check Psychiatric Care Setting
 - a. If Psychiatric Care Setting equals No, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-4a) and will not be in the measure population. Continue processing and proceed to step 7 and initialize the Measure Category Assignment for each strata measure.
 - b. If Psychiatric Care Setting is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-4a) and will be rejected. Continue processing and proceed to step 7 and Initialize the Measure Category Assignment for each strata measure.
 - c. If Psychiatric Care Setting equals Yes, the case will proceed to Patient Referral to Next Level of Care Provider.
4. Check Patient Referral to Next Level of Care Provider
 - a. If Patient Referral to Next Level of Care Provider is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-4a) and will be rejected. Continue processing and proceed to step 7 and Initialize the Measure Category Assignment for each strata measure.
 - b. If Patient Referral to Next Level of Care Provider equals 3, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-4a) and will not be in the measure population. Continue processing and proceed to step 7 and initialize the Measure Category Assignment for each strata measure.
 - c. If Patient Referral to Next Level of Care Provider equals 1, 2, 4 or 5, the case will continue processing and proceed to Number of Antipsychotic Medications Prescribed at Discharge.
5. Check Number of Antipsychotic Medications Prescribed at Discharge
 - a. If Number of Antipsychotic Medications Prescribed at Discharge is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-4a) and will be rejected. Continue processing and proceed to step 7 and Initialize the Measure Category Assignment for each strata measure.
 - b. If Number of Antipsychotic Medications Prescribed at Discharge equals zero, the case will proceed to a Measure Category

Assignment of B for Overall Rate (HBIPS-4a) and will not be in the measure population. Continue processing and proceed to step 7 and initialize the Measure Category Assignment for each strata measure.

c. If Number of Antipsychotic Medications Prescribed at Discharge is greater than or equal 1 or equal to UTD, the case will continue processing and proceed to Number of Antipsychotic Medications Prescribed at Discharge.

6. Check Number of Antipsychotic Medications Prescribed at Discharge

a. If Number of Antipsychotic Medications Prescribed at Discharge equals 1, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-4a) and will be in the measure population. Continue processing and proceed to step 7 and initialize the Measure Category Assignment for each strata measure.

b. If Number of Antipsychotic Medications Prescribed at Discharge is greater than or equal 2 or equal to UTD, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-4a) and will be in the numerator population. Continue processing and proceed to step 7 and initialize the Measure Category Assignment for each strata measure.

7. Initialize the Measure Category Assignment for each strata measure (b-e) = 'B'. Do not change the Measure Category Assignment that was already calculated for the overall rate (HBIPS-4a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-4a) Measure Category Assignment.

8. Check Overall Rate Category Assignment

a. If Overall Rate Category Assignment equals B or X, Set the Measure Category Assignment for the strata measures (HBIPS-4b through HBIPS-4e) = 'B'. Stop processing.

b. If Overall Rate Category Assignment equals D or E, continue processing and proceed to Patient Age at Discharge.

9. Check Patient Age at Discharge

a. If Patient Age at Discharge is greater than or equal to 1 year and less than 13 years, set the Measure Category Assignment for measure HBIPS-4b = Measure Category Assignment for measure HBIPS-4a. Stop processing.

b. If is greater than or equal 13 years, continue processing and proceed to Patient Age at Discharge.

10. Check Patient Age at Discharge

a. If Patient Age at Discharge is greater than or equal 13 years and less than 18 years, set the Measure Category Assignment for measure HBIPS-4c = Measure Category Assignment for measure HBIPS-4a. Stop processing.

b. If Patient Age at Discharge is greater than or equal 18 years, continue processing and proceed to Patient Age at Discharge.

11. Check Patient Age at Discharge

a. If Patient Age at Discharge is greater than or equal 18 years and less than 65 years, set the Measure Category Assignment for measure HBIPS-4d = Measure Category Assignment for measure HBIPS-4a. Stop processing.

b. If Patient Age at Discharge is greater than or equal 65 years, set the Measure Category Assignment for measure HBIPS-4e = Measure Category Assignment for measure HBIPS-4a. Stop processing.

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1) URL

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. A hospital may choose to use a larger sample size than is required. Hospitals whose Initial Patient Population size is less than the minimum number of cases per quarter/month for the stratum cannot sample that stratum.

Regardless of the option used, hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Due to exclusions, hospitals selecting sample cases MUST submit AT LEAST the minimum required sample size.

Quarterly Sampling

For hospitals selecting sample cases for the HBIPS discharge measures, a modified sampling procedure is required. Hospitals selecting sample cases for this set must ensure that each individual stratum's population and effective quarterly sample size meet

the following conditions:

- Select within each of the four individual measure strata. The effective quarterly sample size within a stratum is at least 44 cases per quarter. Cases are placed into the appropriate stratum based upon the patient's age.
- The required quarterly sample size is at least 20% of the stratum population for the quarter.

Quarterly Sample Size

Based on Initial Patient Population for the HBIPS Discharge Measures

Average Quarterly

Stratum Initial Patient Population Size	Minimum Required Stratum Sample Size
---	--------------------------------------

> 877	176
221-877	20% of Initial Patient Population size
44-220	44
< 44	No sampling; 100% Initial Patient Population required

Monthly Sampling

Hospitals selecting sample cases for this set must ensure that each individual stratum population and effective monthly sample size meet the following conditions:

- Select within each of the four individual measure strata. The effective monthly sample size within a stratum is at least 15 cases per month. Cases are placed into the appropriate stratum based upon the patient's age.
- The required monthly sample size is at least 20% of the stratum population for the month.

Monthly Sample Size

Based on Initial Patient Population Size for the HBIPS Measure Set

Average Monthly Stratum Initial Patient Population Size	Minimum Required Stratum Sample Size
---	--------------------------------------

> 295	60
76-295	20% of Initial Patient Population size
15-75	15
< 15	No sampling; 100% Initial Patient Population required

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Electronic Health Record (Only), Paper Records

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at

A.1)

S.26. Level of Analysis (Check *ONLY* the levels of analysis for which the measure is *SPECIFIED AND TESTED*)
[Facility, Other](#)

S.27. Care Setting (Check *ONLY* the settings for which the measure is *SPECIFIED AND TESTED*)
[Behavioral Health : Inpatient, Hospital](#)
 If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

[0552_MeasureTesting_MS5.0_Data.zip](#)

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

[generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information \(e.g., DRG, ICD-9 codes on claims\), Abstracted from a record by someone other than person obtaining original information \(e.g., chart abstraction for quality measure or registry\)](#)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields? (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)

[Some data elements are in defined fields in electronic sources](#)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

[The Joint Commission is in the process of preparing for conversion to eMeasure specifications beginning in 2013 for the HBIPS measure set, including this measure.](#)

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data

collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

Hospitals using this performance measure generally collect measure data via manual review of the paper medical record, the EMR or a combination of both. Collected data are submitted to The Joint Commission on a quarterly basis, by way of contracted performance measurement system vendors, as described previously. Specifications for this measure are freely available to anyone who wishes to use the measure. Feedback from hospitals using this measure indicates that required data elements are generally available in the medical record, and measure specifications are robust and easy to understand. As described above, as feedback from measure users has indicated the need for clarification or revision of measure specifications, this has taken place.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Planned	Current Use (for current use provide URL)
Public Reporting	
Regulatory and Accreditation Programs	
Quality Improvement (Internal to the specific organization)	

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

No enhancements have been required for the measure specifications since the measure was first launched in 2008. Selected References were updated to reflect current guidelines. To the best of our knowledge, there have been no reports of unintended consequences.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications completely harmonized?

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [The Joint Commission](#)

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Co.3 Measure Developer if different from Measure Steward: [The Joint Commission](#)

Co.4 Point of Contact: [Jerod, Loeb, \[jloeb@jointcommission.org\]\(mailto:jloeb@jointcommission.org\), 630-792-5920-](#)

Additional Information

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Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

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[Vice President Quality & Performance Measurement](#)

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The Technical Advisory Panel (TAP) met and identified domains for measurement, endorsed the measurement framework and identified extant measures. After measures were received and evaluated by Joint Commission staff, the TAP met to review the measures and recommend candidate measures to move forward for public comment. Following public comment, the TAP reviewed the comment and recommended a set of measures to move forward for pilot testing. After pilot testing was completed, the TAP reviewed the pilot test results and recommended revisions to the measures for the final measure set.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2008

Ad.3 Month and Year of most recent revision: 08, 2012

Ad.4 What is your frequency for review/update of this measure? Biannual

Ad.5 When is the next scheduled review/update for this measure? 02, 2013

Ad.6 Copyright statement: No royalty or use fee is required for copying or reprinting this manual, but the following are required as a condition of usage: 1) disclosure that the Specifications Manual is periodically updated, and that the version being copied or reprinted may not be up-to-date when used unless the copier or printer has verified the version to be up-to-date and affirms that, and 2) users participating in Joint Commission accreditation, including ORYX® vendors, are required to update their software and associated documentation based on the published manual production timelines.

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: