

THE CLINICAL RATIONALE FOR HOSPITAL-BASED INPATIENT PSYCHIATRIC CORE MEASURE SET

EXECUTIVE SUMMARY

The National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) is uniquely positioned to provide information to varied targeted audiences on the use of data to enrich program evaluation and policy both at the state and community level. NRI has operated the Behavioral Healthcare Performance Measurement System (BHPSM) for the past ten years to assist state psychiatric facilities: compile data for standardized indicators of performance in multiple domains, interpret reports based on those indicators, network with peers, and incorporate performance measure data into quality improvement processes.

Since 2000, NRI has been engaged in evaluating measures that could be combined to form a conceptual “core” set. In 2003, in partnership with National Association of Psychiatric Health Systems (NAPHS), NRI engaged public and private psychiatric hospitals to use a common set of measures to test the feasibility of common measures for all inpatient environments. The pilot project provided evidence that common measures were feasible and these measures could be interpreted in relation to quality of care. Since 2004, NRI and NAPHS, along with NASMHPD and American Psychiatric Association (APA) have engaged The Joint Commission in the development of a core set for inpatient psychiatric hospitals. The test set was voluntarily tested in approximately 200 psychiatric hospitals during calendar year 2007 to determine the validity and reliability of those measures.

The Resource Guide is the result of an extensive literature review and compilation of background information on the seven performance measures that comprise the Hospital-Based Inpatient Psychiatric Services (HBIPS) Core Measure Set of The Joint Commission. For readability, the measures are grouped into four domains.

Screening and assessment in inpatient hospitals is fundamental to providing the best and most accurate treatment. Individuals admitted to inpatient psychiatric hospitals are screened and assessed on multiple domains, including but not limited to precipitating events, risk of harm to self or others, trauma history, substance use, strengths, and resources.

The use of restraint and seclusion has come under growing scrutiny in the past several years. Many states and hospitals have actively reduced the use of these interventions and committed to eliminating their use. The Joint Commission has applied the definitions of restraint and seclusion promulgated through the Centers for Medicare and Medicaid Services. Both organizations have stated that the use of restraint and seclusion should be limited to situations deemed objectively to meet the threshold of imminent danger to self or others and when used must be rigorously monitored and analyzed to prevent future use.

The practice of care providers prescribing multiple antipsychotic medications has begun to receive close attention in recent years. There is considerable variability in the prevalence of multiple antipsychotic medications across different treatment settings. However, it is widely known that individuals within inpatient settings receive multiple medications, especially antipsychotic medications.

Continuity of care is an important and vital topic that is receiving considerable attention within the mental health community. The transition from inpatient to outpatient settings involves assisting the individual to navigate and secure resources and informing care providers of current, past, and future treatments. Care providers must develop discharge care plans and partner with outpatient providers to increase stable community living and decrease future hospitalizations.

FACT SHEET INITIAL SCREENING

HBIPS-1 ADMISSION SCREENING

Clients admitted to a hospital-based inpatient psychiatric setting who are screened by the third day post admission for all of the following: risk of violence to self, risk of violence to others, substance use, psychological trauma history, and patient strengths.

CLINICAL RELEVANCE AND JUSTIFICATION

Risk to Others

- A structured approach includes a pre-set list of questions while an unstructured approach relies heavily on the individual's responses and the care provider's judgment.
- Clinical training on tools is required for consistent results as well as confidence in results for treatment planning.
- Personal factors play a role in predicting violence in individuals and groups.
- Assessing risk is vital to providing a safe environment.

Risk to Self

- There is a higher rate of suicidal risk in inpatient settings.
- The physical environment may pose risks to individuals with suicidal thoughts.
- Identify and document both risk factors and protective factors to inform treatment planning.

Substance Use

- There is a high rate of co-occurring substance use among individuals with mental disorders. (average 38% of individuals served)
- Alcohol and other substances interfere with the therapeutic intent of psychotropic medication.
- Inappropriate use of prescribed medications can lead to relapse.
- Substance use issues should be treated in concert with mental health issues.

Psychological Trauma

- A significant proportion of individuals served in inpatient psychiatric settings have experienced trauma (average 43%-81%).
- Traumatic events are broadly defined to include personal harm, natural disasters, terrorism, and significant loss.
- Past responses to crises influence current response to crises and treatment plan.

Patient Strengths

- A focus on strengths supports recovery and person-centeredness.
- Strengths assessments identify resources that can enhance individuals' management of their illness and re-engagement with the community.
- Strengths assessments build on identifying abilities, interests, and achievements.
- Strengths assessments include multiple life domains such as where the person lives, works, socializes, and learns.

EVALUATING RESOURCES

The choice of assessment tools must take into consideration a number of clinical and environmental concerns. Some specific concerns of care providers and hospitals include the training requirements and the fidelity of the tool's content to the treatment models in practice or proposed. The psychometric properties of the tools should be determined and the impact of adjusting tools for clinical and environmental differences should be considered. While various screenings and assessments are expected, a consolidation of effort should not outweigh the integrity of the process and the goal of informing an individualized and appropriate care model.

FACT SHEET RESTRAINT AND SECLUSION

HBIPS-2 HOURS OF PHYSICAL RESTRAINT USE

The total numbers of hours that all clients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.

HBIPS 3 HOURS OF SECLUSION USE

The total numbers of hours that all clients admitted to a hospital-based inpatient psychiatric setting were maintained in seclusion.

CLINICAL RELEVANCE AND JUSTIFICATION

- Seclusion and restraint are coercive interventions that should be limited to imminent danger.
- Leadership and administrative monitoring have a significant role in reduction efforts.
- Several hospitals have documented the elimination of restraint and seclusion.
- Some hospitals have documented reduced elopements and staff injuries.
- There are increased financial, staff, and treatment costs associated with the use of restraint and seclusion.
- Using a coping questionnaire provides both staff and individuals with strategies for alternatives to restraint and seclusion.
- There has been no evidence to support better outcomes for individuals who experience a restraint or seclusion.
- Individuals with a restraint or seclusion event have longer hospital stays and more medications.
- Individuals with a history of trauma have a 7-fold increase in the likelihood of restraint or seclusion.
- Younger individuals experience restraint and seclusion as punishment.

EVALUATING RESOURCES

With the heightened attention over the last ten years to decrease the use of seclusion and restraint in psychiatric facilities, care providers have more options for successful strategies and developing safety plans that decrease the likelihood of using these practices. When evaluating the literature for applicability of a model to a setting, care providers and hospitals must consider the clinical environment where the study was conducted. In addition, facilities should evaluate the implications for staff training to instill a new approach to interaction with individuals served.

To decrease the use of seclusion and restraint, effective monitoring tools must be considered. These tools should be assessed for their ability to track actual time of events, precursors, staffs involved, alternative interventions, and outcomes. Other considerations might include tracking the use of alternative interventions where a seclusion or restraint event did not result. Such tracking can serve as a marker of accomplishments in alternatives to seclusion and restraint and identify the shift in staffs' attitudes toward these practices.

FACT SHEET MULTIPLE ANTIPSYCHOTIC MEDICATIONS

HBIPS 4 DISCHARGE ON MULTIPLE ANTIPSYCHOTIC MEDICATION

Clients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications.

HBIPS 5 DISCHARGE ON MULTIPLE ANTIPSYCHOTIC MEDICATION WITH APPROPRIATE JUSTIFICATION

Clients who are discharged on multiple antipsychotic medications with appropriate justification, where these justifications are limited to failed trials of monotherapy, cross-tapering planned or in progress, and augmentation of Clozapine.

CLINICAL RELEVANCE AND JUSTIFICATION

- There is considerable variability in prescribing patterns across care providers. Multiple antipsychotic medication rates range from 30%-40%.
- Multiple medications increase costs. Medication changes may increase the length of the hospital stay.
- Medication algorithms provide guidance to care providers, but are not widely used or consistently monitored.
- Most research indicated no benefit to polypharmacy when the individual did not have a history of treatment failure with monotherapy.
- Documentation of history of medication treatments, effectiveness, duration, and side effects may not be easily retrieved from clinical records for individuals whose psychiatric treatment history spans many care providers and many years.
- Post-discharge medication compliance for polypharmacy is unknown, since little research has addressed this issue.

EVALUATING RESOURCES

As the second generation of antipsychotic medications flourishes in the mental health community, care providers and individuals served are working to find the most clinically relevant and cost-efficient way to treat psychiatric symptoms. Consumer-run agencies, advocacy groups, and clinical associations have developed educational materials about the use of antipsychotic medications. Literature on medication algorithms may be another useful source for care providers when evaluating their policies and practices.

There is diverse and growing literature about the use of multiple antipsychotic medications. Empowering individuals to manage the medications that effectively control their symptoms is a collaboration between the care providers and the individuals served. Issues of medication adherence need to be addressed coincident to developing a medication regime for post hospitalization. Clinical tools are needed to assist care providers to track previously tried medications and make this information readily available for subsequent hospitalizations and outpatient care providers.

FACT SHEET CONTINUING CARE PLAN

HBIPS-6 POST DISCHARGE CONTINUING CARE PLAN CREATED

Clients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created that contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications, and next level of care recommendations.

HBIPS-7 POST DISCHARGE CONTINUING CARE PLAN TRANSMITTED TO NEXT LEVEL OF CARE PROVIDER

Clients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity by the 5th day post discharge.

CLINICAL RELEVANCE AND JUSTIFICATION

- Continuity of care planning has positive effects on outcomes.
- There are financial benefits for the inpatient hospital when re-hospitalization rates are lowered.
- Successful transitions make beds available for new clients in acute distress or waiting for hospital placement.
- Some individuals may be less likely to keep follow-up appointments; additional transitional activities may be needed to effect community placement.
- Providing the information directly to the care provider ensures the information is available when the client arrives for care.
- Therapeutic transition models have shown positive effects and demonstrated engaging the individual served with the hospital in the transition plan.

EVALUATING RESOURCES

Discharge care planning can have profound implications on the type of community supports and services provided to individuals served in psychiatric hospitals. Hospitals develop a process to assist these individuals in transitioning back to the community. It is important that these plans are clearly outlined, articulated, and provided to the community care providers upon discharge. Discharge care planning checklists and informational resources are available that might be useful to psychiatric hospitals when examining their practices around discharge care planning.

The intended recipient as well as requirements of regulatory or standard-setting entities may dictate/suggest components of a discharge care plan. Hospitals need to consider these diverse entities when developing documentation and clinical practices, noting that one-size does not fit all.