



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 sub criterion 1b).

Brief Measure Information

NQF #: 0557

Corresponding Measures:

De.2. Measure Title: HBIPS-6 Post discharge continuing care plan created

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 with a post discharge continuing care plan created. 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-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification 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-7 (Post Discharge Continuing Care Plan Transmitted).

1b.1. Developer Rationale: As stated above, recent literature supports improved communication among different level of care providers in order to promote continuity of care. A referral to a next level of care provider along with creation and transmission of a continuing care plan which at a minimum contains the reason for hospitalization, the list of discharge medications, discharge diagnosis and next level of care recommendations will result in improved patient outcomes resulting in fewer re-hospitalizations ultimately reducing the ongoing costs of health care. The measure will assist health care organizations (HCOs) to track the number of patients with a continuing care plan created at the time of discharge.

S.4. Numerator Statement: Psychiatric inpatients for whom the post discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations.

S.6. Denominator Statement: Psychiatric inpatient discharges

S.8. Denominator Exclusions: • Patients who expired

- Patients with an unplanned departure resulting in discharge due to elopement
- Patients or their guardians who refused aftercare
- Patients or guardians who refused to sign authorization to release information
- Patients with an unplanned departure resulting in discharge due to failing to return from leave
- Patient's residence is not in the USA, and they are returning to another country after discharge
- Patients readmitted to the same facility within 5 days after discharge

De.1. Measure Type: Process

S.17. Data Source: Electronic Health Record (Only), Paper Records

S.20. Level of Analysis: Facility, Other

IF Endorsement Maintenance – Original Endorsement Date: Aug 05, 2009 **Most Recent Endorsement Date:** Feb 28, 2014

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 sub criteria to pass this criterion and be evaluated against the remaining criteria.***

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

[0557_Evidence_MSF5.0_Data.doc](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Please update any changes in the evidence attachment in red. Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. If there is no new evidence, no updating of the evidence information is needed.

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., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

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.)

IF a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and provide rationale for composite in question 1c.3 on the composite tab.

As stated above, recent literature supports improved communication among different level of care providers in order to promote continuity of care. A referral to a next level of care provider along with creation and transmission of a continuing care plan which at a minimum contains the reason for hospitalization, the list of discharge medications, discharge diagnosis and next level of care recommendations will result in improved patient outcomes resulting in fewer re-hospitalizations ultimately reducing the ongoing costs of health care

The measure will assist health care organizations (HCOs) to track the number of patients with a continuing care plan created 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 maintenance of endorsement. 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 include.) This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.*

The uniqueness of the standards of psychiatric care has made the transition from inpatient psychiatric treatment an understudied area. In response to the lack of standards the search for information for such transitions and the creation of model programs are under development (Epstein-Lubow & Fulton, 2012). Nakanishi, et al., (2010) developed a study to create a clinical pathway for long-term inpatients with schizophrenia. In the study, a clinical pathway was defined as: “an optimal sequencing and timing of interventions by staff for a particular diagnosis or procedure, designed to better utilize resources, maximize quality of care and minimize delays”. Clinical pathways were used to help to better explain the discharge process of each patient. The clinical pathways consisted of three phases and care components. The discharge process was divided into three phases: 1. Assessment and goal setting, 2. Preparation, and 3. Discharge phase. Discharge planning was combined with all three phases, because it was an important care component. In order to examine the validity of clinical pathways in other hospitals, further study is still needed (Nakanishi et al., 2010).

In a randomized controlled trial, Boston University Medical Center created an 11 step process by re-engineering the discharge process that should be completed by the hospital staff before discharge. This process aimed to lower re-hospitalization rates by targeting patients with depression (AHRQ, 2011; Epstein-Lubow & Fulton, 2012). Final results showed a 30% lower rate of re-hospitalizations for the intervention group compared to the control group (0.314 vs. 0.451 visits per person per month). 86% of intervention patients understood what appointments they had post-discharge compared to 79% of the control patients. The general principles of these guidelines created can be used for other transitions such as for patients with dementia or delirium undergoing discharge from medical and psychiatric hospitals to home, to a nursing home, or to an assisted living facility (Jack, et al., 2009;

Epstein-Lubow & Fulton, 2012). Future experimental studies are needed to explore the impact of enhanced continuity of care on patients with SMI (Crawford, et al., 2004).

Based on 13 quarters of data reported to The Joint Commission, HBIPS-6 has an aggregate performance rate of 90.8%, indicating a potential performance gap of 9.2 % as well, when the optimal rate is 100%. Since data collection on this measure began nationally in the fourth quarter of 2008, aggregate performance has improved from 76.7%.

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.

- AHRQ Innovations Exchange: | Standardized Discharge Planning Focusing on Patient Education and Care Coordination Increases Understanding of Postdischarge Needs and Likelihood of Followup Care. (2011). AHRQ Innovations Exchange. Retrieved March 26, 2012, from: <http://www.innovations.ahrq.gov/content.aspx?id=1777>.
- Batscha, C., McDevitt, J., Weiden, P., & Dancy, B. (2011). The effect of an inpatient transition intervention on attendance at the first appointment postdischarge from a psychiatric hospitalization. *Journal of the American Psychiatric Nurses Association*, 17, 330-337.
- Crawford, M., Jonge, E., Freeman, G., & Weaver, T. (2004). Providing continuity of care for people with severe mental illness: A narrative review. *Social Psychiatry and Psychiatric Epidemiology*, 39, 265-272.
- Epstein-Lubow, G., & Fulton, A. T. (2012). Post-hospital transitions for individuals with moderate to severe cognitive impairment. *Annals of Long-Term Care*, 20(3), 18-24.
- Jack, B., Chetty, V., Martin, S., Culpepper, L., Anthony, D., Greenwald, J., et al. (2009). A reengineered hospital discharge program to decrease rehospitalization. *Annals of Internal Medicine*, 150(3), 178-187.
- Nakanishi, M., Sawamura, K., Sato, S., Setoya, Y., & Anzai, N. (2010). Development of a clinical pathwar for long-term inpatients with schizophrenia. *Psychiatry and Clinical Neurosciences*, 64(1), 99-103.

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 maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

No disparities were noted in the literature.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

Not Applicable

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 sub criteria 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):

Care Coordination

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

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/TJC2015B1>

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)

This is not an eMeasure 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)*

No data dictionary Attachment:

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update 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) DO NOT include the rationale for the measure.*

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Psychiatric inpatients for whom the post discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations.

S.5. 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, time period for data collection, 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 (S.14).

Four data elements are used to calculate the numerator:

1. Continuing Care Plan-Discharge Medications - Documentation in the medical record of a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were prescribed at discharge. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day. Allowable Values – 1. The medical record contains a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were ordered at discharge and was transmitted to the next level of care provider no later than the fifth post-discharge day. 2. The medical record contains a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were ordered at discharge but was not transmitted to the next level of care provider by the fifth post-discharge day. 3. The medical record does not contain a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were ordered at discharge or unable to determine from medical record documentation.
2. Continuing Care Plan-Next Level of Care - Documentation in the medical record of a continuing care plan which includes next level of care recommendations. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day. Allowable Values – 1. The medical record contains a continuing care plan which includes next level of care recommendations AND was transmitted to the next level of care provider no later than the fifth post-discharge day. 2. The medical record contains a continuing care plan which includes next level of care recommendations but it was not transmitted to the next level of care provider by the fifth post-discharge day. 3. The medical record does not contain a continuing care plan which includes next level of care recommendations OR unable to determine from medical record documentation.

3. Continuing Care Plan-Principal Discharge Diagnosis - Documentation in the medical record of a continuing care plan which includes the principal discharge diagnosis. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day. Allowable Values – 1. The medical record contains a continuing care plan which includes the principal discharge diagnosis AND was transmitted to the next level of care provider no later than the fifth post-discharge day. 2. The medical record contains a continuing care plan which includes the principal discharge diagnosis but was not transmitted to the next level of care provider by the fifth post-discharge day. 3. The medical record does not contain a continuing care plan which includes the principal discharge diagnosis or unable to determine from medical record documentation.

4. Continuing Care Plan-Reason for Hospitalization - Documentation in continuing care plan includes the reason for hospitalization. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day. Allowable Values – 1. The medical record contains a continuing care plan which includes the reason for hospitalization and was transmitted to the next level of care provider no later than the fifth post-discharge day. 2. The medical record contains a continuing care plan which includes the reason for hospitalization but was not transmitted to the next level of care provider by the fifth post-discharge day. 3. The medical record does not contain a continuing care plan which includes the reason for hospitalization or unable to determine from medical record documentation.

Patients are eligible for the numerator population when they have a continuing care plan created which includes all of the following: the discharge medications, dosage and indication for use or that no medications were prescribed at discharge, next level of care recommendations, the principal discharge diagnosis and the reason for hospitalization.

S.6. Denominator Statement (*Brief, narrative description of the target population being measured*)

Psychiatric inpatient discharges

S.7. Denominator Details (*All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, 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 target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Seven 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-10-CM Other Diagnosis Codes- The CMS ICD-10-CM master code table for other or secondary ICD-10-CM codes associated with the diagnosis for this hospitalization.
5. ICD-10-CM Principal Diagnosis Code- The CMS ICD-10-CM master code table for the diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.
6. 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 OR the patient was readmitted to the same facility within 5 days after discharge. 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 OR the patient's residence is not in the USA, and they are returning to another country after discharge. 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.
7. 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

S.8. 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 or their guardians who refused aftercare
- Patients or guardians who refused to sign authorization to release information
- Patients with an unplanned departure resulting in discharge due to failing to return from leave
- Patient's residence is not in the USA, and they are returning to another country after discharge
- Patients readmitted to the same facility within 5 days after discharge

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, 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, refusing aftercare, refusing to sign authorization to release information, failing to return from leave, residence is not in the USA and they are returning to another country after discharge and readmitted to the same facility within 5 days after discharge are identified by the data element Patient Referral to Next Level of Care Provider

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – 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.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. 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 = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or 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; time period for data, 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 Status equals 6, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-6a) and will not be in the measure population. Continue processing and proceed to step 12 and initialize the Measure Category Assignment for each strata measure.
 - b. 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-6a) and will not be in the measure population. Continue processing and proceed to step 12 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-6a) and will be rejected. Continue processing and proceed to step 16 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-6a) and will be rejected. Continue processing and proceed to step 12 and Initialize the Measure Category Assignment for each strata measure.
 - b. If Patient Referral to Next Level of Care Provider equals 2 or 3, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-6a) and will not be in the measure population. Continue processing and proceed to step 12 and initialize the Measure Category Assignment for each strata measure.
 - c. If Patient Referral to Next Level of Care Provider equals 1, 4 or 5, the case will continue processing and proceed to Initialize Missing Counter.
5. Initialize Missing Counter to equal zero. Initialize No CarePlan Counter to equal zero. Continue processing and proceed to Continuing Care Plan-Principal Discharge Diagnosis.
6. Check Continuing Care Plan-Principal Discharge Diagnosis
 - a. If Continuing Care Plan-Principal Discharge Diagnosis equals 3, add one to No CarePlan Counter. Continue processing and proceed to Continuing Care Plan-Reason for Hospitalization.
 - b. If Continuing Care Plan-Principal Discharge Diagnosis is missing, add one to Missing Counter. Continue processing and proceed to Continuing Care Plan-Reason for Hospitalization.
 - c. If Continuing Care Plan-Principal Discharge Diagnosis equals 1 or 2, continue processing and proceed to Continuing Care Plan-Reason for Hospitalization.
7. Check Continuing Care Plan-Reason for Hospitalization
 - a. If Continuing Care Plan-Reason for Hospitalization equals 3, add one to No CarePlan Counter. Continue processing and proceed to Care Plan-Discharge Medications.
 - b. If Continuing Care Plan-Reason for Hospitalization is missing, add one to Missing Counter. Continue processing and proceed to Care Plan-Discharge Medications
 - c. If Continuing Care Plan-Reason for Hospitalization equals 1 or 2, continue processing and proceed to Care Plan-Discharge Medications.
8. Check Continuing Care Plan-Discharge Medications
 - a. If Continuing Care Plan-Discharge Medications equals 3, add one to No CarePlan Counter, Continue processing and proceed to Continuing Care Plan-Next Level of Care.
 - b. If Continuing Care Plan-Discharge Medications is missing, add one to Missing Counter. Continue processing and proceed to Continuing Care Plan-Next Level of Care.
 - c. If Continuing Care Plan-Discharge Medications equals 1 or 2, continue processing and proceed to Continuing Care Plan-Next Level of Care.
9. Check Continuing Care Plan-Next Level of Care
 - a. If Continuing Care Plan-Next Level of Care equals 3, add one to No CarePlan Counter. Continue processing and proceed to Missing Counter.
 - b. If Continuing Care Plan-Next Level of Care is missing, add one to Missing Counter. Continue processing and proceed to Missing Counter.
 - c. If Continuing Care Plan-Next Level of Care equals 1 or 2, continue processing and proceed to Missing Counter.
10. Check Missing Counter
 - a. If Missing Count is greater than zero, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-

6a) and will be rejected. Continue processing and proceed to step 12 and Initialize the Measure Category Assignment for each strata measure.

b. If Missing Count equals zero, continue processing and proceed to No CarePlan Counter.

11. Check No CarePlan Counter

a. If No CarePlan Counter is greater than zero, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-6a) and will be in the measure population. Continue processing and proceed to step 12 and initialize the Measure Category Assignment for each strata measure.

b. If No CarePlan Counter equals zero, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-6a) and will be in the numerator population. Continue processing and proceed to step 12 and initialize the Measure Category Assignment for each strata measure.

12. Initialize the Measure Category Assignment for each strata measure (b-e) equal 'B'. Do not change the Measure Category Assignment that was already calculated for the overall rate (HBIPS-6a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-6a) Measure Category Assignment. Continue processing and proceed to Overall Rate Category Assignment.

13. Check Overall Rate Category Assignment

a. If Overall Rate Category Assignment equals B or X, retain the Measure Category Assignment for the strata measures (HBIPS-6b through HBIPS-6e) equals B. Stop processing.

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

14. 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 the measure HBIPS-6b equal to Measure Category Assignment for measure HBIPS-6a. Stop processing.

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

15. Check Patient Age at Discharge

a. If Patient Age at Discharge is greater than or equal to 13 years and less than 18 years, set the Measure Category Assignment for the measure HBIPS-6c equal to Measure Category Assignment for measure HBIPS-6a. Stop processing.

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

16. Check Patient Age at Discharge

a. If Patient Age at Discharge is greater than or equal to 18 years and less than 65 years, set the Measure Category Assignment for the measure HBIPS-6d equal to Measure Category Assignment for measure HBIPS-6a. Stop processing.

b. If Patient Age at Discharge is greater than or equal to 65 years, set the Measure Category Assignment for the measure HBIPS-6e equal to Measure Category Assignment for measure HBIPS-6a. Stop processing.

S.15. 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

Minimum Required

Stratum Initial Patient Population Size

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

Minimum Required

Stratum Initial Patient Population Size

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.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

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

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Electronic Health Record (Only), Paper Records

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data is collected.)

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

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility, Other

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Behavioral Health : Inpatient, Hospital

If other:

S.22. 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.)

2. Validity – See attached Measure Testing Submission Form

[0557_MeasureTesting_MS5.0_Data.zip](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes SDS factors is no longer prohibited during the SDS Trial Period (2015-2016). Please update sections 1.8, 2a2, 2b2, 2b4, and 2b6 in the Testing attachment and S.14 and S.15 in the online submission form in accordance with the requirements for the SDS Trial Period. NOTE: These sections must be updated even if SDS factors are not included in the risk-adjustment strategy. If yes, and your testing attachment does not have the additional questions for the SDS Trial please add these questions to your testing attachment:

What were the patient-level sociodemographic (SDS) variables that were available and analyzed in the data or sample used? For example, patient-reported data (e.g., income, education, language), proxy variables when SDS data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate).

Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or sociodemographic factors) used in the statistical risk model or for stratification by risk (e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of $p < 0.10$; correlation of x or higher; patient factors should be present at the start of care)

What were the statistical results of the analyses used to select risk factors?

Describe the analyses and interpretation resulting in the decision to select SDS factors (e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects)

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*) Update this field for **maintenance of endorsement**.

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. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

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. Please also complete and attach the NQF Feasibility Score Card.

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. Required for maintenance of endorsement. Describe difficulties (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 PRO 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.

Specific Plan for Use	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 (update for maintenance of endorsement), provide:

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

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.)

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. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (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.)
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. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.
Since implementation, the Notes for Abstraction section of the data element for Patient Referral to Next Level of Care Provider has been updated to clarify issues that have been identified after review of the feedback received from measure users. To the best of our knowledge, there have been no reports of unintended consequences.

4c.2. Please explain any unexpected benefits from implementation of this measure.

4d1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured

or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

4d1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

4d2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

4d2.2. Summarize the feedback obtained from those being measured.

4d2.3. Summarize the feedback obtained from other users

4d.3. Describe how the feedback described in 4d.2 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

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 of Related Measures

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 harmonized to the extent possible?

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](#)

Co.2 Point of Contact: [JohnMarc, Alban, \[jalban@jointcommission.org\]\(mailto:jalban@jointcommission.org\), 630-792-5304-](#)

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

Ad.1 Workgroup/Expert Panel involved in measure development

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

[Frank Ghinassi, PhD \(Chair\)](#)

[Vice President Quality & Performance Measurement](#)

[Western Psychiatric Institute & Clinic](#)

[University of Pittsburgh School of Medicine](#)

[Pittsburgh, PA](#)

[Richard Bosworth, RN](#)

[Director of Data Systems Management & Evaluation \(retired\)](#)

[Colorado Mental Health Institute at Fort Logan](#)

[Denver, CO](#)

[Ann Doucette, PhD](#)

[Senior Research Scientist](#)

[Center for Health Sciences Research & Policy](#)

[George Washington University Medical Center](#)

[Washington, DC](#)

[Sue Eisen, PhD](#)

[Health Research Scientist](#)

[Associate Professor of Health Services](#)

[Edith Nourse Rogers Memorial Veterans Hospital](#)

[Center for Health Quality, Outcomes & Economics Research](#)

[Bedford, MA](#)

[Pam Galbraith, RN, MBA](#)

ValueOptions of New Mexico (retired)
Albuquerque, NM

Douglas Hancock, MA
Consultant
Cedar Park, TX

Richard Hermann, MD
Director, Center for Quality Assessment & Improvement in Mental Health
Associate Professor of Medicine & Psychiatry
Tufts- New England Medical Center
Boston, MA

Pablo Hernandez, MD
Administrator
South Florida Evaluation and Treatment Center Annex
Miami, FL

Karen Johnson, MSW
Assistant Vice President, Clinical Operations
Universal Health Services
Chicago, IL

Kathy Jordan- Sedgeman, MS, APRN
Director of HR Services and Labor Relations
University of Michigan Health Systems Human Resources
Ann Arbor, MI

Michael Lambert, PhD
Professor
Brigham Young University
Provo, UT

John Oldham, MD
Senior Vice President and Chief of Staff, The Menninger Clinic
Executive Vice-Chairman for Clinical Affairs and Development
Menninger Dept. Psychiatry & Behavioral Sciences Baylor College of Medicine
Houston, TX

Steven Onken, PhD
Associate, Mental Health Services Research
MHSRET Center
Honolulu, HI

Joseph Parks, MD
Medical Director
State of Missouri Dept. of Mental Health
Jefferson City, MO

Johan Smith, MBA
Vice President, Operations & Development
Horizon Health Corporation- Mental Health Outcomes
Lewisville, TX

Liaison Members:

Elizabeth Stallings, BSN
American Hospital Association
Chief Operating Officer
Mt. Diablo Medical Pavilion
Concord, CA

Gregory B. Teague, PhD
SAMHSA
Associate Professor
FMHI / University of South Florida
Tampa, FL

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: