



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 #: 1922

Corresponding Measures:

De.2. Measure Title: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

Co.1.1. Measure Steward: The Joint Commission

De.3. Brief Description of Measure: The proportion of patients, age greater than and equal to 1 year, admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of hospitalization for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths.

1b.1. Developer Rationale: Evidence exists that there is a high prevalence of co-occurring substance use disorders as well as history of trauma among persons admitted to acute psychiatric settings. Professional literature suggests that these factors are under-identified yet integral to current psychiatric status and should be assessed in order to develop appropriate treatment (Ziedonis, 2004; NASMHPD, 2005). Similarly, persons admitted to inpatient settings require a careful assessment of risk for violence and the use of seclusion and restraint. Careful assessment of risk is critical to safety and treatment. Effective, individualized treatment relies on assessments that explicitly recognize patients' strengths. These strengths may be characteristics of the individuals themselves, supports provided by families and others, or contributions made by the individuals' community or cultural environment (Rapp, 1998). In the same way, inpatient environments require assessment for factors that lead to conflict or less than optimal outcomes.

As stated above, recent literature supports the routine initial screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths to assist the clinician in determining which patients require a more in depth assessment based on findings which will ultimately form the basis for an appropriate treatment plan. The reduction in the under-detection of violence risk, SUD and trauma history will in turn decrease the chance of psychiatric relapse and lead to improved medication compliance which will ultimately reduce the ongoing costs of psychiatric treatment. And finally, by focusing on patient strengths instead of problems during the screening process, the patient will become empowered to embrace the ongoing recovery model of treatment thereby reducing the need for readmission to more restrictive levels of treatment such as inpatient care. The measure will assist health care organizations (HCOs) to track admission screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths. Evidence exists that there is a high prevalence of co-occurring substance use disorders as well as history of trauma among persons admitted to acute psychiatric settings. Professional literature suggests that these factors are under-identified yet integral to current psychiatric status and should be assessed in order to develop appropriate treatment (Ziedonis, 2004; NASMHPD, 2005). Similarly, persons admitted to inpatient settings require a careful assessment of risk for violence and the use of seclusion and restraint. Careful assessment of risk is critical to safety and treatment. Effective, individualized treatment relies on assessments that explicitly recognize patients' strengths. These strengths may be characteristics of the individuals themselves, supports provided by families and others, or contributions made by the individuals' community or cultural environment (Rapp, 1998). In the same way, inpatient environments require assessment for factors that lead to conflict or less than optimal outcomes.

The literature supports the routine initial screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths to assist the clinician in determining which patients require a more in depth assessment based on findings which will ultimately form the basis for an appropriate treatment plan. The reduction in the under-detection of violence risk, SUD and trauma history will in turn decrease the chance of psychiatric relapse and lead to improved medication compliance which will ultimately reduce the ongoing costs of psychiatric treatment. And finally, by focusing on patient strengths instead of problems during the screening process, the patient will become empowered to embrace the ongoing recovery model of treatment thereby

reducing the need for readmission to more restrictive levels of treatment such as inpatient care.

The measure will assist health care organizations (HCOs) to track admission screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths. As stated above, recent literature supports the routine initial screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths to assist the clinician in determining which patients require a more in depth assessment based on findings which will ultimately form the basis for an appropriate treatment plan. The reduction in the under-detection of violence risk, SUD and trauma history will in turn decrease the chance of psychiatric relapse and lead to improved medication compliance which will ultimately reduce the ongoing costs of psychiatric treatment. And finally, by focusing on patient strengths instead of problems during the screening process, the patient will become empowered to embrace the ongoing recovery model of treatment thereby reducing the need for readmission to more restrictive levels of treatment such as inpatient care.

The measure will assist health care organizations (HCOs) to track admission screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths.

S.4. Numerator Statement: Psychiatric inpatients with admission screening within the first three days of admission for all of the following: risk of violence to self or others; substance use; psychological trauma history; and patient strengths

S.6. Denominator Statement: Psychiatric inpatient discharges

S.8. Denominator Exclusions: • Patients for whom there is an inability to complete admission screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths within the first three days of admission due to the patient's inability or unwillingness to answer screening questions

• Patients with a Length of Stay = or less than 3 days or = or greater than 365 days

De.1. Measure Type: Process

S.17. Data Source: Electronic Health Records, Paper Medical Records

S.20. Level of Analysis: Facility, Other

IF Endorsement Maintenance – Original Endorsement Date: Mar 04, 2014 **Most Recent Endorsement Date:** Mar 04, 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

[1922_evidence_attachment_7.1_HBIPS1.docx](#)

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

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

Yes

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 COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Evidence exists that there is a high prevalence of co-occurring substance use disorders as well as history of trauma among persons admitted to acute psychiatric settings. Professional literature suggests that these factors are under-identified yet integral to current psychiatric status and should be assessed in order to develop appropriate treatment (Ziedonis, 2004; NASMHPD, 2005). Similarly, persons admitted to inpatient settings require a careful assessment of risk for violence and the use of seclusion and restraint. Careful assessment of risk is critical to safety and treatment. Effective, individualized treatment relies on assessments that explicitly recognize patients' strengths. These strengths may be characteristics of the individuals themselves, supports provided by families and others, or contributions made by the individuals' community or cultural environment (Rapp, 1998). In the same way, inpatient environments require assessment for factors that lead to conflict or less than optimal outcomes.

As stated above, recent literature supports the routine initial screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths to assist the clinician in determining which patients require a more in depth assessment based on findings which will ultimately form the basis for an appropriate treatment plan. The reduction in the under-detection of violence risk, SUD and trauma history will in turn decrease the chance of psychiatric relapse and lead to improved medication compliance which will ultimately reduce the ongoing costs of psychiatric treatment. And finally, by focusing on patient strengths instead of problems during the screening process, the patient will become empowered to embrace the ongoing recovery model of treatment thereby reducing the need for readmission to more restrictive levels of treatment such as inpatient care. The measure will assist health care organizations (HCOs) to track admission screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths. Evidence exists that there is a high prevalence of co-occurring substance use disorders as well as history of trauma among persons admitted to acute psychiatric settings. Professional literature suggests that these factors are under-identified yet integral to current psychiatric status and should be assessed in order to develop appropriate treatment (Ziedonis, 2004; NASMHPD, 2005). Similarly, persons admitted to inpatient settings require a careful assessment of risk for violence and the use of seclusion and restraint. Careful assessment of risk is critical to safety and treatment. Effective, individualized treatment relies on assessments that explicitly recognize patients' strengths. These strengths may be characteristics of the individuals themselves, supports provided by families and others, or contributions made by the individuals' community or cultural environment (Rapp, 1998). In the same way, inpatient environments require assessment for factors that lead to conflict or less than optimal outcomes.

The literature supports the routine initial screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths to assist the clinician in determining which patients require a more in depth assessment based on findings which will ultimately form the basis for an appropriate treatment plan. The reduction in the under-detection of violence risk, SUD and trauma history will in turn decrease the chance of psychiatric relapse and lead to improved medication compliance which will ultimately reduce the ongoing costs of psychiatric treatment. And finally, by focusing on patient strengths instead of problems during the screening process, the patient will become empowered to embrace the ongoing recovery model of treatment thereby reducing the need for readmission to more restrictive levels of treatment such as inpatient care.

The measure will assist health care organizations (HCOs) to track admission screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths. As stated above, recent literature supports the routine initial screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths to assist the clinician in determining which patients require a more in depth assessment based on findings which will ultimately form the basis for an appropriate treatment plan. The reduction in the under-detection of violence risk, SUD and trauma history will in turn decrease the chance of psychiatric relapse and lead to improved medication compliance which will ultimately reduce the ongoing costs of psychiatric treatment. And finally, by focusing on patient strengths instead of problems during the screening process, the patient will become empowered to embrace the ongoing recovery model of treatment thereby reducing the need for readmission to more restrictive levels of treatment such as inpatient care.

The measure will assist health care organizations (HCOs) to track admission screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths.

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 (4b1) under Usability and Use.

#1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed, Last Updated: Sep 01, 2020

Below are the data from 2009-2018. The Year of data submission is the first row followed by N, the number of Hospitals that have directly submitted data to the Joint Commission. Descriptive statistics include mean, std. dev, min, max, median, first and 3rd quartiles (Q1 and Q3) along the deciles listed at the 10 percentile (10th pctl), etc.

Year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
N	300	323	475	484	522	673	1054	1082	742	726
Mean	0.87073	0.918	0.91833	0.95211	0.94764	0.88469	0.90865	0.91536	0.93886	0.93725
Std. Dev.	0.19	0.1429	0.1449	0.0878	0.1242	0.2209	0.1665	0.1629	0.1214	0.1346
Max	1	1	1	1	1	1	1	1	1	1
Q3	0.99096	0.99868	0.99736	0.99928	0.9991	0.99769	0.99824	0.99846	0.99905	1
Median	0.94479	0.97829	0.9769	0.98447		0.98894	0.9809	0.97998	0.98408	0.98262
Q1	0.82917	0.90942	0.91373	0.9466		0.95755	0.9078	0.90643	0.91808	0.93452
Min	0.0082	0.18258	0	0.26987		0.00836	0.00357	0	0	0.05068
10th Pctl	0.64043	0.75051	0.76257	0.87302		0.87561	0.57728	0.71264	0.75	0.85333
20th Pctl	0.80694	0.87957	0.89394	0.92754		0.94467	0.86036	0.87195	0.88166	0.91406
30th Pctl	0.86897	0.92727	0.92912	0.95816		0.96724	0.93333	0.93155	0.93931	0.94788
40th Pctl	0.91918	0.95975	0.95978	0.97521		0.98028	0.96553	0.96382	0.9673	0.96999
60th Pctl	0.9722	0.98884	0.98745	0.99257		0.99461	0.98942	0.99184	0.99238	0.99145
70th Pctl	0.98656	0.99644	0.99528	0.99679		0.9976	0.99563	0.99664	0.99694	0.99733
80th Pctl	0.99346	1	1	1	1	0.99932	1	1	1	1
90th Pctl	1	1	1	1	1	1	1	1	1	1
# Patients	206992	224505	311947	333425		337484	386345	518224	538940	425128

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.

See data in 1b.2

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 (4b1) under Usability and Use.

There is a great deal of literature supporting admission screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths. There is no mention of disparities related to race or socioeconomic status regarding admission screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths.

The literature supports male veterans, adolescents, the elderly, Native Americans, those with mood disorders, co morbid substance abuse disorders and a history of physical and sexual abuse as the most vulnerable group of patients at higher risk for suicide (U.S. Preventive Services Task Force, 2004). Swanson, et al. (1990) and Mullen (2000) noted that those with mental illness who were violent were more likely to have a lower socioeconomic status.

Young male veterans are also more likely to experience SUD especially when combined with trauma history (Substance Abuse and Mental Health Services Administration, 2007). Patients with co-occurring SMI and SUD were more likely to be unemployed, white and female according to the Substance Abuse and Mental Health Services Administration (2003).

For data source see data in 1b.2

Rates by Population Group

Gender	2013	2014	2015	2016	2017
Male	0.961	0.960	0.927	0.931	0.950
Female	0.973	0.917	0.941	0.950	0.955

Hispanic Ethnicity	2013	2014	2015	2016	2017
Hispanic	0.952	0.933	0.919	0.938	0.949
Non-Hispanic	0.967	0.937	0.935	0.940	0.952

Race	2013	2014	2015	2016	2017
White	0.969	0.945	0.934	0.941	0.952
African American	0.964	0.935	0.928	0.933	0.950
American Indian	0.941	0.937	0.893	0.904	0.927
Asian	0.961	0.950	0.933	0.934	0.949
Pacific Islander	0.951	0.943	0.924	0.909	0.929

Age Category	2013	2014	2015	2016	2017
1-12 years	0.981	0.981	0.961	0.954	0.968
13-17 years	0.984	0.980	0.963	0.962	0.965
18-64 years	0.961	0.932	0.930	0.937	0.950
65 years and above	0.953	0.876	0.910	0.924	0.941

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):

Behavioral Health : Alcohol, Substance Use/Abuse, Behavioral Health : Suicide

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

Health and Functional Status : Change, Person-and Family-Centered Care, Safety

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.)

<https://manual.jointcommission.org/releases/TJC2018B1/HospitalBasedInpatientPsychiatricServices.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)

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)

Attachment **Attachment:** HBIPS_Code_Tables-636794265723952869.xlsx

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure **Attachment:**

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

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.

Yes

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.

The ICD-10-CM code table for Mental Disorders was revised to reflect the ICD-10 code updates for Fiscal Year (FY) 2019, effective for discharges October 1, 2018.

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 with admission screening within the first three days of admission for all of the following: risk of violence to self or others; substance use; psychological trauma history; and patient strengths

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).

Five data elements are used to calculate the numerator:

1. Patient Strengths - Documentation in the medical record that an admission screening for a minimum of two patient strengths was performed within the first three days of admission. Allowable values: Yes, No/UTD, or X unable to complete admission screening.

2. Psychological Trauma History - Documentation in the medical record that an admission screening for a psychological trauma history was performed within the first three days of admission. Allowable values: Yes, No/UTD, or X unable to complete admission screening.

3. Substance Use - Documentation in the medical record that an admission screening for substance use and alcohol use which occurred over the past twelve (12) months was performed within the first three days of admission. The screening must include: the type, amount, frequency of use and any problems due to past use. Allowable values: Yes, No/UTD, or X unable to complete admission screening.

4. Violence Risk to Others - Documentation in the medical record that an admission screening for violence risk to others over the past six months was performed within the first three days of admission. Violence Risk to Others includes: threats of violence and/or actual commission of violence toward others. Documentation should include violence risk within the 6 months prior to admission AND any lifetime risk of violence to others beyond the 6 months prior to admission. Allowable values: Yes, No/UTD, or X unable to complete admission screening.

5. Violence Risk to Self - Documentation in the medical record that an admission screening for violence risk to self over the past six

months was performed within the first three days of admission. Violence Risk to Self includes: ideation, plans/preparation and/or intent to act if ideation present, past suicidal behavior and risk/protective factors within the 6 months prior to admission. Allowable values: Yes, No/UTD, or X unable to complete admission screening.

Patients are eligible for the numerator population when the allowable value equals “yes” for all five data elements: Patient Strengths, Psychological Trauma History, Substance Use, Violence Risk to Others and Violence Risk to Self as defined above.

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).

Included Populations:

- Patients with ICD-10-CM Principal or Other Diagnosis Codes for Mental Disorders as defined in Appendix A, Table 10.01 (See S.2b.)

(See S.2b for attached code table)

Six data elements are used to calculate the denominator:

1. Admission Date – The month, day and year of admission to acute inpatient care.
2. Birthdate - The month, day and year the patient was born.
3. Discharge Date – The month day and year the patient was discharged from acute care, left against medical advice or expired during the stay.
4. ICD-10-CM Other Diagnosis Codes- The other or secondary (ICD-10-CM) codes associated with the diagnosis for this hospitalization.
5. ICD-10-CM Principal Diagnosis Code- The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.
6. 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.

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

- Patients for whom there is an inability to complete admission screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths within the first three days of admission due to the patient’s inability or unwillingness to answer screening questions

- Patients with a Length of Stay = or less than 3 days or = or greater than 365 days

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 for whom screening cannot be completed due to the patient’s inability or unwillingness to answer assessment questions within the first three days of admission OR patients with a previous admission to the psychiatric unit during a single hospitalization.
- Length of stay (LOS) in days is equal to the Discharge Date minus the Admission Date. If the LOS is less than 3 days or greater than

365 days, the patient is excluded.

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) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years
- Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years
- Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years
- Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 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 Discharge and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure

2. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date.

3. Check Length of Stay

a. If Length of Stay is less than or equal to 3 days or greater than or equal to 365 days, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing.

b. If Length of Stay is greater than 3 days and less than 365 days, continue processing and proceed to Psychiatric Care Setting.

4. Check Psychiatric Care Setting

a. If Psychiatric Care Setting equals No, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing.

b. If Psychiatric Care Setting equals Yes, continue processing.

5. Initialize Missing Counter to equal zero. Initialize No Screening Counter to equal zero, Initialize Incomplete Screening Counter to equal zero. Continue processing and proceed to Patient Strengths.

6. Check Patient Strengths

a. If Patient Strengths equals No, add one to No Screening Counter. Continue processing and proceed to Psychological Trauma History.

b. If Patient Strengths is missing, add one to Missing Counter. Continue processing and proceed to Psychological Trauma History.

c. If Patient Strengths equals Yes or X, Continue processing and proceed to check Patient Strengths.

7. Check Patient Strengths

a. If Patient Strengths equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Psychological Trauma History.

b. If Patient Strengths equals Yes, Continue processing and proceed to Psychological Trauma History.

8. Check Psychological Trauma History

a. If Psychological Trauma History equals No, add one to No Screening Counter. Continue processing and proceed to Substance Use.

b. If Psychological Trauma History is missing, add one to Missing Counter. Continue processing and proceed to Substance Use.

c. If Psychological Trauma History equals Yes or X, Continue processing and proceed to check Psychological Trauma History.

9. Check Psychological Trauma History

a. If Psychological Trauma History equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Substance Use.

b. If Psychological Trauma History equal Yes, Continue processing and proceed to Substance Use.

10. Check Substance Use

a. If Substance Use equals No, add one to No Screening Counter. Continue processing and proceed to Violence Risk to Others.

b. If Substance Use is missing, add one to Missing Counter. Continue processing and proceed to Violence Risk to Others.

c. If Substance Use equals Yes or X, Continue processing and proceed to check Substance Use.

11. Check Substance Use

a. If Substance Use equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Violence Risk to Others.

b. If Substance Use equal Yes, Continue processing and proceed to Violence Risk to Others.

12. Check Violence Risk to Others

a. If Violence Risk to Others equals No, add one to No Screening Counter. Continue processing and proceed to Violence Risk to Self.

b. If Violence Risk to Others is missing, add one to Missing Counter. Continue processing and proceed to Violence Risk to Self.

c. If Violence Risk to Others equals Yes or X, Continue processing and proceed to check Violence Risk to Others.

13. Check Violence Risk to Others

a. If Violence Risk to Others equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Violence Risk to Self.

b. If Violence Risk to Others equal Yes, Continue processing and proceed to Violence Risk to Self.

14. Check Violence Risk to Self

a. If Violence Risk to Self equals No, add one to No Screening Counter. Continue processing and proceed to Incomplete Screening Counter.

b. If Violence Risk to Self is missing, add one to Missing Counter. Continue processing and proceed to Incomplete Screening Counter.

c. If Violence Risk to Self equals Yes or X, Continue processing and proceed to check Violence Self.

15. Check Violence Risk to Self

a. If Violence Risk to Self equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Incomplete Screening Counter.

b. If Violence Risk to Self equal Yes, Continue processing and proceed to Incomplete Screening Counter.

16. Check Incomplete Screening Counter

a. If Incomplete Screening Counter equals 5, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Continue processing and proceed to initialize the Measure Category Assignment for each strata measure.

b. If Incomplete Screening Counter is less than five, continue processing and proceed to Missing Counter.

17. Check Missing Counter

a. If Missing Counter is more than zero, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-1a) and

will be rejected. Proceed to step initialize the Measure Category Assignment for each strata measure.

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

18. Check No Screening Counter

a. If No Screening Counter is greater than zero, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-1a) and will be in the measure population. Continue processing and proceed to step 19 and initialize the Measure Category Assignment for each strata measure.

b. If No Screening Counter equals zero, the case will proceed to a Measure Category Assignment of E and will be in the measure population. Continue processing and proceed to step 19 and initialize the Measure Category Assignment for each strata measure.

19. 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-1a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-1a) Measure Category Assignment. Continue processing and proceed to Overall Rate Category Assignment.

20. Check Overall Rate Category Assignment

a. If Overall Rate Category Assignment equals B, retain the Measure Category Assignment for the strata measures (HBIPS-1b through HBIPS-1e) equals B. Stop processing.

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

21. 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 HBIP-1b equal to Measure Category Assignment for measure HBIP-1a. 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.

22. 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 HBIP-1c equal to Measure Category Assignment for measure HBIP-1a. 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.

23. 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 HBIP-1d equal to Measure Category Assignment for measure HBIP-1a. Stop processing.

b. If Patient Age at Discharge is greater than or equal to 65 years, set the Measure Category Assignment for the measure HBIP-1e equal to Measure Category Assignment for measure HBIP-1a. Stop processing.1. Run all cases that are included in the Initial Patient Population for HBIPS Discharge and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure

2. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date.

3. Check Length of Stay

a. If Length of Stay is less than or equal to 3 days or greater than or equal to 365 days, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing.

b. If Length of Stay is greater than 3 days and less than 365 days, continue processing and proceed to Psychiatric Care Setting.

4. Check Psychiatric Care Setting

a. If Psychiatric Care Setting equals No, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing.

b. If Psychiatric Care Setting equals Yes, continue processing.

5. Initialize Missing Counter to equal zero. Initialize No Screening Counter to equal zero, Initialize Incomplete Screening Counter to equal zero. Continue processing and proceed to Patient Strengths.

6. Check Patient Strengths

a. If Patient Strengths equals No, add one to No Screening Counter. Continue processing and proceed to Psychological Trauma

History.

- b. If Patient Strengths is missing, add one to Missing Counter. Continue processing and proceed to Psychological Trauma History.
- c. If Patient Strengths equals Yes or X, Continue processing and proceed to check Patient Strengths.

7. Check Patient Strengths

- a. If Patient Strengths equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Psychological Trauma History.
- b. If Patient Strengths equals Yes, Continue processing and proceed to Psychological Trauma History.

8. Check Psychological Trauma History

- a. If Psychological Trauma History equals No, add one to No Screening Counter. Continue processing and proceed to Substance Use.
- b. If Psychological Trauma History is missing, add one to Missing Counter. Continue processing and proceed to Substance Use.
- c. If Psychological Trauma History equals Yes or X, Continue processing and proceed to check Psychological Trauma History.

9. Check Psychological Trauma History

- a. If Psychological Trauma History equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Substance Use.
- b. If Psychological Trauma History equal Yes, Continue processing and proceed to Substance Use.

10. Check Substance Use

- a. If Substance Use equals No, add one to No Screening Counter. Continue processing and proceed to Violence Risk to Others.
- b. If Substance Use is missing, add one to Missing Counter. Continue processing and proceed to Violence Risk to Others.
- c. If Substance Use equals Yes or X, Continue processing and proceed to check Substance Use.

11. Check Substance Use

- a. If Substance Use equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Violence Risk to Others.
- b. If Substance Use equal Yes, Continue processing and proceed to Violence Risk to Others.

12. Check Violence Risk to Others

- a. If Violence Risk to Others equals No, add one to No Screening Counter. Continue processing and proceed to Violence Risk to Self.
- b. If Violence Risk to Others is missing, add one to Missing Counter. Continue processing and proceed to Violence Risk to Self.
- c. If Violence Risk to Others equals Yes or X, Continue processing and proceed to check Violence Risk to Others.

13. Check Violence Risk to Others

- a. If Violence Risk to Others equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Violence Risk to Self.
- b. If Violence Risk to Others equal Yes, Continue processing and proceed to Violence Risk to Self.

14. Check Violence Risk to Self

- a. If Violence Risk to Self equals No, add one to No Screening Counter. Continue processing and proceed to Incomplete Screening Counter.
- b. If Violence Risk to Self is missing, add one to Missing Counter. Continue processing and proceed to Incomplete Screening Counter.
- c. If Violence Risk to Self equals Yes or X, Continue processing and proceed to check Violence Self.

15. Check Violence Risk to Self

- a. If Violence Risk to Self equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Incomplete Screening Counter.
- b. If Violence Risk to Self equal Yes, Continue processing and proceed to Incomplete Screening Counter.

16. Check Incomplete Screening Counter

- a. If Incomplete Screening Counter equals 5, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Continue processing and proceed to initialize the Measure Category Assignment for each strata measure.
- b. If Incomplete Screening Counter is less than five, continue processing and proceed to Missing Counter.

17. Check Missing Counter

- a. If Missing Counter is more than zero, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-1a) and will be rejected. Proceed to step initialize the Measure Category Assignment for each strata measure.
- b. If Missing Counter equals zero, continue processing and proceed to No Screening Counter.

18. Check No Screening Counter

- a. If No Screening Counter is greater than zero, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-1a) and will be in the measure population. Continue processing and proceed to step 19 and initialize the Measure Category Assignment for each strata measure.
- b. If No Screening Counter equals zero, the case will proceed to a Measure Category Assignment of E and will be in the measure population. Continue processing and proceed to step 19 and initialize the Measure Category Assignment for each strata measure.

19. 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-1a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-1a) Measure Category Assignment. Continue processing and proceed to Overall Rate Category Assignment.

20. Check Overall Rate Category Assignment

- a. If Overall Rate Category Assignment equals B, retain the Measure Category Assignment for the strata measures (HBIPS-1b through HBIPS-1e) equals B. Stop processing.
- b. If Overall Rate Category Assignment equals D, E, or X, continue processing and proceed to Patient Age at Discharge.

21. 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 HBIP-1b equal to Measure Category Assignment for measure HBIP-1a. 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.

22. 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 HBIP-1c equal to Measure Category Assignment for measure HBIP-1a. 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.

23. 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 HBIP-1d equal to Measure Category Assignment for measure HBIP-1a. Stop processing.
- b. If Patient Age at Discharge is greater than or equal to 65 years, set the Measure Category Assignment for the measure HBIP-1e equal to Measure Category Assignment for measure HBIP-1a. 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 an instrument-based performance measure (e.g., 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

221-977 20% of the 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.)

Specify calculation of response rates to be reported with performance measure results.

Not applicable

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 Records, Paper Medical 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 are collected.)

IF instrument-based, identify the specific instrument(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)

No data collection instrument provided

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)

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.)

Not applicable

2. Validity – See attached Measure Testing Submission Form
[1922_MeasureTesting_7.1_HBIPS1-636910245898485704.docx](#)

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. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

No

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. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

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).

Although The Joint Commission had intended to pursue the process to convert this measure to an electronic quality measure (eCQM), this has not occurred for the following reasons:

- The adoption of eCQMs may be difficult for free-standing psychiatric facilities because the electronic medical record (EMR) has not been consistently integrated across these facilities.
- It has been the experience of The Joint Commission that it can be difficult and resource intensive to successfully re-engineer a chart-based measure to an eCQM as opposed to new eCQM development.

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 instrument-based, consider implications for both individuals providing 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. 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. If 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).

Not applicable, there are no fees, licensing, or other requirements.

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

#1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed, Last Updated: Sep 01, 2020

within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
	<p>Public Reporting</p> <p>ORYX Performance Measurement Reporting Program https://www.qualitycheck.org/</p> <p>Regulatory and Accreditation Programs</p> <p>Hospital Accreditation Program http://jointcommission.org</p> <p>Quality Improvement (external benchmarking to organizations) America's Hospitals: Improving Quality and Safety – The Joint Commission's Annual Report 2017 https://www.jointcommission.org/annualreport.aspx</p> <p>Quality Improvement (Internal to the specific organization) ORYX Performance Measurement Report Not available to public; only accessible to the organization</p>

4a1.1 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
- Name of program and sponsor: ORYX Performance Measurement Reporting Program/The Joint Commission
- Purpose: The Joint Commission's ORYX initiative integrates performance measurement data into the accreditation process. ORYX measurement requirements support Joint Commission-accredited organizations in their quality improvement efforts
- Geographic area and number and percentage of accountable entities and patients included: Nationwide; 726 free-standing psychiatric hospitals and hospitals with psychiatric units accredited by The Joint Commission
- Level of measurement and setting: Level of measurement and setting: facility level of measurement, inpatient setting
- Name of program and sponsor: America's Hospitals: Improving Quality and Safety – The Joint Commission's Annual Report 2017/The Joint Commission
- Purpose: The Joint Commission's ORYX initiative integrates performance measurement data into the accreditation process. ORYX measurement requirements support Joint Commission-accredited organizations in their quality improvement efforts
- Geographic area and number and percentage of accountable entities and patients included: Nationwide; 726 free-standing psychiatric hospitals and hospitals with psychiatric units accredited by The Joint Commission
- Level of measurement and setting: Level of measurement and setting: facility level of measurement, inpatient setting
- Name of program and sponsor: ORYX Performance Measurement Report/The Joint Commission
- Purpose: The Joint Commission's ORYX initiative integrates performance measurement data into the accreditation process. ORYX measurement requirements support Joint Commission-accredited organizations in their quality improvement efforts
- Geographic area and number and percentage of accountable entities and patients included: Nationwide; 726 free-standing psychiatric hospitals and hospitals with psychiatric units accredited by The Joint Commission
- Level of measurement and setting: Level of measurement and setting: facility level of measurement, inpatient setting
- Name of program and sponsor: Hospital Accreditation Program/The Joint Commission
- Purpose: The Joint Commission's ORYX initiative integrates performance measurement data into the accreditation process. ORYX measurement requirements support Joint Commission-accredited organizations in their quality improvement efforts
- Geographic area and number and percentage of accountable entities and patients included: Nationwide; 726 free-standing

psychiatric hospitals and hospitals with psychiatric units accredited by The Joint Commission

- Level of measurement and setting: Level of measurement and setting: facility level of measurement, inpatient setting

4a1.2. 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?)

Not applicable

4a1.3. 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.)

Not applicable

4a2.1.1. 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.

Measure rates are provided to the hospital via a quarterly ORYX Performance Measure Report. This applies to all entities reporting the measure.

The Joint Commission utilizes an email process for hospital contact related to their measure rates and analysis. Response is provided in a timely manner either by email or directly by phone. Additionally, the data is available publicly through The Joint Commission Quality Check website. Individual hospital data for each rolling yearly time period are viewable and can be downloaded from this website.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

Patient level data is aggregated at the hospital level quarterly. The hospital Performance Measure Report and Quality Check website are updated. A users guide to the Performance Measure Report is posted on the Joint Commission website. Quality Check includes yearly and quarterly hospital rates, state and national averages, and the top 10 percentile at the national and state level.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

The Joint Commission utilizes an automated feedback system with access available to the measured entities and the vendors contracted by measured entities. A clinical lead is responsible for each individual measure set. The system is monitored on a daily basis and response is provided typically within 8 business hours. If queries cannot be managed via written response, arrangements are made to address any issues or concerns via phone.

4a2.2.2. Summarize the feedback obtained from those being measured.

Queries submitted via the automated feedback system have decreased significantly for the HBIPS measure set in the past 3 years. (522 in 2016, 288 in 2017, 187 for 2018 YTD). There have been no issues with the data elements for this measure and no updates needed to the data element specifications based upon feedback received.

4a2.2.3. Summarize the feedback obtained from other users

Same as above in 4a2.2.2.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Note: all feedback is tracked and considered. If upon analysis there are trends noted giving cause for updates, this is reviewed by the measure work-group to confirm the need for revision. Additionally, The Joint Commission engages a Technical Advisory Panel (TAP) that is consulted on an as needed basis for approval of updates that may require their additional expertise. All measure

specifications are reviewed twice a year and updates are made as needed based on feedback from the measure users, input from the TAP, or changes in the guidelines.

Modifications to this measure have not been required based upon feedback received.

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.

4b1. 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.

Though 2009 to 2nd quarter 2018, a binomial random effects model was used to determine if there was a change in rates over time with time as a fixed effect and healthcare organization as a random effect. The results of the model show statistical significant over time ($P < 0.001$) and an odd ratio estimate of time to be 1.183.

4b2. 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).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

To the best of our knowledge, there have been no unexpected findings and no reports of unintended consequences.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

A study published in July 2018, compared results on psychiatric performance measures among cohorts of hospitals with different characteristics that elected to begin reporting on the HBIPS measures at various points in time.

Quarterly reporting of Hospital-Based Inpatient Psychiatric Services (HBIPS) measures to the Joint Commission was used to examine trends in performance among four hospital cohorts that began reporting in 2009 (N=243), 2011 (N=139), 2014 (N=137), or 2015 (N=372).

Results demonstrated that all cohorts significantly improved across quarters for admission screening.

Citation:

Rasinski, K.A., Schmaltz, S.P., Williams, S.C., & Baker, D.W. (2018). Trends in results of HBIPS National Performance Measures and association with year of adoption. *Psychiatric Services*, 69(7):784-790.

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.

Yes

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

0104 : Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
 0110 : Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
 0111 : Bipolar Disorder: Appraisal for risk of suicide
 1365 : Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
 2152 : Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
 2599 : Alcohol Screening and Follow-up for People with Serious Mental Illness

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.
 SUB-1 Alcohol Use Screening STEWARD: The Joint Commission

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?

No

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

Five of the six NQF endorsed measures are provider level measures, 2599 is a health plan measure. All pertain to the ambulatory setting for patients. All (except 2152) are specific to the diagnoses of major depression and/or bipolar disorder. The measures only evaluate one aspect of screening: either suicide risk or alcohol or substance use. Measures 0104, 0110, 0111, 2159, and 2599 only evaluate patients age 18 years and older. The SUB-1 measure pertains to all inpatients 18 years and older, with screening limited to substance use. HBIPS-1 addresses inpatient organizational performance for all psychiatric diagnoses and evaluates the care of all patient ages (greater than 1 year). Additionally, HBIPS-1 evaluates several aspects of screening (risk of violence to self or others, substance use, psychological trauma history and patient strengths).

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.)

Not Applicable

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.

No appendix Attachment:

Contact Information

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

Co.2 Point of Contact: JohnMarc, Alban, jalban@jointcommission.org, 630-792-5304-

Co.3 Measure Developer if different from Measure Steward: The Joint Commission

Co.4 Point of Contact: JohnMarc, Alban, jalban@jointcommission.org, 630-792-5304-

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.

Ann Doucette, PhD
Claremont Graduate University

Scott Dziengelski
National Association for Behavioral Healthcare

Frank A Ghinassi, PhD, ABPP (Chair)
President and CEO
Rutgers Health, University Behavioral Health Care

Richard Hermann, MD, MS
Tufts University School of Medicine, Tufts-NEMC

Karen E. Johnson, MSW
Universal Health Services, Inc.

Michael Lambert, PhD
Brigham Young University

Kathleen McCann, RN, PhD
National Association for Behavioral Healthcare

Dr. John Oldham, MD
Baylor College of Medicine

Lucille M Schacht, PhD, CPHQ
NRI, Inc

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.

The TAP remains engaged with The Joint Commission and meets on an as needed basis to offer consultation or to suggest updates relative to guideline changes/recommendations.

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: 01, 2019

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? 07, 2019

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: Recent revision is dated January 1, 2019. This represents the date the specifications go into effect. The specifications were published in October 2018.