OVERVIEW OF HBIPS CORE MEASURE SET

Behavioral Healthcare Performance Measurement System

The final specifications for the HBIPS core measure set were released by The Joint Commission on May 30, 2008 with an optional start date of October 1, 2008. NRI has named the final HBIPS set to correspond with a set number and a specific measure number to differentiate the test set from the final set. For example, HBIPS 1.3 is from final set #1, measure #3. This naming mechanism will allow for a clear indication of future changes.

HBIPS 1.1 INITIAL SCREENING

Definition: Percent of clients discharged that were screened by the 3rd 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.

Rationale: Substantial 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.

HBIPS 1.2 HOURS OF PHYSICAL RESTRAINT USE

Definition: Total hours all clients spent in physical restraint as a proportion of total inpatient hours.

Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint are limited to situations deemed objectively to meet the threshold of imminent danger and when used are rigorously monitored and analyzed to prevent future

© National Association of State Mental Health Program Directors Research Institute, Inc (NRI) 07/2010
BHPMS Office: 209 Madison Street, Suite 401, Alexandria, VA 22314 (703) 682-9476

use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).

HBIPS 1.3 HOURS OF SECLUSION USE

Definition: Total hours all clients spent in seclusion as a proportion of total inpatient hours.

Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint are limited to situations deemed objectively to meet the threshold of imminent danger and when used are rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).

HBIPS 1.4 DISCHARGE ON MULTIPLE ANTIPSYCHOTIC MEDICATIONS

Definition: Percent of clients discharged on two or more antipsychotic medications as a proportion of clients discharged on one or more antipsychotic medications.

Rationale: Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Gilmer et al., 2007; Kreyenbuhl et al., 2006; Ganguly et al., 2004, Stahl et al., 2004, Covell et al., 2002). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe and Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Stahl et al., 2004; Ananth et al., 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (National Association of State Mental Health Program Directors, 2001; University Health System Consortium, 2006; Gilmer, 2007; Centorrino, 2004). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (APA Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation of clozapine with another second-generation antipsychotic (Tranulis et al., 2008). Among patients without a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic

© National Association of State Mental Health Program Directors Research Institute, Inc (NRI) 07/2010
BHPMS Office: 209 Madison Street, Suite 401, Alexandria, VA 22314 (703) 682-9476

polypharmacy over monotherapy (Shim, 2007; Ananth et al., 2004; Centorrino, 2004; Stahl et al., 2004; Portkin, 2002). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a client on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

HBIPS 1.5 DISCHARGE ON MULTIPLE ANTIPSYCHOTIC MEDICATIONS WITH APPROPRIATE JUSTIFICATION

Definition: Percent of clients discharged on multiple antipsychotic medications with appropriate justification as a proportion of clients discharged on two or more antipsychotic medications.

Rationale: Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Gilmer et al., 2007; Kreyenbuhl et al., 2006; Ganguly et al., 2004, Stahl et al., 2004, Covell et al., 2002). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe and Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Stahl et al., 2004; Ananth et al., 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (National Association of State Mental Health Program Directors, 2001; University Health System Consortium, 2006; Gilmer, 2007; Centorrino, 2004). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (APA Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation of clozapine with another second-generation antipsychotic (Tranulis et al., 2008). Among patients without a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Shim, 2007; Ananth et al., 2004; Centorrino, 2004; Stahl et al., 2004; Portkin, 2002). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a client on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

© National Association of State Mental Health Program Directors Research Institute, Inc (NRI) 07/2010

HBIPS 1.6 CONTINUING CARE PLAN CREATED

Definition: Percent of clients discharged with a continuing care plan created that includes all of the following: reason for hospitalization, discharge diagnosis, discharge medications, and next level of care recommendations.

Rationale: Patients may not be able to fully report to their next level of care health-care provider their course of hospitalization or discharge treatment recommendations. The aftercare instructions given to the client may not be available to the next level of care provider at the client's initial intake or follow-up appointment. In order to provide optimum care, next level of care providers need to know details of precipitating events immediately preceding hospital admission, the client's treatment course during hospitalization including rationale and target symptoms for medications changed, discharge medications and next level of care recommendations (AACP, 2001).

HBIPS 1.7 CONTINUING CARE PLAN TRANSMITTED

Definition: Percent of clients discharged with a continuing care plan that is transmitted to next level of care provider by the 5th day post discharge.

Rationale: Patients may not be able to fully report to their next level of care health-care provider their course of hospitalization or discharge treatment recommendations. The aftercare instructions given to the client may not be available to the next level of care provider at the client's initial intake or follow-up appointment. In order to provide optimum care, next level of care providers need to know details of precipitating events immediately preceding hospital admission, the client's treatment course during hospitalization including rationale and target symptoms for medications changed, discharge medications and next level of care recommendations (AACP, 2001).

ADDITIONAL INFORMATION

References: NRI, Inc. BHPMS Implementation Guide, Version 5.1. 2009

The Joint Commission, Specification Manual for The Joint Commission National Quality Core Measures. V2010A. October 2008

Complete references are available throughout the Implementation Guide.

© National Association of State Mental Health Program Directors Research Institute, Inc (NRI) 07/2010