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 #: 0641
Corresponding Measures:
De.2. **Measure Title:** HBIPS-3 Hours of seclusion use
Co.1.1. **Measure Steward:** The Joint Commission
De.3. **Brief Description of Measure:** The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.
1b.1. **Developer 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 is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is 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).

The literature supports a reduction in the use of physical restraint and seclusion. A reduction in the use of physical restraint and seclusion will improve patient safety, reduce overall organizational costs, leading to a decrease in staff and patient injuries and an increase in staff productivity. And finally, focusing on behavioral interventions to defuse aggressive and violent behaviors will result in less retraumatization for patients with trauma histories leading to shortened and improved recovery.

The measure will assist health care organizations (HCOs) to track seclusion use to determine patterns and trends to aid the organization in efforts to decrease use.

S.4. **Numerator Statement:** The total number of hours that all psychiatric inpatients were held in seclusion

Numerator Basis: The numerator evaluates the number of hours of seclusion; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.
S.6. **Denominator Statement:** Number of psychiatric inpatient days

Denominator basis per 1,000 hours

To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per total patient days.
S.8. **Denominator Exclusions:** Total leave 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: May 05, 2010 **Most Recent Endorsement Date:** Oct 24, 2019

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
0641_evidence_attachment_7.1HBIPS3.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.
No

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.
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 is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is 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).

The literature supports a reduction in the use of physical restraint and seclusion. A reduction in the use of physical restraint and seclusion will improve patient safety, reduce overall organizational costs, leading to a decrease in staff and patient injuries and an increase in staff productivity. And finally, focusing on behavioral interventions to defuse aggressive and violent behaviors will result in less retraumatization for patients with trauma histories leading to shortened and improved recovery.

The measure will assist health care organizations (HCOs) to track seclusion use to determine patterns and trends to aid the organization in efforts to decrease use.

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.*
Below are the data from 2009-2018 adjusted per 1000 patient days. 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. Also included are the number of cases/occurrences that contributed to the numerator

Year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	
N	294	313	465	475	510	659	1028	1053	733	718	
Mean	0.20606	0.2834	0.24286	0.23201	0.22525	0.26393	0.96798	0.57638	0.35771	0.27541	
Std. Dev.		0.3686	0.8655	0.6633	0.8126	0.6616	0.804	13.9456	6.5887	2.2963	1.2133
Max	2.875	10.06	9.548	15.336	11.305	9.464	403.303	175.932	50.136	18.962	
Q3	0.24183	0.24879	0.20981	0.18452	0.19416	0.16997	0.188	0.16533	0.15968	0.15452	
Median	0.06943	0.06381	0.05519	0.05093	0.05197	0.04775	0.03446	0.029	0.03077	0.02967	

Q1	0.00876	0.00991	0.00746	0.00856	0.00702	0.00196	0	0	0	0
Min	0	0	0	0	0	0	0	0	0	0
10th Pctl		0	0	0	0	0	0	0	0	0
20th Pctl		0.00315	0.00285	0.00226	0.0034	0.00229	0	0	0	0
30th Pctl		0.015	0.01558	0.01503	0.01501	0.01267	0.00614	0	0	0.00148	0
40th Pctl		0.02792	0.03806	0.02967	0.03046	0.02986	0.02285	0.01089	0.00918	0.0118	0.00712
60th Pctl		0.12121	0.11738	0.10112	0.09257	0.08306	0.0748	0.06731	0.06009	0.06219	0.06084
70th Pctl		0.18658	0.19684	0.17319	0.1476	0.13766	0.11607	0.12648	0.12581	0.11708	0.11825
80th Pctl		0.29585	0.31968	0.27233	0.26621	0.27488	0.23799	0.25825	0.2309	0.22713	0.2144
90th Pctl		0.53417	0.66975	0.5441	0.52806	0.52895	0.59584	0.64355	0.54005	0.49618	0.52923
# Cases	12933	15074	26034	25987	26885	26192	31552	32755	28997	15040	

The Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded $5.3 million in State Incentive Grants to eight states to develop evidence-based practices and guidelines to reduce the use of restraint and seclusion in psychiatric facilities with an ultimate goal of eliminating all use in the U.S. (Curie, 2005). According to Bergk et al (2008) the prevalence of seclusion and physical restraint use varies from 0% to 66% in US health care organizations. Evidence supporting the reduced use of restraint and seclusion centers on alternative behavioral interventions. Crisis Prevention Institute (CPI) techniques, such as the Nonviolent Crisis Intervention® training program, when used in a variety of settings has been successful in reducing or eliminating the use of physical restraint and seclusion (LaFond, 2007). De-escalation of a patient in crisis is a valuable therapeutic intervention that can be used by psychiatric professionals when dealing with violent or aggressive patients. For example, the Four S Model was developed by Delaney, Pitula and Perraud as a way of reducing seclusion and restraint use. The four S's are safety, support, structure and symptom management (Stokowski, 2007). Researchers at one facility developed the New Directions program which is another program geared towards children and adolescents that helped staff divert situations that would normally result in restraint and seclusion (American Psychiatric Association [APA], American Psychiatric Nurses Association [APNA], National Association of Psychiatric Health Systems & American Hospital Association [NAPHS], 2003).

A significant reduction in the use of restraint and seclusion was reported by several facilities after staff were trained in NASMHPD's Six Core Strategies© curriculum to prevent and reduce restraint and seclusion. The decreased use ranged from 90% reduction to no restraint or seclusion use (SAMHSA, 2011). A study conducted in the Pennsylvania state hospital system examining a restraint and seclusion reduction program resulted in a reduction in seclusion from 10.8 to 1.3 hours per 1,000 patient days and restraint from 11.9 to 1.9 hours per 1,000 patient days (Smith et al., 2005).

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.*

LaRue et al (2009) noted through a recent review of the literature that age (young and middle-aged), male gender, being an immigrant and a diagnosis of bipolar disorder or schizophrenia were several factors increasing the likelihood of being secluded. One study conducted from 2006 through 2010 in mental health facilities in Canada showed that the oldest patients were 46% less likely to be restrained or secluded than younger patients and patients who are unemployed are 22% more likely to be restrained or secluded (Canadian Institute for Health Information [CIHI], 2011). According to CIHI (2011), males are also more likely to be placed in seclusion.

For gender, Hispanic ethnicity and race, data are provided by median seclusion time for those with a seclusion since the denominator data was not broken down by these demographic categories. For age group the measure rates are provided.

For data source see data in 1b.2

Median Seclusion Time (in minutes) for patients that were restrained

Gender	2013	2014	2015	2016	2017
Male	105	70	75	80	76
Female	60	60	64	60	60

Hispanic Ethnicity	2013	2014	2015	2016	2017
Hispanic	76	105	135	160	160
Non-Hispanic		60	60	66	66	61

Race	2013	2014	2015	2016	2017
White	60	65	75	70	65
African American	65	66	73	90	80
American Indian	119	66	73	90	80
Asian	124	61	107	90	115
Pacific Islander	59	115	765	765	765

Median Measure Rate (per 1,000 patient hours) by age group

Age Category	2013	2014	2015	2016	2017
1-12 years	0.17	0.16	0.21	0.10	0.08
13-17 years	0.06	0.05	0.04	0.04	0.03
18-64 years	0.04	0.03	0.03	0.03	0.03
65+ years	0.00	0.00	0.00	0.00	0.00

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

Not applicable

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

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

Person-and Family-Centered Care, Safety, Safety : Overuse

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.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.
Data element Minutes of Seclusion:
• Notes for Abstraction were updated to clarify the priority for tracking time in restraint/seclusion when a patient is placed in restraint and seclusion at the same time.

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).
The total number of hours that all psychiatric inpatients were held in seclusion

Numerator Basis: The numerator evaluates the number of hours of seclusion; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.

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).
Three data elements are used to calculate the numerator:

1. Event Date*- The month, day and year of the event.

2. Event Type* - The measure-related event being identified. Allowable values: 1. Physical Restraint 2. Seclusion

3. Minutes of Seclusion - The total minutes recorded in the medical record that a patient was held in Event Type 2 (seclusion) for the associated Event Date. Allowable values 1-1440 minutes

*The data elements Event Date and Event Type are used for both HBIPS-2: (Hours of Physical Restraint Use) and HBIPS-3 (Hours of Seclusion Use).
Patients are eligible for the numerator population when a seclusion event occurs.

Seclusion is the involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving. This definition is noted in the data element Minutes of Seclusion included with the submission.

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

Denominator basis per 1,000 hours

To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per total patient days.

S.7. **Denominator Details** *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*
IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).
Seven data elements are used to calculate the denominator:

1. 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. 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.

4. Psychiatric Inpatient Days - Medicare Only* - The sum of the number of days each Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status).

5. Psychiatric Inpatient Days – Non-Medicare Only* - The sum of the number of days each non-Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status).

6. Total Leave Days - Medicare Only* - The aggregate number of leave days for Medicare patients during the month.

7. Total Leave Days – Non-Medicare Only* - The aggregate number of leave days for non-Medicare patients during the month.

* The distinction between Medicare and Non-Medicare was added to account for the adoption of the HBIPS measures by the Centers for Medicare and Medicaid Services (CMS) Inpatient Psychiatric Facilities Quality Reporting Program

Populations: All psychiatric inpatient days.

S.8. **Denominator Exclusions** *(Brief narrative description of exclusions from the target population)*
Total leave 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 who are on leave defined as an authorized or unauthorized absence of the patient from a psychiatric care setting, excluding discharges, during which the patient is absent from the psychiatric care setting at the time of the daily census and is not under the direct supervision of psychiatric care setting staff while absent.

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:**
Ratio
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 = Lower 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-2 and 3 and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure.

2. Check Event Type

a. If Event Type equals 1, the case will proceed to a Measure Category Assignment of U for Overall Rate (HBIPS-3a) and will not be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.
b. If Event Type equals 2, continue processing and proceed to Minutes of Seclusion.

3. Check Minutes of Seclusion

a. If Minutes of Seclusion is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-3a) and will be rejected. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.
b. If Minutes of Seclusion equals UTD, the case will proceed to a Measure Category Assignment of Y for Overall Rate (HBIPS-3a) and will be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.
c. If Minutes of Seclusion equals a Not able to Determine Value, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-3a) and will be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.

4. Check Overall Rate Category Assignment

a. If Overall Rate Category Assignment equals U, Set the Measure Category Assignment for the strata measures (HBIPS-3b through HBIPS-3e) = ´U´. Stop processing.
b. If Overall Rate Category Assignment equals E, X or Y, continue processing and proceed to Patient Age at Time of Event.

5. Initialize the Measure Category Assignment for each strata measure (b-e) = ´B´. Do not change the Measure Category Assignment or Total Overall Restraint Minutes that was already calculated for the overall rate (HBIPS-3a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate´s (HBIPS-3a) Measure Category Assignment.

6. Check Patient Age at Time of Event

a. If Patient Age at Time of Event is greater than or equal 1 years and less than 13 years, set the Measure Category Assignment for measure HBIPS-3b = Measure Category Assignment for measure HBIPS-3a. Stop processing.
b. If Patient Age at Time of Event is greater than or equal 13 years, continue processing and proceed to Patient Age at Time of Event.

7. Check Patient Age at Time of Event

a. If Patient Age at Time of Event is greater than or equal 13 years and less than 18 years, set the Measure Category Assignment for measure HBIPS-3c = Measure Category Assignment for measure HBIPS-3a. Stop processing.
b. If Patient Age at Time of Event is greater than or equal 18 years, continue processing and proceed to Patient Age at Time of Event.

8. Check Patient Age at Time of Event

a. If Patient Age at Time of Event is greater than or equal 18 years and less than 65 years, set the Measure Category Assignment for measure HBIPS-3d = Measure Category Assignment for measure HBIPS-3a. Stop processing.
b. If Patient Age at Time of Event is greater than or equal 65 years, set the Measure Category Assignment for measure HBIPS-3e = Measure Category Assignment for measure HBIPS-3a. Stop processing.

9. Measure Calculation for Aggregated Denominator. Denominator: For the overall measure and each strata measure calculate the denominator rate by aggregating the Psychiatric Inpatient Days and Leave Days. Number of Denominator Cases for the overall measure = (Psychiatric Inpatient Days – Leave Days), for all patients for the reporting month. Number of Denominator Cases for each strata measure = (Psychiatric Inpatient Days – Leave Days), for all patients with a Patient Age (Reporting Date - Birthdate) appropriate for the strata for the reporting month where Reporting Date is the last date of the reporting month that the census data is being reported. Performance Measurement Systems can refer to the Joint Commission's ORYX Technical Implementation Guide for information concerning the aggregation of HCO level data, including the Observed Rate and Population Size for this measure.

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.
The measure is not eligible for sampling.

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
0641_MeasureTesting_7.1_HBIPS3-636910247882951263.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,
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 within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
	Public Reporting ORYX Performance Measurement Reporting Program https://www.qualitycheck.org/ Payment Program Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program https://www.medicare.gov/hospitalcompare/search.html Regulatory and Accreditation Programs Hospital Accreditation Program http://jointcommission.org 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 Quality Improvement (Internal to the specific organization) ORYX Performance Measurement Report Not available to public; only accessible to the organization

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: Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program/Centers for Medicare & Medicaid Services

• Purpose: The IPFQR Program gives consumers care quality information to help them make more informed decisions about their healthcare options. This includes providing consumers with data about quality measures that aim to assess and foster improvement in the quality of care provided to patients with mental illness.

The IPFQR Program encourages facilities and clinicians to improve the quality of inpatient care. The program helps by making sure providers know about and report on the best practices for their facilities and type of care they give by submitting quality data to CMS annually.

• Geographic area and number and percentage of accountable entities and patients included: United States All IPFs paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) have to meet IPFQR Program requirements. As of 12/1/2018, there are 1,635 participating providers in the IPFQR Program.

• Level of measurement and setting: The IPF PPS applies to inpatient psychiatric services given by psychiatric hospitals or psychiatric units (also known as mental health or behavioral health units) in Acute Care Hospitals (ACHs) or Critical Access Hospitals (CAHs) in the United States that participate in Medicare.

• 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 major issues with the data elements for this measure. Trends in the few questions raised focused on determination of time in restraints vs. time in seclusion.

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.

Notes for Abstraction were updated for the data element Minutes of Seclusion to clarify the priority for tracking time in restraint vs. seclusion when a patient is placed in restraint and seclusion at the same time.

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 Poisson 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 and the number of patient days as the offset variable. The results of the model show statistical significant increase in rates over time ($P<0.001$) and an estimate of 0.032 for the fixed effect time variable.

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 seclusion hours significantly dropped over the six reporting periods for all cohorts except 2011.

Citation:
Rasinksi, 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.
No

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

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

5a. Harmonization of Related Measures
The measure specifications are harmonized with related measures;
OR
The differences in specifications are justified

5a.1. **If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**
Are the measure specifications harmonized to the extent possible?

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

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
Professor
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.