Hospital Based Inpatient Psychiatric Services (HBIPS)

Set Measures

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Measure Short Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-1</td>
<td>Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed</td>
</tr>
<tr>
<td>HBIPS-2</td>
<td>Hours of physical restraint use</td>
</tr>
<tr>
<td>HBIPS-3</td>
<td>Hours of seclusion use</td>
</tr>
<tr>
<td>HBIPS-4</td>
<td>Patients discharged on multiple antipsychotic medications</td>
</tr>
<tr>
<td>HBIPS-5</td>
<td>Patients discharged on multiple antipsychotic medications with appropriate justification</td>
</tr>
<tr>
<td>HBIPS-6</td>
<td>Post discharge continuing care plan created</td>
</tr>
<tr>
<td>HBIPS-7</td>
<td>Post discharge continuing care plan transmitted to next level of care provider upon discharge</td>
</tr>
</tbody>
</table>

General Data Elements

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Collected For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>All Records,</td>
</tr>
<tr>
<td>Birthdate</td>
<td>All Records,</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>All Records, Not collected for HBIPS-2 and HBIPS-3</td>
</tr>
<tr>
<td>Discharge Status</td>
<td>All Records, Not collected for HBIPS-2 and HBIPS-3; Used in algorithm for PC-04 and PC-05</td>
</tr>
<tr>
<td>Event Date</td>
<td>All Records, Not collected for HBIPS-1, 4, 5, 6 and 7</td>
</tr>
<tr>
<td>Event Type</td>
<td>All Records, Not collected for HBIPS-1, 4, 5, 6 and 7</td>
</tr>
<tr>
<td>ICD-9-CM Other Diagnosis Codes</td>
<td>All Records, Optional for HBIPS-2 and HBIPS-3; Used in algorithm for PC-01, 02, 04, and 05</td>
</tr>
<tr>
<td>ICD-9-CM Other Procedure Codes</td>
<td>All Records, Optional for All HBIPS Records; Used in algorithm for PC-01, 02, 04 and 05</td>
</tr>
<tr>
<td>ICD-9-CM Other Procedure Dates</td>
<td>All Records, Optional for All HBIPS Records</td>
</tr>
<tr>
<td>ICD-9-CM Principal Diagnosis Code</td>
<td>All Records, Optional for HBIPS-2 and HBIPS-3; Used in algorithm for PC-01, 02, 04, and 05</td>
</tr>
</tbody>
</table>
ICD-9-CM Principal Procedure Code | All Records, Optional for All HBIPS Records; Used in algorithm for PC-01, 02, 04 and 05
---|---
ICD-9-CM Principal Procedure Date | All Records, Optional for All HBIPS Records
Payment Source | All Records, Optional for HBIPS-2 and HBIPS-3
Point of Origin for Admission or Visit | All Records, Optional for HBIPS-2, HBIPS-3; Used in algorithm for PC-04, PC-05
Psychiatric Care Setting | All Records,
Sex | All Records,

Algorithm Output Data Elements

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Collected For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Category Assignment</td>
<td>Calculation, Transmission, Hospital Clinical Data File</td>
</tr>
<tr>
<td>Measurement Value</td>
<td>Calculation, Transmission, Hospital Clinical Data File</td>
</tr>
</tbody>
</table>

Measure Set Specific Data Elements

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Collected For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate Justification for Multiple Antipsychotic Medications</td>
<td>HBIPS-5,</td>
</tr>
<tr>
<td>Continuing Care Plan-Discharge Medications</td>
<td>HBIPS-6, HBIPS-7,</td>
</tr>
<tr>
<td>Continuing Care Plan-Next Level of Care</td>
<td>HBIPS-6, HBIPS-7,</td>
</tr>
<tr>
<td>Continuing Care Plan-Principal Discharge Diagnosis</td>
<td>HBIPS-6, HBIPS-7,</td>
</tr>
<tr>
<td>Continuing Care Plan-Reason for Hospitalization</td>
<td>HBIPS-6, HBIPS-7,</td>
</tr>
<tr>
<td>Minutes of Physical Restraint</td>
<td>HBIPS-2,</td>
</tr>
<tr>
<td>Minutes of Seclusion</td>
<td>HBIPS-3,</td>
</tr>
<tr>
<td>Number of Antipsychotic Medications Prescribed at Discharge</td>
<td>HBIPS-4, HBIPS-5,</td>
</tr>
<tr>
<td>Patient Referral to Next Level of Care Provider</td>
<td>HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7,</td>
</tr>
<tr>
<td>Patient Strengths</td>
<td>HBIPS-1,</td>
</tr>
<tr>
<td>Psychiatric Inpatient Days - Medicare Only</td>
<td>HBIPS-2, HBIPS-3,</td>
</tr>
<tr>
<td>Psychiatric Inpatient Days-Non-Medicare Only</td>
<td>HBIPS-2, HBIPS-3,</td>
</tr>
<tr>
<td>Psychological Trauma History</td>
<td>HBIPS-1,</td>
</tr>
<tr>
<td>Substance Use</td>
<td>HBIPS-1,</td>
</tr>
<tr>
<td>Total Leave Days - Medicare Only</td>
<td>HBIPS-2, HBIPS-3,</td>
</tr>
<tr>
<td>Total Leave Days-Non-Medicare Only</td>
<td>HBIPS-2, HBIPS-3,</td>
</tr>
<tr>
<td>Violence Risk to Others</td>
<td>HBIPS-1,</td>
</tr>
<tr>
<td>Violence Risk to Self</td>
<td>HBIPS-1,</td>
</tr>
</tbody>
</table>

Related Materials

Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
**Hospital-Based Inpatient Psychiatric Services (HBIPS) Measure Set Initial Patient Population**

The HBIPS measure set is unique in that there are two distinct Initial Patient Populations within the measure set, one for the discharge measures (HBIPS-1, HBIPS-4, HBIPS-5, HBIPS-6, and HBIPS-7) and the other for event measures (HBIPS-2 and HBIPS-3).

**Initial Patient Population for Discharge Measures (HBIPS-1, HBIPS-4, HBIPS-5, HBIPS-6, and HBIPS-7)**

The population of the HBIPS discharge measures can be identified by using three data elements that are common to the discharge performance measures in the HBIPS set:

- ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes
- **Discharge Date-HBIPS**
- **Birthdate-HBIPS**

The HBIPS Discharge Topic Population is defined as patients discharged from the hospital with an ICD-9-CM Principal or Other Diagnosis Code for Psychiatric Services as defined in Appendix A, Table 10.1 and a Patient Age at Discharge (**Discharge Date-HBIPS** − **Birthdate-HBIPS**) >= 1 year. There are four distinct strata or sub-populations within the HBIPS Discharge Topic Population, each identified by a specific age range. The patients in each stratum are counted in the HBIPS Initial Patient Population for discharge measures of multiple measures.

<table>
<thead>
<tr>
<th>Discharge Measures</th>
<th>Age Strata</th>
<th>Initial Patient Population</th>
</tr>
</thead>
</table>
HBIPS-1a, 4a, 5a, 6a, and 7a (overall measures) | Age greater than and equal to 1 year | The count of all patients in strata 1, 2, 3, and 4
---|---|---
HBIPS-1b, 4b, 5b, 6b, and 7b | Age 1 year through 12 years | The count of all patients in stratum 1
HBIPS-1c, 4c, 5c, 6c, and 7c | Age 13 years through 17 years | The count of all patients in stratum 2
HBIPS-1d, 4d, 5d, 6d, and 7d | Age 18 years through 64 years | The count of all patients in stratum 3
HBIPS-1e, 4e, 5e, 6e, and 7e | Age greater than and equal to 65 years | The count of all patients in stratum 4

Patients discharged from the hospital with an ICD-9-CM Principal or Other Diagnosis Code for Psychiatric Services as defined in Appendix A, Table 10.1 are included in one of the HBIPS Strata Initial Populations for discharge measures and are eligible to be sampled if they have:

**Discharge Stratum 1 – Age 1 year through 12 years stratum** – A Patient Age at Discharge \((\text{Discharge Date-HBIPS} − \text{Birthdate-HBIPS}) >= 1 \text{ year and } < 13 \text{ years}\)

**Discharge Stratum 2 - Age 13 years through 17 years stratum** – A Patient Age at Discharge \((\text{Discharge Date-HBIPS} − \text{Birthdate-HBIPS}) >= 13 \text{ years and } < 18 \text{ years}\)

**Discharge Stratum 3 - Age 18 years through 64 years stratum** – A Patient Age at Discharge \((\text{Discharge Date-HBIPS} − \text{Birthdate-HBIPS}) >= 18 \text{ years and } < 65 \text{ years}\)

**Discharge Stratum 4 - Age greater than and equal to 65 years stratum** – A Patient Age at Discharge \((\text{Discharge Date-HBIPS} − \text{Birthdate-HBIPS}) >= 65 \text{ years}\)
HBIPS Initial Patient Population Algorithm

Start HBIPS Initial Patient Population logic sub-routine

Variable Key:
- Patient Age at Discharge
- Patient Age at Time of Event
- Initial Patient Population Reject Case Flag

Note: Patients for which an event occurred and the Event Date is not initially captured electronically must be added to the Event Population during manual data abstraction.

Process all cases that have successfully reached the point in the Data Processing Flow which calls this Initial Patient Population Algorithm. Do not process cases that have been rejected before this point in the Data Processing Flow. Note: Patients that fall into the HBIPS Initial Patient Population are processed as multiple cases. Do not combine multiple events into one case and do not combine event information and discharge information into one case.

Event Date

Date Exists

process as an event case

Date Does Not Exist – potential HBIPS discharge case

ICD-9-CM Principal or Other Diagnosis Code

On Table 10.1

Patient Age at Discharge (in years) = Discharge Date minus Birthdate

Use the month and day portion of admission date and birthdate to yield the most accurate age.

Patient Age at Discharge = 0 years

Patient Age at Discharge >= 1 years

Psychiatric Care Setting

= N

Missing or =Y

Patient is in the HBIPS Discharge Topic Population

Set Initial Patient Population Reject Case Flag = "No"

H

L

Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
Initial Patient Population for Event Measures (HBIPS-2 and HBIPS-3)
The population of the HBIPS event measures can be identified by using two data elements that are common to the event performance measures in the HBIPS set:

- Event Date
- Psychiatric Care Setting

The HBIPS Event Topic Population (common to all HBIPS event measures) is defined as patients with an event (Event Date exists) while they are in the hospital with a Patient Age at Time of Event (Event Date – Birthdate-HBIPS) >= 1 year and the patient was in a Psychiatric Care Setting (=‘Y’) when the event occurred. There are four distinct strata or sub-populations within the HBIPS Event Topic Population, each identified by a specific age range. The patients in each stratum are counted in the HBIPS Initial Patient Population for event measures of multiple measures.
Patients for which an event occurs (Event Date exists) while in a Psychiatric Care Setting (=‘Y’) in the hospital are included in one of the Strata Initial Populations for the event measures. There is no sampling for the HBIPS event measures. All patients in the Initial Population for HBIPS event measures are automatically sampled.

**Event Stratum 1 – Age 1 year through 12 years stratum** – A Patient Age at Time of Event (Event Date – Birthdate-HBIPS) >= 1 year and < 13 years

**Event Stratum 2 - Age 13 years through 17 years stratum** – A Patient Age at Time of Event (Event Date – Birthdate-HBIPS) >= 13 years and < 18 years

**Event Stratum 3 - Age 18 years through 64 years stratum** – A Patient Age at Time of Event (Event Date – Birthdate-HBIPS) >= 18 years and < 65 years

**Event Stratum 4 - Age greater than and equal to 65 years stratum** – A Patient Age at Time of Event (Event Date – Birthdate-HBIPS) >= 65 years
**Patient Age at Time of Event** (in years) = Event Date minus Birthdate

Use the month and day portion of admission date and birthdate to yield the most accurate age

Patient Age at Time of Event

- >= 1 years

Psychiatric Care Setting

- N
  - Patient is not in the HBIPS Event Topic Population
  - Patient is not eligible for any HBIPS Event strata

- Y
  - Set Initial Patient Population reject Case Flag = "Yes"

**Note:** Initial Patient Population Size – Medicare Only and Non-Medicare Only for HBIPS Event measures are not derived from those cases that pass through the Initial Patient Population algorithm. Instead, these data are derived from the HBIPS census data calculated by (Psychiatric Inpatient Days - Total Leave Days).

Patient is in the HBIPS Event Topic Population

- Set Initial Patient Population Reject Case Flag = "No"

Patient Age at Time of Event

- >= 1 years and < 13 years
  - Patient is in the 1st HBIPS Event stratum
  - Patient is eligible for the 1st HBIPS Event stratum

- >= 13 years and < 18 years
  - Patient is in the 2nd HBIPS Event stratum
  - Patient is eligible for the 2nd HBIPS Event stratum

- >= 18 years and < 65 years
  - Patient is in the 3rd HBIPS Event stratum
  - Patient is eligible for the 3rd HBIPS Event stratum

- >= 65 years
  - Patient is in the 4th HBIPS Event stratum
  - Patient is eligible for the 4th HBIPS Event stratum

**Note:** This Discharge Date check exists for those organizations with one data stream for both discharge and event cases. If one case is identified as being in both populations, the data must still be separated into multiple cases for transmission purposes.

Discharge Date

- Date Exists
  - Include patient in the Initial Patient Population of the appropriate Event measures

- Date Does Not Exist
  - not a potential HBIPS discharge case

Return to Data Processing Flow: End (Data Transmission section)
Sample Size Requirements

Sample Size Requirements for HBIPS Discharge Measures (HBIPS-1, HBIPS-4, HBIPS-5, HBIPS-6, and HBIPS-7)

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. Because the sample for a measure set will rarely be equal to the effective sample due to exclusions and contraindications, hospitals selecting sample cases MUST submit AT LEAST the minimum required sample size.

The following sample size tables for each option automatically build in the number of cases needed to obtain the required sample sizes. For information concerning how to perform sampling, refer to the Population and Sampling Specifications section in this manual.

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 meets 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*

<table>
<thead>
<tr>
<th>Hospital's Measures</th>
<th>Average Quarterly Stratum Initial Patient Population Size “N”</th>
<th>Minimum Required Stratum Sample Size “n”</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 877</td>
<td>20% of the Initial Patient Population</td>
<td></td>
</tr>
<tr>
<td>221 – 877</td>
<td>20% of the Initial Patient Population</td>
<td></td>
</tr>
<tr>
<td>44 – 220</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>&lt; 44</td>
<td>No sampling; 100% of the Initial Patient Population is required</td>
<td></td>
</tr>
</tbody>
</table>

Monthly Sampling

For hospitals selecting sample cases for HBIPS discharge measures, a modified sampling procedure is required. Hospitals selecting sample cases for this set must ensure that each individual strata population and effective monthly sample size meets 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 for the HBIPS Discharge Measures

<table>
<thead>
<tr>
<th>Hospital's Measures</th>
<th>Average Monthly Stratum Initial Patient Population Size “N”</th>
<th>Minimum Required Stratum Sample Size “n”</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 295</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>76 – 295</td>
<td>20% of the Initial Patient Population</td>
<td></td>
</tr>
<tr>
<td>15 – 75</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>&lt; 15</td>
<td>No sampling; 100% of the Initial Patient Population is required</td>
<td></td>
</tr>
</tbody>
</table>

### Sample Size Examples

All sampled strata in HBIPS should be used in the calculation of all HBIPS discharge measures. All of the HBIPS discharge measures’ specific exclusion criteria are used to filter out cases that do not belong in the measure denominator. Using HBIPS-1b as an example, include cases covering all sampled strata, although the measure-specific exclusion criteria would only allow cases with an age of 1 year through 12 years to be included in the denominator.

- **Quarterly sampling:**
  - When applicable, larger hospitals must also abide by the required quarterly sample sizes for the four individual measure strata a minimum of 44 required sample cases per stratum when Initial Patient Population size is 44 or greater.
  - The HBIPS Initial Patient Population sizes for a hospital are 5, 100, 221, and 876 patients respectively per quarter. The required quarterly sample sizes would be 5, 44, 45, and 176.
    - The 1st stratum is less than the minimum required quarterly sample size, so 100% of this stratum is sampled.
    - The 2nd stratum has 100 patients per quarter, which falls in the average quarterly population size of 44 to 220 patients, so 44 cases are sampled.
    - The 3rd stratum has 221 patients per quarter, which requires a 20% sample size, of 45 cases (twenty percent of 221 equals 44.2 rounded to the next highest whole number = 45).
    - The 4th stratum has 876 patients per quarter, which is more than the maximum condition, so a minimum of 176 cases are required to be sampled.

- **Monthly sampling:**
  - When applicable, larger hospitals must also abide by the required monthly sample sizes for the four individual measure strata a minimum of 15 required sample cases per stratum when Initial Patient Population size is 15 or greater.
The HBIPS Initial Patient Population sizes for a hospital are 5, 45, 294 and 400 patients respectively in July. The required monthly sample sizes would be 5, 15, 59, and 60.

- The 1st stratum is less than the minimum required monthly sample size, so 100% of this stratum is sampled.
- The 2nd stratum has 45 patients per month, which falls in the average monthly population size of 15 to 75 patients, so 15 cases are sampled.
- The 3rd stratum has 294 patients per month, which requires a 20% sample size, of 59 cases (twenty percent of 294 equals 58.8 rounded to the next highest whole number = 59).
- The 4th stratum has 400 patients per month, which is more than the maximum condition, so a minimum of 60 cases are required to be sampled.

Sampling Size Requirements for HBIPS Event Measures (HBIPS-2 and HBIPS-3)
The measures HBIPS-2 and HBIPS-3 are not eligible for sampling and will use the entire Initial Patient Population for reporting.
Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Set Measure ID: HBIPS-1

| Set Measure ID | Performance Measure Name                                      |
|----------------|================================================================|
| HBIPS-1a       | Admission Screening- Overall Rate                             |
| HBIPS-1b       | Admission Screening- Children (1 through 12 years)            |
| HBIPS-1c       | Admission Screening- Adolescent (13 through 17 years)         |
| HBIPS-1d       | Admission Screening- Adult (18 through 64 years)              |
| HBIPS-1e       | Admission Screening- Older Adult (≥65 years)                  |

Performance Measure Name: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed

Description: Patients admitted to a hospital-based inpatient psychiatric setting who are screened 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.

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.

Type of Measure: Process

Improvement Noted As: Increase in the rate

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

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- Patient Strengths
- Psychological Trauma History
- **Substance Use**
- **Violence Risk to Others**
- **Violence Risk to Self**

**Denominator Statement:** Psychiatric inpatient discharges

**Included Populations:**

- Patients with *ICD-9-CM Principal or Other Diagnosis Codes* for Mental Disorders as defined in Appendix A, Table 10.1

**Excluded Populations:**

- 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
- Patients with a Length of Stay ≤ 3 days or ≥ 365 days

**Data Elements:**

- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *ICD-9-CM Other Diagnosis Codes*
- *ICD-9-CM Principal Diagnosis Code*
- *Psychiatric Care Setting*

**Risk Adjustment:** No.

**Data Collection Approach:** Retrospective data sources for required data elements include administrative/billing data and medical records.

**Data Accuracy:** Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

**Measure Analysis Suggestions:** The data elements for each of the five initial assessment elements provide an opportunity to assess each component individually. However, completion of all five initial assessment categories is required for this measure.

**Sampling:** Yes. For additional information see the **Sampling Section**.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**

• NASMHPD. (2005) Position Statement on Services and Supports to Trauma Survivors. Alexandria, VA: NASMHPD.

Measure Algorithm:
HBIPS-1: Admission Screening For Violence Risk, Substance Use, Psychological Trauma History And Patient Strengths Completed.

**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; history of psychological trauma history; and patient strengths.

**Denominator Statement:** Psychiatric inpatient discharges.

---

**Variable Key:**
- Patient Age at Discharge
- Length of Stay
- Missing Counter
- No Screening Counter
- Incomplete Screening Counter

**Specification Table:**

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Stratified Measure Name</th>
<th>Patient Age (Age Ranges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-1</td>
<td>Overall</td>
<td><strong>2</strong></td>
</tr>
<tr>
<td>HBIPS-1a</td>
<td>Children</td>
<td>0-12 years</td>
</tr>
<tr>
<td>HBIPS-1b</td>
<td>Adolescent</td>
<td>13-17 years</td>
</tr>
<tr>
<td>HBIPS-1c</td>
<td>Adult</td>
<td>18-64 years</td>
</tr>
<tr>
<td>HBIPS-1d</td>
<td>Older Adult</td>
<td>65 years</td>
</tr>
</tbody>
</table>

* Each case will be placed in the measure stratum according to the age group within which the case’s age falls in after the Category Assignments are completed and overall rate is calculated.

**NOTE:** No Screening, Missing and Incomplete Screening Counters must be added to identify the specific initial screenings that are missing.
HBIPS-1

Add 1 to Missing Counter → Missing

Psychological Trauma History → N

Add 1 to No Screening Counter

= Y, X

Psychological Trauma History → X

Add 1 to Incomplete Screening Counter

= Y

Add 1 to Missing Counter → Missing

Substance Use → N

Add 1 to No Screening Counter

= Y, X

Substance Use → X

Add 1 to Incomplete Screening Counter

= Y

Add 1 to Missing Counter → Missing

Violence Risk to Others → N

Add 1 to No Screening Counter

= Y, X

Violence Risk to Others → X

Add 1 to Incomplete Screening Counter

= Y

NOTE: No Screening, Missing and Incomplete Screening Counters must be stored to identify the specific initial screenings that are missing.

Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
Initialize the Measure Category Assignment for each strata measure \((b-e) = 'B'\).
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.

- \(\text{Overall Rate Category Assignment}\)
  - \(B \text{ or } X\)
  - \(D \text{ or } E\)

- \(\text{Patient Age At Discharge}\)
  - \(\geq 1 \text{ and } < 13 \text{ years}\)
  - \(\geq 13\)

- \(\text{For Stratified Measure HBIPS-1b}\)
  - Set the Measure Category Assignment for measure HBIPS-1b = Measure Category Assignment for measure HBIPS-1a

- \(\text{For Stratified Measure HBIPS-1c}\)
  - Set the Measure Category Assignment for measure HBIPS-1c = Measure Category Assignment for measure HBIPS-1a

- \(\text{For Stratified Measure HBIPS-1d}\)
  - Set the Measure Category Assignment for measure HBIPS-1d = Measure Category Assignment for measure HBIPS-1a

- \(\geq 18 \text{ and } < 65 \text{ years}\)
  - \(\geq 65 \text{ years}\)

- \(\text{For Stratified Measure HBIPS-1e}\)
  - Set the Measure Category Assignment for measure HBIPS-1e = Measure Category Assignment for measure HBIPS-1a

Stop

Related Topics

a. Table of Contents
Appendix A - ICD-9-CM Code Tables
Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Set Measure ID: HBIPS-2

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Performance Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-2a</td>
<td>Physical Restraint- Overall Rate</td>
</tr>
<tr>
<td>HBIPS-2b</td>
<td>Physical Restraint- Children (1 through 12 years)</td>
</tr>
<tr>
<td>HBIPS-2c</td>
<td>Physical Restraint- Adolescent (13 through 17 years)</td>
</tr>
<tr>
<td>HBIPS-2d</td>
<td>Physical Restraint- Adult (18 through 64 years)</td>
</tr>
<tr>
<td>HBIPS-2e</td>
<td>Physical Restraint- Older Adult (≥ 65 years)</td>
</tr>
</tbody>
</table>

Performance Measure Name: Hours of physical restraint use

Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.

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 and 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).

Type of Measure: Process

Improvement Noted As: Decrease in the rate

Numerator Statement: The total number of hours that all psychiatric inpatients were maintained in physical restraint

Numerator Basis: The numerator evaluates the number of hours of physical restraint; 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.

Included Populations:
- Patients for whom at least one physical restraint event is reported during the month

Excluded Populations: None

Data Elements:
- **Event Date**
- **Event Type**
**Minutes of Physical Restraint**

**Denominator Statement:** Number of psychiatric inpatient days

**Denominator Basis:** per 1,000 hours

**Included Populations:**
- All psychiatric inpatient days

**Excluded Populations:**
- Total leave days

**Data Elements:**
- *Admission Date*
- *Birthdate*
- *Psychiatric Care Setting*
- *Psychiatric Inpatient Days - Medicare Only*
- *Psychiatric Inpatient Days-Non-Medicare Only*
- *Total Leave Days - Medicare Only*
- *Total Leave Days-Non-Medicare Only*

**Risk Adjustment:** No.

**Data Collection Approach:** Retrospective data sources for required data elements include administrative/billing data and medical records.

**Data Accuracy:** Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

**Measure Analysis Suggestions:** In order to further examine the issue of restraint use within a facility it may be useful to study the incidence of physical restraint use by collecting additional information about the clinical justification for use.

**Sampling:** No.

**Data Reported As:** Aggregate rate generated from count data reported as a ratio.

**Selected References:**

**Measure Algorithm:**
HBIPS-2: Hours of Physical Restraint Use

Numerator Statement: The total number of hours that all psychiatric inpatients spent in physical restraint

Denominator Statement: Number of psychiatric inpatient days

Variable Key:
Patient Age at Time of Event

Stratification Table For Numerator:

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Stratified Measure Name</th>
<th><em>Patient Age (Age Range)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-2a</td>
<td>Overall Rate</td>
<td></td>
</tr>
<tr>
<td>HBIPS-2b</td>
<td>Children</td>
<td>1-12 years</td>
</tr>
<tr>
<td>HBIPS-2c</td>
<td>Adolescent</td>
<td>13-17 years</td>
</tr>
<tr>
<td>HBIPS-2d</td>
<td>Adult</td>
<td>18-64 years</td>
</tr>
<tr>
<td>HBIPS-2e</td>
<td>Older Adult</td>
<td>&gt;= 65 years</td>
</tr>
</tbody>
</table>

* Each case will be placed in the measure stratum according to the age group within which the case's age falls in after the Category Assignments are completed and overall rate is calculated.
** No allowable value for overall rate. Includes all Ages of Psychiatric inpatients.

Note:
- Any reference to Restraint indicates a Physical Restraint Event.
- Each event driven by the Event Date is processed as a unique Episode of Care (EOC).
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-2a).

The rest of the algorithm will set the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-2a) Measure Category Assignment.

---

For Stratified Measure HBIPS-2b

Set the Measure Category Assignment for the strata measures (HBIPS-2b through HBIPS-2a) = 'B'

---

For Stratified Measure HBIPS-2c

Set the Measure Category Assignment for measure HBIPS-2c = Measure Category Assignment for measure HBIPS-2a

---

For Stratified Measure HBIPS-2d

Set the Measure Category Assignment for measure HBIPS-2d = Measure Category Assignment for measure HBIPS-2a

---

For Stratified Measure HBIPS-2e

Set the Measure Category Assignment for measure HBIPS-2e = Measure Category Assignment for measure HBIPS-2a

---

Stop
Measure Calculation for Aggregated Denominator

Denominator
For the overall measure and each strata measure calculate the denominator 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.

Related Topics
a. Table of Contents
z. Appendix A - ICD-9-CM Code Tables
Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Set Measure ID: HBIPS-3

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Performance Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-3a</td>
<td>Seclusion- Overall Rate</td>
</tr>
<tr>
<td>HBIPS-3b</td>
<td>Seclusion- Children (1 through 12 years)</td>
</tr>
<tr>
<td>HBIPS-3c</td>
<td>Seclusion- Adolescent (13 through 17 years)</td>
</tr>
<tr>
<td>HBIPS-3d</td>
<td>Seclusion- Adult (18 through 64 years)</td>
</tr>
<tr>
<td>HBIPS-3e</td>
<td>Seclusion- Older Adult (≥ 65 years)</td>
</tr>
</tbody>
</table>

Performance Measure Name: Hours of seclusion use

Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.

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).

Type of Measure: Process

Improvement Noted As: Decrease in the rate
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.

Included Populations:

- Patients for whom at least one seclusion event is reported during the month

Excluded Populations: None

Data Elements:

- **Event Date**
- **Event Type**
- **Minutes of Seclusion**

Denominator Statement: Number of psychiatric inpatient days

Denominator Basis: per 1,000 hours

Included Populations:

- All psychiatric inpatient days

Excluded Populations:

- Total leave days

Data Elements:

- **Admission Date**
- **Birthdate**
- **Psychiatric Care Setting**
- **Psychiatric Inpatient Days - Medicare Only**
- **Psychiatric Inpatient Days-Non-Medicare Only**
- **Total Leave Days - Medicare Only**
- **Total Leave Days-Non-Medicare Only**

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative/billing data and medical records.

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: In order to further examine the issue of seclusion use within your facility it may be useful to study the incidence of seclusion use by collecting additional information about the clinical justification for use.
**Sampling:** No.

**Data Reported As:** Aggregate rate generated from count data reported as a ratio.

**Selected References:**


**Measure Algorithm:**
HBIPS-3: Hours of Seclusion Use

Numerator Statement: The total number of hours that all psychiatric inpatients spent in seclusion

Denominator Statement: Number of psychiatric inpatient days

Variable Key:
Patient Age at Time of Event

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Stratified Measure Name</th>
<th>Patient Age (Age Ranges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-3a</td>
<td>Overall Rate</td>
<td>**</td>
</tr>
<tr>
<td>HBIPS-3b</td>
<td>Children</td>
<td>1-12 years</td>
</tr>
<tr>
<td>HBIPS-3c</td>
<td>Adolescent</td>
<td>13-17 years</td>
</tr>
<tr>
<td>HBIPS-3d</td>
<td>Adult</td>
<td>18-64 years</td>
</tr>
<tr>
<td>HBIPS-3e</td>
<td>Older Adult</td>
<td>&gt;= 65 years</td>
</tr>
</tbody>
</table>

* Each case will be placed in the measure stratum according to the age group within which the case's age falls in after the Category Assignments are completed and overall rate is calculated.
** No allowable value for overall rate. Includes all Ages of Psychiatric Inpatients.

Note:
- Each event as driven by the Event Date is processed as a unique Episode of Care (EOC).

Start

Run all cases that are included in the Initial Patient Population for HBIPS-2,3 and pass the edits defined in the Transmission Data Processing Flow Clinical through this measure.

Event Type

= 1

Not in Numerator

= 2

For Overall Rate (HBIPS-3a)

Case will be rejected

Minutes of Seclusion

= UTD

For Overall Rate (HBIPS-3a)

Non-UTD value

For Overall Rate (HBIPS-3a)

In Measure Population

Numerator Population

For Overall Rate (HBIPS-3a)

HBIPS-3 H

Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
Initialize the Measure Category Assignment for each strata measure (b-e) = 'B'.

Do not change the Measure Category Assignment or Total Overall Seclusion 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.

For Stratified Measure HBIPS-3b

For Stratified Measure HBIPS-3c

For Stratified Measure HBIPS-3d

Stop
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:

\[
\text{Number of Denominator Cases for the overall measure} = (\text{Psychiatric Inpatient Days} - \text{Leave Days})
\]

for all patients for the reporting month

\[
\text{Number of Denominator Cases for each strata measure} = (\text{Psychiatric Inpatient Days} - \text{Leave Days})
\]

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.
Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Set Measure ID: HBIPS-4

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Performance Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-4a</td>
<td>Multiple Antipsychotic Medications at Discharge- Overall Rate</td>
</tr>
<tr>
<td>HBIPS-4b</td>
<td>Multiple Antipsychotic Medications at Discharge- Children (1 through 12 years)</td>
</tr>
<tr>
<td>HBIPS-4c</td>
<td>Multiple Antipsychotic Medications at Discharge- Adolescent (13 through 17 years)</td>
</tr>
<tr>
<td>HBIPS-4d</td>
<td>Multiple Antipsychotic Medications at Discharge- Adult (18 through 64 years)</td>
</tr>
<tr>
<td>HBIPS-4e</td>
<td>Multiple Antipsychotic Medications at Discharge- Older Adult (≥ 65 years)</td>
</tr>
</tbody>
</table>

Performance Measure Name: Patients discharged on multiple antipsychotic medications

Description: Patients discharged from a hospital-based inpatient psychiatric setting 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 (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocyz, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & 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 (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in treatment resistant patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 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 (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl, & Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient 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.

Type of Measure: Process
Improvement Noted As: Decrease in the rate

Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications

- Included Populations: Not applicable
- Excluded Populations: None

Data Elements:
- Number of Antipsychotic Medications Prescribed at Discharge

Denominator Statement: Psychiatric inpatient discharges

Included Populations:
- Patients with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders as defined in Appendix A, Table 10.1 discharged on one or more routinely scheduled antipsychotic medications (refer to Appendix B, Table 10.0-Antipsychotic Medications)

Excluded Populations:
- Patients who expired
- Patients with an unplanned departure resulting in discharge due to elopement
- Patients with an unplanned departure resulting in discharge due to failing to return from leave

Data Elements:
- Birthdate
- Discharge Date
- Discharge Status
- ICD-9-CM Other Diagnosis Codes
- ICD-9-CM Principal Diagnosis Code
- Number of Antipsychotic Medications Prescribed at Discharge
- Patient Referral to Next Level of Care Provider
- Psychiatric Care Setting

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative/billing data and medical records.

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: For quality improvement purposes, the measurement system may want to create reports to identify patients discharged on two or more antipsychotic medications without appropriate supporting documentation. This would allow healthcare organizations to target education efforts.
Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:


Measure Algorithm:
HBIPS-4: Patients Discharged On Multiple Antipsychotic Medications

Numerator Statement: Psychiatric inpatients who are discharged on two or more routinely scheduled antipsychotic medications.

Denominator Statement: Psychiatric inpatient discharges.

Variable Key:
Patient Age at Discharge

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Stratified Measure Name</th>
<th>Patient Age (Age Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-4a</td>
<td>Overall Rate</td>
<td>**</td>
</tr>
<tr>
<td>HBIPS-4b</td>
<td>Children</td>
<td>1-12 years</td>
</tr>
<tr>
<td>HBIPS-4c</td>
<td>Adolescent</td>
<td>13-17 years</td>
</tr>
<tr>
<td>HBIPS-4d</td>
<td>Adult</td>
<td>18-64 years</td>
</tr>
<tr>
<td>HBIPS-4e</td>
<td>Older Adult</td>
<td>&gt;= 65 years</td>
</tr>
</tbody>
</table>

* Each case will be placed in the measure stratum according to the age group within which the case's age falls in after the Category Assignments are completed and overall rate is calculated.

** No allowable value for overall rate. Includes all Ages of Psychiatric inpatients.

Flowsheet:

Start

Run all cases that are included in the Initial Patient Population for HBIPS-4, 5, 6, 7 and pass the edits defined in the Transmission Data Processing Flow Clinical through this measure.

Discharge Status

= 1, 2, 3, 4, 5

Psychotropic Care Setting

= Y

Patient Referral to Next Level of Care Provider

= 3

For Overall Rate (HBIPS-4a)

Case was rejected

Number of Antipsychotic Medications Prescribed at Discharge

= 0

For Overall Rate (HBIPS-4a)

Number of Antipsychotic Medications Prescribed at Discharge

= 1

Numerator Population

For Overall Rate (HBIPS-4a)

Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
Note: Initialize the Measure Category Assignment for each strata measure (b,e) = 'B'.

Do not change the Measure Category Assignment that was already calculated for the overall rate (HBIPS-4a).

The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-4a) Measure Category Assignment.

Overall Rate Category Assignment = B or X
= D or E

Patient Age At Discharge >=1 and <13 years

For Stratified Measure HBIPS-4b
Set the Measure Category Assignment for measure HBIPS-4b = Measure Category Assignment for measure HBIPS-4a

Patient Age At Discharge >=13

For Stratified Measure HBIPS-4c
Set the Measure Category Assignment for measure HBIPS-4c = Measure Category Assignment for measure HBIPS-4a

Patient Age At Discharge >=18

For Stratified Measure HBIPS-4d
Set the Measure Category Assignment for measure HBIPS-4d = Measure Category Assignment for measure HBIPS-4a

Patient Age At Discharge >=18 and <65 years

For Stratified Measure HBIPS-4e
Set the Measure Category Assignment for measure HBIPS-4e = Measure Category Assignment for measure HBIPS-4a

>= 65 years

Stop
Appendix A - ICD-9-CM Code Tables
Appendix B - Medication Tables
Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Set Measure ID: HBIPS-5

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Performance Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-5a</td>
<td>Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Overall Rate</td>
</tr>
<tr>
<td>HBIPS-5b</td>
<td>Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Children (1 through 12 years)</td>
</tr>
<tr>
<td>HBIPS-5c</td>
<td>Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Adolescent (13 through 17 years)</td>
</tr>
<tr>
<td>HBIPS-5d</td>
<td>Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Adult (18 through 64 years)</td>
</tr>
<tr>
<td>HBIPS-5e</td>
<td>Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Older Adult (≥ 65 years)</td>
</tr>
</tbody>
</table>

Performance Measure Name: Patients discharged on multiple antipsychotic medications with appropriate justification

Description: Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification

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 (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganoczy, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & 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 (Ananth, Parameswaran, & Gunatilake, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University HealthSystem Consortium, 2006). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in treatment resistant patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 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 (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl, & Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient 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.

**Type of Measure:** Process

**Improvement Noted As:** Increase in the rate

**Numerator Statement:** Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification

- **Included Populations:** Not applicable
- **Excluded Populations:** None

**Data Elements:**
- *Appropriate Justification for Multiple Antipsychotic Medications*

**Denominator Statement:** Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications

- **Included Populations:** Not applicable
- **Excluded Populations:**
  - Patients who expired
  - Patients with an unplanned departure resulting in discharge due to elopement
  - Patients with an unplanned departure resulting in discharge due to failing to return from leave
  - Patients with a length of stay ≤ 3 days

**Data Elements:**
- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *Discharge Status*
- *ICD-9-CM Other Diagnosis Codes*
- *ICD-9-CM Principal Diagnosis Code*
- *Number of Antipsychotic Medications Prescribed at Discharge*
- *Patient Referral to Next Level of Care Provider*
- *Psychiatric Care Setting*

**Risk Adjustment:** No.

**Data Collection Approach:** Retrospective data sources for required data elements include administrative/billing data and medical records.

**Data Accuracy:** Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

**Measure Analysis Suggestions:** For quality improvement purposes, the measurement system
may want to create reports to identify patients discharged on two or more antipsychotic medications without appropriate supporting documentation. This would allow healthcare organizations to target education efforts.

**Sampling:** Yes. For additional information see the Sampling Section.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**


**Measure Algorithm:**
HBIPS-5: Patients Discharged On Multiple Antipsychotic Medications With Appropriate Justification.

**Numerator Statement:** Psychiatric inpatients who are discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.

**Denominator Statement:** Psychiatric inpatients who are discharged on two or more routinely scheduled antipsychotic medications.

---

**Variable Key:**
- Patient Age at Discharge
- Length of Stay

**Stratification Table:**

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Stratified Measure Name</th>
<th>Patient Age (Age Ranges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-5a</td>
<td>Overall Rate</td>
<td></td>
</tr>
<tr>
<td>HBIPS-5b</td>
<td>Children</td>
<td>1-12 years</td>
</tr>
<tr>
<td>HBIPS-5c</td>
<td>Adolescent</td>
<td>13-17 years</td>
</tr>
<tr>
<td>HBIPS-5d</td>
<td>Adult</td>
<td>18-84 years</td>
</tr>
<tr>
<td>HBIPS-5e</td>
<td>Older Adult</td>
<td>85 years</td>
</tr>
</tbody>
</table>

* Each case will be placed in the measure stratum according to the age group within which the case's age falls in after the Category Assignments are completed and overall rate is calculated.

**Not Allowable Value for overall rate:** Includes all ages of Psychiatric inpatients

---

**Specified Flowchart:**

1. Run all cases that are included in the initial patient population for HBIPS-1, 4, 5, 6, 7 and pass the edits defined in the Transmission Data Processing Flow. Clinically through this measure.

2. Length of Stay (in days) + Discharge Date - Admission Date

3. Discharge Status:
   - Length of Stay > 3 days
   - Length of Stay = 20, 30
   - <01, 02, 03, 04, 05, 06, 07, 21, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70

4. Psychiatric Care Setting

5. Patient Referral to Next Level of Care Provider:
   - Patient Referral to Next Level of Care Provider = Y
   - Patient Referral to Next Level of Care Provider = N

6. Number of Antipsychotic Mediations Prescribed at Discharge:
   - Number of Antipsychotic Mediations Prescribed at Discharge = 1, 2, 4, 5
   - Number of Antipsychotic Mediations Prescribed at Discharge = UTD

7. Appropriate Justification for Multiple Antipsychotic Medications:
   - Appropriate Justification for Multiple Antipsychotic Medications = 1, 2, 3
   - Appropriate Justification for Multiple Antipsychotic Medications = 4, 5

8. Discharge Status:
   - Discharge Status = Y

9. For Overall Rate (HBIPS-5a):
   - Case will be excluded
   - Numerator Population

10. For Overall Rate (HBIPS-5c):
    - Case will be excluded
    - Numerator Population

11. For Overall Rate (HBIPS-5d):
    - Case will be excluded
    - Numerator Population
Initialize the Measure Category Assignment for each strata measure (b-e) = 'B'.
Do not change the Measure Category Assignment that was already calculated for the overall rate (HBIPS-5a).
The rest of the algorithm will set the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-5a) Measure Category Assignment.

Overall Rate Category Assignment

= B or X

= D or E

Patient Age At Discharge

>=1 and <13 years

>=13

Patient Age At Discharge

>=13 and <18 years

>=10

Patient Age At Discharge

>=18 and <65 years

>= 65 years

For Stratified Measure HBIPS-5b

Set the Measure Category Assignment for HBIPS-5b = Measure Category Assignment for measure HBIPS-5a

For Stratified Measure HBIPS-5c

Set the Measure Category Assignment for HBIPS-5c = Measure Category Assignment for measure HBIPS-5a

For Stratified Measure HBIPS-5d

Set the Measure Category Assignment for HBIPS-5d = Measure Category Assignment for measure HBIPS-5a

For Stratified Measure HBIPS-5e

Set the Measure Category Assignment for HBIPS-5e = Measure Category Assignment for measure HBIPS-5a

Stop

Related Topics

a. Table of Contents
Appendix A - ICD-9-CM Code Tables
Appendix B - Medication Tables
Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Set Measure ID: HBIPS-6

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Performance Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-6a</td>
<td>Post Discharge Continuing Care Plan- Overall Rate</td>
</tr>
<tr>
<td>HBIPS-6b</td>
<td>Post Discharge Continuing Care Plan- Children (1 through 12 years)</td>
</tr>
<tr>
<td>HBIPS-6c</td>
<td>Post Discharge Continuing Care Plan- Adolescent (13 through 17 years)</td>
</tr>
<tr>
<td>HBIPS-6d</td>
<td>Post Discharge Continuing Care Plan- Adult (18 through 64 years)</td>
</tr>
<tr>
<td>HBIPS-6e</td>
<td>Post Discharge Continuing Care Plan- Older Adult (≥ 65 years)</td>
</tr>
</tbody>
</table>

Performance Measure Name: Post discharge continuing care plan created

Description: Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created

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 the patient may not be available to the next level of care provider at the patient’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 patient’s treatment course during hospitalization, discharge medications and next level of care recommendations (American Association of Community Psychiatrists [AACP], 2001).

Type of Measure: Process

Improvement Noted As: Increase in the rate

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

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- Continuing Care Plan-Discharge Medications
- Continuing Care Plan-Next Level of Care
- Continuing Care Plan-Principal Discharge Diagnosis
- Continuing Care Plan-Reason for Hospitalization

Denominator Statement: Psychiatric inpatient discharges
Included Populations:

- Patients referred for next level of care with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders as defined in Appendix A, Table 10.1

Excluded Populations:

- Patients who expired
- Patients with an unplanned departure resulting in discharge due to elopement
- Patients or their guardians who refused aftercare
- Patients or guardians who refused to sign authorization to release information
- Patients with an unplanned departure resulting in discharge due to failing to return from leave

Data Elements:

- Birthdate
- Discharge Date
- Discharge Status
- ICD-9-CM Other Diagnosis Codes
- ICD-9-CM Principal Diagnosis Code
- Patient Referral to Next Level of Care Provider
- Psychiatric Care Setting

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative/billing data and medical records.

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: The data elements for each of the four discharge elements provide an opportunity to assess each component individually. However, completion of all four discharge categories is required for this measure.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:


Measure Algorithm:
HBIPS-6: Post Discharge Continuing Care Plan Created.

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

Denominator Statement: Psychiatric inpatient discharges.

Variable Key:
- Patient Age at Discharge
- Missing Counter
- No CarePlan Counter

Stratification Table:

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Stratified Measure Name</th>
<th>*Patient Age (Age Ranges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-6a</td>
<td>Overall Rate</td>
<td>1-12 years</td>
</tr>
<tr>
<td>HBIPS-6b</td>
<td>Children</td>
<td>13-17 years</td>
</tr>
<tr>
<td>HBIPS-6c</td>
<td>Adolescent</td>
<td>18-64 years</td>
</tr>
<tr>
<td>HBIPS-6d</td>
<td>Adult</td>
<td>&gt;= 65 years</td>
</tr>
<tr>
<td>HBIPS-6e</td>
<td>Older Adult</td>
<td></td>
</tr>
</tbody>
</table>

* Each case will be placed in the measure stratum according to the age group within which the case's age falls in after the Category. Assignments are completed and overall rate is calculated.

** No allowable value for overall rate. Includes all Ages of Psychiatric inpatients
Initialize the Measure Category Assignment for each strata measure (b-e) = 'B'.

Do not change the Measure Category Assignment that was already calculated for the overall rate (HBIPS-6a).

The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-6a) Measure Category Assignment.

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**Related Topics**

- Table of Contents

Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
Appendix A - ICD-9-CM Code Tables
Measure Information Form

Measure Set: Hospital Based Inpatient Psychiatric Services (HBIPS)

Set Measure ID: HBIPS-7

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Performance Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-7a</td>
<td>Post Discharge Continuing Care Plan Transmitted- Overall Rate</td>
</tr>
<tr>
<td>HBIPS-7b</td>
<td>Post Discharge Continuing Care Plan Transmitted - Children (1 through 12 years)</td>
</tr>
<tr>
<td>HBIPS-7c</td>
<td>Post Discharge Continuing Care Plan Transmitted - Adolescent (13 through 17 years)</td>
</tr>
<tr>
<td>HBIPS-7d</td>
<td>Post Discharge Continuing Care Plan Transmitted - Adult (18 through 64 years)</td>
</tr>
<tr>
<td>HBIPS-7e</td>
<td>Post Discharge Continuing Care Plan Transmitted - Older Adult (≥65 years)</td>
</tr>
</tbody>
</table>

Performance Measure Name: Post discharge continuing care plan transmitted to next level of care provider upon discharge

Description: Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity

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 the patient may not be available to the next level of care provider at the patient’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 patient’s treatment course during hospitalization including rationale and target symptoms for medications changed, discharge medications and next level of care recommendations (American Association of Community Psychiatrists [AACP], 2001).

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Psychiatric inpatients for whom the post discharge continuing care plan was transmitted to the next level of care

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- Continuing Care Plan-Discharge Medications
- Continuing Care Plan-Next Level of Care
- Continuing Care Plan-Principal Discharge Diagnosis
• Continuing Care Plan-Reason for Hospitalization

Denominator Statement: Psychiatric inpatient discharges

Included Populations:

• Patients referred for next level of care with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders as defined in Appendix A, Table 10.1

Excluded Populations:

• Patients who expired
• Patients with an unplanned departure resulting in discharge due to elopement
• Patients or their guardians who refused aftercare
• Patients or guardians who refused to sign authorization to release information
• Patients with an unplanned departure resulting in discharge due to failing to return from leave

Data Elements:

• Birthdate
• Discharge Date
• Discharge Status
• ICD-9-CM Other Diagnosis Codes
• ICD-9-CM Principal Diagnosis Code
• Patient Referral to Next Level of Care Provider
• Psychiatric Care Setting

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative/billing data and medical records.

Data Accuracy: Hospitals may wish to implement periodic audits to monitor and ensure data accuracy.

Measure Analysis Suggestions: The data elements for each of the four discharge elements provide an opportunity to assess each component individually. However, completion of all four discharge categories is required for this measure.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

Measure Algorithm:

HBIPS-7: Post Discharge Continuing Care Plan Transmitted To Next Level Of Care Provider Upon Discharge.

Numerator Statement: Psychiatric inpatients for whom the post discharge continuing care plan was transmitted to the next level of care.

Denominator Statement: Psychiatric inpatient discharges.


Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)

Variable Key:
- Patient Age at Discharge
- Missing Counter
- Delayed Plan Counter
- No CarePlan Counter

Stratification Table:

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Stratified Measure Name</th>
<th>*Patient Age (Age Ranges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-7a</td>
<td>Overall Rate</td>
<td>**</td>
</tr>
<tr>
<td>HBIPS-7b</td>
<td>Children</td>
<td>1-12 years</td>
</tr>
<tr>
<td>HBIPS-7c</td>
<td>Adolescent</td>
<td>13-17 years</td>
</tr>
<tr>
<td>HBIPS-7d</td>
<td>Adult</td>
<td>18-64 years</td>
</tr>
<tr>
<td>HBIPS-7e</td>
<td>Older Adult</td>
<td>&gt;=65 years</td>
</tr>
</tbody>
</table>

* Each case will be placed in the measure stratum according to the age group within which the case's age falls in after the Category Assignments are completed and overall rate is calculated.
** No allowable value for overall rate. Includes all Ages of Psychiatric inpatients
Initialize the Measure Category Assignment for each strata measure (b-e) = 'B'.

Do not change the Measure Category Assignment that was already calculated for the overall rate (IBIPS-7a).

The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's [HBIPS-7a] Measure Category Assignment.

1. **Overall Rate Category Assignment**
   
   - = B or X
   
   - = D or E

2. **Patient Age At Discharge**
   
   - >=1 and <13 years
   
   - >=13

3. **Patient Age At Discharge**
   
   - >=13 and <18 years
   
   - >=18

4. **Patient Age At Discharge**
   
   - >=18 and <65 years
   
   - >= 65 years

For Stratified Measure HBIPS-7b:

- Set the Measure Category Assignment for the strata measures [HBIPS-7b through HBIPS-7e] = 'B'

For Stratified Measure HBIPS-7c:

- Set the Measure Category Assignment for HBIPS-7b = Measure Category Assignment for measure HBIPS-7a

For Stratified Measure HBIPS-7d:

- Set the Measure Category Assignment for HBIPS-7d = Measure Category Assignment for measure HBIPS-7a

For Stratified Measure HBIPS-7e:

- Set the Measure Category Assignment for HBIPS-7e = Measure Category Assignment for measure HBIPS-7a

Stop
Appendix A - ICD-9-CM Code Tables
**Data Element**

*Name: Admission Date*

**Collected For:** All Records

**Definition:** The month, day, and year of admission for inpatient care.

**Suggested Data Collection Question:**

What is the date the patient was admitted to inpatient care?

**Format:**

*Length:* 10 – MM-DD-YYYY (includes dashes)  
*Type:* Date  
*Occurs:* 1

**Allowable Values:**

- MM = Month (01-12)  
- DD = Day (01-31)  
- YYYY = Year (2001-Current Year)

**Notes for Abstraction:**

- The intent of this data element is to determine the date that the patient was actually admitted to inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.  
- A patient of a hospital is considered an inpatient upon issuance of written doctor’s orders to that effect. (Refer to the Medicare Claims Processing Manual, Chapter 3, Section 40.2.2.)  
- For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.  
- For patients that are admitted for surgery and/or a procedure, if the admission order states the date the orders were written and they are effective for the surgery/procedure date, then the date of the surgery/procedure would be the admission date. If the medical record reflects that the admission order was written prior to the actual date the patient was admitted and there is no reference to the date of the surgery/procedure, then the date the order was written would be the admission date.  
- For HBIPS only, admission dates prior to 2001 are acceptable.

**Suggested Data Sources:**

**PRIORITY ORDER FOR THESE SOURCES**
Face sheet
Physician orders
UB-04, Field Location: 12

Additional Notes:

Guidelines for Abstraction:

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<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Admit to observation</td>
</tr>
<tr>
<td></td>
<td>Arrival date</td>
</tr>
</tbody>
</table>
Data Element Name: Appropriate Justification for Multiple Antipsychotic Medications

Collected For: HBIPS-5,

Definition: Documentation in the medical record of appropriate justification for discharging the patient on two or more routine antipsychotic medications.

Suggested Data Collection Question: Is there documentation in the medical record of appropriate justification for the patient being discharged on two or more antipsychotic medications?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
1  The medical record contains documentation of a history of a minimum of three failed multiple trials of monotherapy.
2  The medical record contains documentation of a recommended plan to taper to monotherapy due to previous use of multiple antipsychotic medications OR documentation of a cross-taper in progress at the time of discharge.
3  The medical record contains documentation of augmentation of Clozapine.
4  The medical record contains documentation of a justification other than those listed in Allowable Values 1-3.
5  The medical record does not contain documentation supporting the reason for being discharged on two or more antipsychotic medications OR unable to determine from medical record documentation.

Notes for Abstraction:
If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit.

The recommended plan to taper to monotherapy must appear in the continuing care plan transmitted to the next level of care provider. All other justifications may be documented anywhere in the medical record.

"Failed multiple trials of monotherapy" comprises a history of three or more failed trials by history in which there was a lack of sufficient improvement in symptoms or functioning. The documentation should include at a minimum the names of the antipsychotic medications that previously failed.

A cross-taper plan is defined as a plan to decrease the dosage of one or
more antipsychotic medications while increasing the dosage of another antipsychotic medication to a level which results in controlling the patient's symptoms with one antipsychotic medication. The cross-taper plan must list the names of the medications intended to increase and taper off. The recommended plan must include the name(s) of the medication(s) to be tapered.

Suggested Data Sources:
- Aftercare discharge plan
- Continuing care plan
- Discharge plan
- Final discharge summary
- History and physical
- Interim discharge summary
- Medication reconciliation form
- Physician discharge orders
- Physician progress notes
- Referral form

Additional Notes:

Guidelines for Abstraction:

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<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
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<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Birthdate

Collected For: All Records

Definition: The month, day, and year the patient was born.

Note: For discharge measures, e.g., HBIPS-1, 4, 5, 6, 7, All PC measures, patient's age (in years) is calculated by Discharge Date minus Birthdate. For event measures, e.g., HBIPS-2, 3, patient's age at time of event (in years) is calculated by Event Date minus Birthdate. The algorithm to calculate age must use the month and day portion of birthdate, and discharge date or event, as appropriate to yield the most accurate age.

Suggested Data Collection Question: What is the patient’s date of birth?

Format: Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values: MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (1880-9999)

Notes for Abstraction: Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources:
- Emergency department record
- Face sheet
- Registration form
- UB-04, Field Location: 10

Additional Notes: 

Guidelines for Abstraction:

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: CMS Certification Number

Collected For: HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC PC, Transmission, Optional for all records

Definition: Hospital’s six digit acute care CMS Certification Number (CCN).

Note: This data element is not used by the HBIPS measure set. It is remaining in the data dictionary to support the common Initial Patient Population and Sample XML file layout. If data is transmitted for this data element associated to the HBIPS measure set, all edits and rules associated to this data element will be applied to the HBIPS data.

Suggested Data Collection Question: What is the hospital’s six digit acute care CMS Certification Number?

Format: Length: 6
Type: Character
Occurs: 1

Allowable Values: Any valid six digit CMS Certification Number.

The first two digits are the numeric state code. The third digit of zero represents an acute facility. The third digit of “1” and fourth digit of “3” represents a Critical Access Hospital (CAH).

Notes for Abstraction: None

Suggested Data Sources: None

Additional Notes: None

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
**Data Element Name:** Continuing Care Plan-Discharge Medications

**Collected For:** HBIPS-6, HBIPS-7,

**Definition:** Documentation in the medical record of a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were prescribed at discharge. Such documentation should be transmitted to the next level of care provider by the **fifth post-discharge day**.

**Suggested Data Collection Question:** Is there documentation in the medical record of a continuing care plan which includes the discharge medications, dosage and indication for use or states no medications were prescribed at discharge **AND** was the continuing care plan including discharge medications transmitted to the next level of care provider no later than the **fifth post-discharge day**?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**

1. The medical record contains a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were ordered at discharge and was transmitted to the next level of care provider no later than the **fifth post-discharge day**.

2. The medical record contains a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were ordered at discharge but was not transmitted to the next level of care provider by the **fifth post-discharge day**.

3. The medical record does not contain a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were ordered at discharge or unable to determine from medical record documentation.

**PROGRAMMER NOTE:**
In order to identify the specific continuing care plan components that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each discharge component can be performed.

**Notes for Abstraction:**
If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit.

If the hospital has an electronic medical record (EMR) and the next level of care provider has access to the complete hospital EMR, select allowable
The EMR should contain documentation that the next level of care provider has access to the EMR.

A continuing care plan may consist of one document or several documents which could be considered a continuing care “packet”. The hospital must be able to identify which document(s) make up the continuing care plan and the hospital must identify what specific documents are transmitted to the next level of care provider.

The first post-discharge day is defined as the day after discharge.

Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access. Giving a copy of the continuing care plan to the patient does not comprise transmission.

Medications are defined as any prescription medications, sample medications, herbal remedies, vitamins, nutriceuticals, over-the-counter drugs and any product designated by the Food and Drug Administration (FDA) as a drug (Taken from the 2009 Comprehensive Accreditation Manual for Hospitals: The Official Handbook (CAMH)).

All medications must have the names, dosage and indication for use listed in the continuing care plan. The indication for use can be as short as one to two words, but must be present for all medications, not just psychotropic medications.

**Suggested Data Sources:**
- Aftercare discharge plan
- Continuing care plan
- Discharge plan
- Final discharge summary
- Interim discharge summary
- Medication reconciliation form
- Physician discharge orders
- Physician progress notes
- Referral form

**Additional Notes:** The next level of care providers include the follow-up prescribing inpatient or outpatient clinician, prescribing inpatient or outpatient entity, the treating inpatient or outpatient clinician or the treating inpatient or outpatient entity as described below. If the patient has referrals to more than one clinician or entity for follow-up, the prescribing clinician or entity is considered to be the primary next level of care provider. The order of precedence for transmission of the continuing care plan is listed below.

- The follow-up prescribing inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for managing the patient’s medication regime after hospital discharge.
- The treating inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for the primary treatment of the
Some examples of inpatient or outpatient clinicians include, but are not limited to: primary care physician, psychiatrist, advanced practice nurse (APN), physician assistant (PA) Master of Social Work (MSW) and psychologist. Titles of qualified psychiatric practitioners vary from state to state.

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Routinely scheduled medications</td>
<td>• None</td>
</tr>
<tr>
<td>• PRN medications</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Continuing Care Plan-Next Level of Care

Collected For: HBIPS-6, HBIPS-7,

Definition: Documentation in the medical record of a continuing care plan which includes next level of care recommendations. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day.

Suggested Data Collection Question: Is there documentation in the medical record of a continuing care plan which includes next level of care recommendations AND was the continuing care plan including next level of care recommendations transmitted to the next level of care provider no later than the fifth post-discharge day?

Format:

<table>
<thead>
<tr>
<th>Length</th>
<th>Type</th>
<th>Occurs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alphanumeric</td>
<td>1</td>
</tr>
</tbody>
</table>

Allowable Values:

1  The medical record contains a continuing care plan which includes next level of care recommendations AND was transmitted to the next level of care provider no later than the fifth post-discharge day.

2  The medical record contains a continuing care plan which includes next level of care recommendations but it was not transmitted to the next level of care provider by the fifth post-discharge day.

3  The medical record does not contain a continuing care plan which includes next level of care recommendations OR unable to determine from medical record documentation.

PROGRAMMER NOTE:
In order to identify the specific continuing care plan components that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each discharge component can be performed.

Notes for Abstraction:
If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit.

If the hospital has an electronic medical record (EMR) and the next level of care provider has access to the complete hospital EMR, select allowable value 1. The EMR must contain documentation that the next level of care provider has access to the EMR.

A continuing care plan may consist of one document or several documents which could be considered a continuing care “packet”. The hospital must
be able to identify which document(s) make up the continuing care plan and the hospital must identify what specific documents are transmitted to the next level of care provider.

The first post-discharge day is defined as the day after discharge.

Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access. Giving a copy of the continuing care plan to the patient does not comprise transmission.

Next level of care recommendations may include, but are not limited to: Axis III follow-up, social work and benefits follow-up, pending legal issues and peer support, i.e., Alcoholics Anonymous, Narcotics Anonymous.

Suggested Data Sources:
- Aftercare discharge plan
- Continuing care plan
- Discharge plan
- Final discharge summary
- Interim discharge summary
- Medication reconciliation form
- Physician discharge orders
- Physician progress notes
- Referral form

Additional Notes: The next level of care providers include the follow-up prescribing inpatient or outpatient clinician, prescribing inpatient or outpatient entity, the treating inpatient or outpatient clinician or the treating inpatient or outpatient entity as described below. If the patient has referrals to more than one clinician or entity for follow up, the prescribing clinician or entity is considered to be the primary next level of care provider. The order of precedence for transmission of the continuing care plan is listed below.

- The follow-up prescribing inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for managing the patient’s medication regime after hospital discharge.
- The treating inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for the primary treatment of the patient in the absence of medications.
- Some examples of inpatient or outpatient clinicians include, but are not limited to: primary care physician, psychiatrist, advanced practice nurse (APN), physician assistant (PA) Master of Social Work (MSW) and psychologist. Titles of qualified psychiatric practitioners vary from state to state.

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
</table>

Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
Next level of care recommendations may include, but are not limited to:

- Appointment with outpatient clinician or entity
- Axis III follow-up
- Social work and benefits follow-up
- Pending legal issues, e.g., follow-up with probation officer
- Peer support, i.e., Alcoholics Anonymous, Narcotics Anonymous
- Home-based services

- None
Data Element Name: Continuing Care Plan-Principal Discharge Diagnosis

Collected For: HBIPS-6, HBIPS-7,

Definition: Documentation in the medical record of a continuing care plan which includes the principal discharge diagnosis. Such documentation should be transmitted to the next level of care provider by the **fifth post-discharge day**.

Suggested Data Collection Question: Is there documentation in the medical record of a continuing care plan which includes the principal discharge diagnosis AND was the continuing care plan including the principal discharge diagnosis transmitted to the next level of care provider no later than the **fifth post-discharge day**?

Format:  
Length: 1  
Type: Alphanumeric  
Occurs: 1

Allowable Values:  
1 The medical record contains a continuing care plan which includes the principal discharge diagnosis AND was transmitted to the next level of care provider no later than the fifth post-discharge day.

2 The medical record contains a continuing care plan which includes the principal discharge diagnosis but was not transmitted to the next level of care provider by the **fifth post-discharge day**.

3 The medical record does not contain a continuing care plan which includes the principal discharge diagnosis or unable to determine from medical record documentation.

Programmer Note: In order to identify the specific continuing care plan components that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each discharge component can be performed.

Notes for Abstraction: If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit.

If the hospital has an electronic medical record (EMR) and the next level of care provider has access to the complete hospital EMR, select allowable value 1. The EMR should contain documentation that the next level of care provider has access to the EMR.

A continuing care plan may consist of one document or several documents which could be considered a continuing care "packet". The hospital must be able to identify which document(s) make up the continuing care plan.
and the hospital must identify what specific documents are transmitted to the next level of care provider within the required timeframe.

The first post-discharge day is defined as the day after discharge.

Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access. Giving a copy of the continuing care plan to the patient does not comprise transmission.

**Suggested Data Sources:**
- Aftercare discharge plan
- Continuing care plan
- Discharge plan
- Final discharge summary
- Interim discharge summary
- Medication reconciliation form
- Physician discharge orders
- Physician progress notes
- Referral form

**Additional Notes:** The next level of care providers include the follow-up prescribing inpatient or outpatient clinician, prescribing inpatient or outpatient entity, the treating inpatient or outpatient clinician or the treating inpatient or outpatient entity as described below. If the patient has referrals to more than one clinician or entity for follow up, the prescribing clinician or entity is considered to be the primary next level of care provider. The order of precedence for transmission of the continuing care plan is listed below.

- The follow-up prescribing inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for managing the patient’s medication regime after hospital discharge.
- The treating inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for the primary treatment of the patient in the absence of medications.
- Some examples of inpatient or outpatient clinicians include, but are not limited to: primary care physician, psychiatrist, advanced practice nurse (APN), physician assistant (PA) Master of Social Work (MSW) and psychologist. Titles of qualified psychiatric practitioners vary from state to state.

**Guidelines for Abstraction:**

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Data Element Name: Continuing Care Plan-Reason for Hospitalization

Collected For: HBIPS-6, HBIPS-7,

Definition: Documentation in continuing care plan includes the reason for hospitalization. Such documentation should be transmitted to the next level of care provider by the fifth post-discharge day.

Suggested Data Collection Question: Is there documentation in the medical record of a continuing care plan which includes the reason for hospitalization AND was the continuing care plan including the reason for hospitalization transmitted to the next level of care provider no later than the fifth post-discharge day?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1. The medical record contains a continuing care plan which includes the reason for hospitalization and was transmitted to the next level of care provider no later than the fifth post-discharge day.

2. The medical record contains a continuing care plan which includes the reason for hospitalization but was not transmitted to the next level of care provider by the fifth post-discharge day.

3. The medical record does not contain a continuing care plan which includes the reason for hospitalization or unable to determine from medical record documentation.

PROGRAMMER NOTE: In order to identify the specific continuing care plan components that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each discharge component can be performed.

Notes for Abstraction: If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit.

If the hospital has an electronic medical record (EMR) and the next level of care provider has access to the complete hospital EMR, select allowable value 1. The EMR should contain documentation that the next level of care provider has access to the EMR.

A continuing care plan may consist of one document or several documents which could be considered a continuing care "packet". The hospital must be able to identify which document(s) make up the continuing care plan and the hospital must identify what specific documents are transmitted to
the next level of care provider.

The first post-discharge day is defined as the day after discharge.

Methods for transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, EMR access. Giving a copy of the continuing care plan to the patient does not comprise transmission.

The reason for hospitalization should be a short synopsis describing the events the patient experienced prior to this hospitalization. The reason for hospitalization may be listed as the triggering or precipitating event.

Suggested Data Sources:
- Aftercare discharge plan
- Continuing care plan
- Discharge plan
- Final discharge summary
- Interim discharge summary
- Medication reconciliation form
- Physician discharge orders
- Physician progress notes
- Referral form

Additional Notes: The next level of care providers include the follow-up prescribing inpatient or outpatient clinician, prescribing inpatient or outpatient entity, the treating inpatient or outpatient clinician or the treating inpatient or outpatient entity as described below. If the patient has referrals to more than one clinician or entity for follow-up, the prescribing clinician or entity is considered to be the primary next level of care provider. The order of precedence for transmission of the continuing care plan is listed below.

- The follow-up prescribing inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for managing the patient’s medication regime after hospital discharge.
- The treating inpatient or outpatient clinician or entity is the clinician, hospital or clinic that is responsible for the primary treatment of the patient in the absence of medications.
- Some examples of inpatient or outpatient clinicians include, but are not limited to: primary care physician, psychiatrist, advanced practice nurse (APN), physician assistant (PA) Master of Social Work (MSW) and psychologist. Titles of qualified psychiatric practitioners vary from state to state.

Guidelines for Abstraction:

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Data Element Name: *Discharge Date*

Collected For: All Records, Not collected for HBIPS-2 and HBIPS-3

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this stay.

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?

Format: Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (2001-Current Year)

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

For HBIPS only, if the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.

Suggested Data Sources:
- Face sheet
- Progress notes
- Physician orders
- Discharge summary
- Nursing discharge notes
- Transfer note
- UB-04, Field Location: 6

Additional Notes:

Guidelines for Abstraction:

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</table>
**Data Element Name:** Discharge Status

**Collected For:** All Records, Not collected for HBIPS-2 and HBIPS-3; Used in algorithm for PC-04 and PC-05

**Definition:** The place or setting to which the patient was discharged.

**Suggested Data Collection Question:** What was the patient’s discharge disposition?

**Format:**
- **Length:** 2
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**

01 **Discharged to home care or self care (routine discharge)**
   
   Usage Note: Includes discharge to home; home on oxygen if DMS only; any other DMS only; group home, foster care, independent living and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs.

02 **Discharged/transferred to a short term general hospital for inpatient care**

03 **Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care**
   
   Usage Note: Medicare-indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed. For reporting other discharges/transfers to nursing facilities, see 04 and 64.

04 **Discharged/transferred to a facility that provides custodial or supportive care**
   
   Usage Note: Includes intermediate care facility (ICF) if specifically designated at a state level. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities.

05 **Discharged/transferred to a designated cancer center or children’s hospital**
   
   Usage Note: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at [http://www3.cancer.gov/cancercenters/centerslist.html](http://www3.cancer.gov/cancercenters/centerslist.html)
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
Usage Note: Report this code when the patient is discharged/transferred to home with a written plan of care (tailored to the patient’s medical needs) for home care services.

07 Left against medical advice or discontinued care

20 Expired

21 Discharged/transferred to court/law enforcement
Usage Note: Includes transfers to incarceration facilities such as jail, prison or other detention facilities.

30 Still Patient

43 Discharged/transferred to a federal health care facility
Usage Note: Discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran’s Administration hospital or a Veteran’s Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.

50 Hospice - home

51 Hospice - medical facility (certified) providing hospice level of care

61 Discharged/transferred to hospital-based Medicare approved swing bed
Usage Note: Medicare-used for reporting patients discharged/transferred to a SNF level of care within the hospital’s approved swing bed arrangement.

62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital

63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
Usage Note: For hospitals that meet the Medicare criteria for LTCH certification.

64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
Discharged/transferred to a Critical Access Hospital (CAH)

Discharged/transferred to another type of health care institution not defined elsewhere in this code list (See Code 05)

Joint Commission NOTE:
If state assigned codes are used, it is the measurement system’s responsibility to crosswalk the code to one of the allowable values listed above for the purposes of ORYX®.

NOTE: The Joint Commission is aware that there are additional UB-04 allowable values for this data element; however, they are not used for the national quality core measures set at this time.

Notes for Abstraction:
- The values for *Discharge Status* are taken from the National Uniform Billing Committee (NUBC) manual which is used by the billing/HIM to complete the UB-04.
- Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the UB-04 value is what is reflected in the medical record. For abstraction purposes, it is important that the medical record reflect the appropriate discharge status. If the abstractor determines through chart review that the claim information discharge status is not what is reflected in the medical record, she/he should correct and override the downloaded value.
- It would be appropriate to work with your billing office to develop processes that can be incorporated to improve medical record documentation to support the appropriate discharge status and to ensure consistency between the claim information discharge status and the medical record.
- Allowable Value 30 (Still patient) is a valid value for HBIPS-2 and HBIPS-3 because these measures are collected concurrently. This allowable value is not valid for discharge measures, including, HBIPS-1, 4, 5, 6 and 7 and PC measures.
- If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.

Suggested Data Sources:
- Face sheet
- Progress notes
- Physician orders
- Discharge summary
- Discharge instruction sheet
- Nursing discharge notes
- Social service notes
- Transfer record
**Additional Notes:**

**Guidelines for Abstraction:**

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<td>• Refer to Appendix E, Table 2.5 Discharge Status Disposition.</td>
<td>• None</td>
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</tbody>
</table>
**Data Element Name:** Event Date

**Collected For:** All Records, Not collected for HBIPS-1, 4, 5, 6 and 7

**Definition:** The date the associated event type occurred.

**Suggested Data Collection Question:** What is the date recorded in the medical record that the associated event type occurred?

**Format:**
- **Length:** 10 – MM-DD-YYYY (includes dashes)
- **Type:** Date
- **Occurs:** 1

**Allowable Values:**
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (2001-Curren Year)

**Notes for Abstraction:** Medical record documentation only should be used to collect this data element.

This information is abstracted once for each day on which an event (Event Type) occurs during the patient’s hospitalization. A patient may have multiple events during the hospitalization.

**Suggested Data Sources:**
- Licensed independent practitioner orders
- Nursing notes
- Nursing flow sheet
- Observation sheets
- Physician orders
- Progress notes
- Psychiatrist notes
- Restraint monitoring form
- Therapist notes

**Additional Notes:**

**Guidelines for Abstraction:**

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</table>
Data Element Name: Event Type

Collected For: All Records, Not collected for HBIPS-1, 4, 5, 6 and 7

Definition: The measure-related event being identified.

Suggested Data Collection Question: What is the identified measure-related event?

Format: Length: 1
        Type: Alphanumeric
        Occurs: 1

Allowable Values: 1. Physical Restraint
                  2. Seclusion

Notes for Abstraction: This information is abstracted once for each type of event that occurs on a specific day (Event Date) during the patient’s hospitalization. A patient may have multiple events during the hospitalization.

Suggested Data Sources: None

Additional Notes:

Guidelines for Abstraction:

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</table>
Data Element Name: Health Care Organization Identifier

Collected For: HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC PC, Transmission, Aggregate Data File, Patient Population Data File

Definition: A unique number, assigned by The Joint Commission, to identify the health care organization that is accredited by The Joint Commission. This number is used to identify and group a health care organization's HCO-Level performance measure data.

Suggested Data Collection Question: What is the Joint Commission’s unique identification number for the provider?

Format: Length: 6
Type: Numeric
Occurs: 1

Allowable Values: 1 – 999,999

Notes for Abstraction: None

Suggested Data Sources: Does not apply, assigned by The Joint Commission.

Additional Notes:

Guidelines for Abstraction:

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Data Element Name: *ICD-9-CM Other Diagnosis Codes*

Collected For: All Records, Optional for HBIPS-2 and HBIPS-3; Used in algorithm for PC-01, 02, 04, and 05

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis for this hospitalization.

Suggested Data Collection Question: What were the ICD-9-CM other diagnosis codes selected for this medical record?

Format: 
- **Length:** 6 (implied decimal point)
- **Type:** Alphanumeric
- **Occurs:** 17

Allowable Values: Any valid ICD-9-CM diagnosis code

Notes for Abstraction: None

Suggested Data Sources:
- Face sheet
- Discharge summary
- UB-04, Field Locations: 67A-Q
  NOTE: Medicare will only accept codes listed in fields A-H

Additional Notes:

### Guidelines for Abstraction:

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**Data Element Name:** ICD-9-CM Other Procedure Codes

**Collected For:** All Records, Optional for All HBIPS Records; Used in algorithm for PC-01, 02, 04 and 05

**Definition:** The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes identifying all significant procedures other than the principal procedure.

**Note:** If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, ICD-9-CM Other Procedure Date exists, etc.) will apply.

**Suggested Data Collection Question:** What were the ICD-9-CM code(s) selected as other procedure(s) for this record?

**Format:**
- **Length:** 5 (with or without decimal point)
- **Type:** Alphanumeric
- **Occurs:** 5

**Allowable Values:** Any valid ICD-9-CM procedure code

**Notes for Abstraction:** None

**Suggested Data Sources:**
- Face sheet
- Discharge summary
- UB-04, Field Location: 74A-E

**Additional Notes:**

**Guidelines for Abstraction:**

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Data Element Name:  
*ICD-9-CM Other Procedure Dates*

Collected For:  
All Records, Optional for All HBIPS Records

Definition:  
The month, day, and year when the associated procedure(s) was (were) performed.

Note: If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, *ICD-9-CM Other Procedure Codes* exists, etc.) will apply.

Suggested Data Collection Question:  
What were the date(s) the other procedure(s) were performed?

Format:  
Length: 10 – MM-DD-YYYY (includes dashes) or UTD  
Type: Date  
Occurs: 5

Allowable Values:  
MM = Month (01-12)  
DD = Day (01-31)  
YYYY = Year (2001-Current Year)  
UTD = Unable to Determine

Notes for Abstraction:  
- If the procedure date for the associated procedure is unable to be determined from medical record documentation, enter UTD.  
- The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after *Discharge Date]*) and no other documentation is found that provides this information, the abstractor should select “UTD.”

Examples:
- Documentation indicates the *ICD-9-CM Other Procedure Dates* was 02-42-2008. No other documentation in the medical record provides a valid date. Since the *ICD-9-CM Other Procedure Dates* is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD.”
- Patient expires on 02-12-2008 and documentation indicates the *ICD-9-CM Other Procedure Dates* was 03-12-2008. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-9-CM Other Procedure Dates* is after the *Discharge Date* (death), it is outside of the parameters of care and the abstractor should select “UTD.”

Note:  
Transmission of a case with an invalid date as described above will be rejected from the Joint Commission’s Data Warehouse.
Use of “UTD” for ICD-9-CM Other Procedure Dates allows the case to be accepted into the warehouse.

**Suggested Data Sources:**
- Consultation notes
- Face sheet
- Progress notes
- Discharge summary
- Operative report
- Procedure notes
- Diagnostic test reports
- UB-04, Field Locations: 74A-E

**Additional Notes:**

**Guidelines for Abstraction:**

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</table>
Data Element Name: ICD-9-CM Principal Diagnosis Code

Collected For: All Records, Optional for HBIPS-2 and HBIPS-3; Used in algorithm for PC-01, 02, 04, and 05

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization.

Suggested Data Collection Question: What was the ICD-9-CM code selected as the principal diagnosis for this record?

Format: Length: 6 (implied decimal point)
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid ICD-9-CM diagnosis code

Notes for Abstraction: The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

Suggested Data Sources:
- Face sheet
- Discharge summary
- UB-04, Field Location: 67

Additional Notes:

Guidelines for Abstraction:

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<tr>
<td>• Refer to Appendix A, for ICD-9-CM Code Tables (AMI, HF, PN, HBIPS).</td>
<td>• Refer to Appendix A, for ICD-9-CM Code Tables (SCIP).</td>
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</table>
**Data Element Name:** ICD-9-CM Principal Procedure Code

**Collected For:** All Records, Optional for All HBIPS Records; Used in algorithm for PC-01, 02, 04 and 05

**Definition:** The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code that identifies the principal procedure performed during this hospitalization. The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

**Note:** If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, ICD-9-CM Principal Procedure Date exists, etc.) will apply.

**Suggested Data Collection Question:** What was the ICD-9-CM code selected as the principal procedure for this record?

**Format:**
- **Length:** 5 (with or without decimal point)
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:** Any valid ICD-9-CM procedure code.

**Notes for Abstraction:** The principal procedure as described by the Uniform Hospital Discharge Data Set (UHDDS) is one performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

**Suggested Data Sources:**
- Face sheet
- Discharge summary
- UB-04, Field Location: 74

**Additional Notes:**

**Guidelines for Abstraction:**

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**Data Element Name:** ICD-9-CM Principal Procedure Date

**Collected For:** All Records, Optional for All HBIPS Records

**Definition:** The month, day, and year when the principal procedure was performed.

**Note:** If transmitted for the HBIPS measure set, all applicable edits (e.g., valid value, ICD-9-CM Principal Procedure Code exists, etc.) will apply.

**Suggested Data Collection Question:** What was the date the principal procedure was performed?

**Format:**
- **Length:** 10 – MM-DD-YYYY (includes dashes) or UTD
- **Type:** Date
- **Occurs:** 1

**Allowable Values:**
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (2001-Current Year)
- UTD = Unable to Determine

**Notes for Abstraction:**
- If the principal procedure date is unable to be determined from medical record documentation, enter UTD.
- The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format or is outside of the parameters of care [after Discharge Date]) and no other documentation is found that provides this information, the abstractor should select “UTD.”

**Examples:**
- Documentation indicates the ICD-9-CM Principal Procedure Date was 02-42-2008. No other documentation in the medical record provides a valid date. Since the ICD-9-CM Principal Procedure Date is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD.”
- Patient expires on 02-12-2008 and documentation indicates the ICD-9-CM Principal Procedure Date was 03-12-2008. Other documentation in the medical record supports the date of death as being accurate. Since the ICD-9-CM Principal Procedure Date is after the Discharge Date (death), it is outside of the parameter of care and the abstractor should select “UTD.”

**Note:** Transmission of a case with an invalid date as described above will be rejected from the Joint Commission’s Data Warehouse. Use of “UTD” for ICD-9-CM Principal Procedure Date allows the
case to be accepted into the warehouse.

Suggested Data Sources:
- Consultation notes
- Face sheet
- Progress notes
- Discharge summary
- Diagnostic test reports
- Operative notes
- Procedure notes
- UB-04, Field Location: 74

Additional Notes:

Guidelines for Abstraction:

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**Data Element Name:**

*Initial Patient Population Size – Medicare Only*

**Collected For:**


**Note:**

Refer to the Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

**Definition:**

Indicates the number of episode of care (EOC) records identified for a hospital with Medicare listed as a payment source prior to the application of data integrity filters, measure exclusions, and/or sampling methodology for the specified time period.

The data element is based on the hospital's initial identification of Medicare EOC records for a measure set, stratum, or sub-population. Initial Patient Population Size – Medicare Only includes all patients that are billed under Medicare or Title 18. Medicare can be listed as a primary, secondary, tertiary or lower on the list of payment sources for the patient. In addition, patients who are participating as a member of a Medicare HMO/Medicare Advantage are included in the Medicare counts, e.g., Medicare Blue, Humana Gold, Secure Horizons, AARP, Coventry Advantra, etc. This initial data pull utilizes administrative data such as ICD-9-CM diagnosis and procedure codes, admission date, and birthdate.

For the discharge measures (eg. HBIPS-1, 4, PC-01), refer to the Initial Patient Population discussion in the Measure Information section of this manual for more information.

For the HBIPS event measures (HBIPS-2 and 3), the Initial Patient Population Size – Medicare Only is equal to those EOC records in the census data identified as being Medicare EOC records. The HBIPS census data are calculated by (Psychiatric Inpatient Days-Medicare Only - Total Leave Days-Medicare Only). Initial Patient Population Size – Medicare Only is not derived from those cases that pass through the Initial Patient Population algorithm.

**Note:**

If the hospital's data has been sampled, this field contains the population from which the sample was originally drawn, NOT the sample size.

**Suggested Data Collection Question:**

Not Applicable
Non-stratified Measure Sets:

One Initial Patient Population Size – Medicare Only per hospital’s measure set (e.g., AMI, HF, PN, and STK).

Stratified Measure Sets:

One Initial Patient Population Size – Medicare Only per measure set stratum or sub-population the hospital is participating in:
* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

Note:
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the CAC, VTE, and SCIP measure sets.

Allowable Values:
0 through 999,999

Notes for Abstraction:
*Initial Patient Population Size-Medicare Only* must contain the actual number of patients in the population even if the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data.

Suggested Data Sources:
Not Applicable

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
**Data Element Name:**
*Initial Patient Population Size – Non-Medicare Only*

**Collected For:**

**Note:**
Refer to the HBIPS Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

**Definition:**
Indicates the number of episode of care (EOC) records identified for a hospital with Medicare NOT listed as a payment source prior to the application of data integrity filters, measure exclusions, and/or sampling methodology for the specified time period.

The data element is based on the hospital's initial identification of non-Medicare EOC records for a measure set, stratum, or sub-population. This initial data pull utilizes administrative data such as ICD-9-CM diagnosis and procedure codes, admission date, and birthdate.

For the discharge measures (eg. HBIPS-1, 4, PC-01), refer to the Initial Patient Population discussion in the Measure Information section of this manual for more information.

For the HBIPS event measures (HBIPS-2 and 3), the Initial Patient Population Size – Non-Medicare Only is equal to those EOC records in the census data identified as not having Medicare listed as a payment source. The HBIPS census data are calculated by (Psychiatric Inpatient Day-Non-Medicare Only - Total Leave Days-Non-Medicare Only). Initial Patient Population Size – Non-Medicare Only is not derived from those cases that pass through the Initial Patient Population algorithm.

**Note:**
If the hospital’s data has been sampled, this field contains the population from which the sample was originally drawn, NOT the sample size.

**Suggested Data Collection Question:**
Not Applicable

**Format:**
- **Length:** 6
- **Type:** Numeric
- **Occurs:** Non-stratified Measure Sets:
One Initial Patient Population Size – Non-Medicare Only per hospital’s measure set (e.g., AMI, HF, PN, and STK).

**Stratified Measure Sets:**

One Initial Patient Population Size – Non-Medicare Only per measure set stratum or sub-population the hospital is participating in:

* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

**Note:**
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the CAC, VTE, and SCIP measure sets.

**Allowable Values:**

0 through 999,999

**Notes for Abstraction:**

*Initial Patient Population Size-Non-Medicare Only* must contain the actual number of patients in the population even if the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data.

**Suggested Data Sources:**
Not Applicable

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Data Element Name:</td>
<td>Measure Category Assignment</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Collected For:</td>
<td>HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC PC, Calculation, Transmission, Hospital Clinical Data File, Used in calculation of the Joint Commission’s aggregate data and in the transmission of the Hospital Clinical Data file.</td>
</tr>
</tbody>
</table>

**Notes:**

- Episode of care records that calculate with a *Measure Category Assignment* of "X" (missing data) for one or more measures will be rejected by the Joint Commission’s Data Warehouse. Refer to the Missing and Invalid Data section in this manual for more information.
- All hospital measures use this data element. The ORYX Vendor’s calculated *Measure Category Assignment* will be transmitted to the Joint Commission on a quarterly basis with the associated hospital clinical data. These measure results will be used in the Joint Commission’s data quality analysis and continuous measure verification process. ORYX Vendors can refer to the Joint Commission’s *ORYX Data Quality Manual* for more information.

**Definition:**

Calculated measures results for each episode of care (EOC) that is processed through a measure algorithm. Used to summarize the outcome for an EOC that is processed through a specific measure algorithm.

**Suggested Data Collection Question:**

Not Applicable

**Format:**

Length: 1
Type: Character
Occurs: One *Measure Category Assignment* per EOC is expected for every measure that a hospital is participating in.

**Allowable Values:**

- **B Category B - Not in Measure Population**
  For rate-based and continuous variable measures:
  EOC record is not a member of a measure's population.
  For rate-based-ratio measures:
  Does not apply.

- **D Category D - In Measure Population**
For rate-based measures:
EOC record is a member of the measure's population and there has not been an occurrence of the measure.

For rate-based-ratio measures:
Does not apply.

For continuous variable measures:
EOC record is a member of the measure's population and has sufficient accurate and valid data to compute the measurement.

Note:
For continuous variable measures, EOC records that have a Measure Category Assignment of “D” will have an associated Measurement Value.

E  Category E - In Numerator Population
For rate-based measures:
EOC record is a member of the measure's population and there has been an occurrence of the measure.

For rate-based-ratio measures:
Event record is a member of the measure's population and there has been an occurrence of the measure.

For continuous variable measures:
Does not apply.

U  Category U – Not In Numerator Population

For rate-based-proportion measures:
Does not apply

For rate-based-ratio measures:
Event record is a member of the measure's population; however, it contains a data element whose allowable value excludes it from the numerator.

For continuous variable measures:
Does not apply.

X  Category X – Data Are Missing
For rate-based and continuous variable measures:
Data are missing that is required to calculate the measure. The record will be rejected by the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse.

Y  Category Y – UTD Allowable Value Does Not Allow Calculation of The Measure
For rate-based measures:
Does not apply.
For rate-based-ratio measures: Event record contains a Date, Time, or Numeric data element with a value of ‘UTD’.

For continuous variable measures: 
EOC record contains a Date, Time, or Numeric data element with a value of ‘UTD’.

**Note:**
For continuous variable measures, EOC records that have a Measure Category Assignment of “Y” will not have an associated _Measurement Value_

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Additional Notes:

<table>
<thead>
<tr>
<th>Guidelines for Abstraction:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusion</td>
</tr>
<tr>
<td>• None</td>
</tr>
</tbody>
</table>
Data Element Name: Measure Set

Collected For: HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC PC, Transmission, Patient Population Data File, Hospital Clinical Data File

Definition: Indicates which measure set (topic) is being transmitted for a hospital.

Suggested Data Collection Question: Not Applicable

Format: Length: 10
Type: Character
Occurs: Hospital Clinical Data file: 1
Hospital Initial Patient Population Data file: 1 – 10

Allowable Values: Refer to the Hospital Clinical Data XML File Layout and the Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

<table>
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<tr>
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<th>Exclusion</th>
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<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
**Data Element Name:** Measurement Value

**Collected For:** HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC PC, Calculation, Transmission, Hospital Clinical Data File, Used in the calculation of the Joint Commission’s aggregate data, Continuous Variable Measures and in the transmission of the Hospital Clinical Data file

**Note:**
- The ORYX Vendor’s calculated Measurement Value will be transmitted to The Joint Commission on a quarterly basis with the associated hospital clinical data. These measure results will be used in the Joint Commission’s data quality analysis and continuous measure verification process. ORYX Vendors can refer to the Joint Commission’s ORYX Data Quality Manual for more information.

**Definition:**
This data element is used to store the calculated results of the measurements that are outputs from continuous variable measure algorithms.

**Note:**
Used in conjunction with Measure Category Assignment when its allowable value = “D” (In Measure Population).

**Suggested Data Collection Question:**
Not Applicable

**Format:**
- **Length:** 6
- **Type:** Numeric
- **Occurs:** One Measurement Value is expected per EOC for every continuous variable measure that a hospital is participating in.

**Allowable Values:** Any valid number

**Notes for Abstraction:** None

**Suggested Data Sources:** Not Applicable

**Additional Notes:**
## Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Minutes of Physical Restraint

Collected For: HBIPS-2,

Definition: The total minutes recorded in the medical record that a patient was maintained in Event Type 1 (physical restraint(s)) for the associated Event Date.

Suggested Data Collection Question: What was the total number of minutes recorded in the medical record that the patient was maintained in Event Type 1 (physical restraint) for the Event Date?

Format: Length: 4 or UTD
Type: Alphanumeric
Occurs: 1

Allowable Values: 1-1440
UTD= Unable to Determine

Notes for Abstraction: Event Type 1 (physical restraint(s)) should be reported in whole minutes. Events less than or equal to 60 seconds should be reported as 1 minute (i.e., event duration of 2 minutes 5 seconds is reported as 3 minutes).

For each patient enter the Minutes of Physical Restraint that corresponds with the Event Date and Event Type.

Select unable to determine when either the start or stop time OR the total number of minutes of Event Type 1 (physical restraint) event is missing from the medical record and the total Minutes of Physical Restraint can not be calculated for the associated Event Date.

See the guidelines for abstraction for definition of an Event Type 1 (physical restraint).

When an Event Type 1 (physical restraint) starts at school or during an off-campus outing; this event should be reported.

Suggested Data Sources:
- Licensed independent practitioner orders
- Nursing flow sheet
- Nursing notes
- Observation sheets
- Physician orders
- Progress notes
- Psychiatrist notes
- Restraint monitoring form
- Therapist notes
**Data Element Name:** Minutes of Seclusion  

**Collected For:** HBIPS-3,  

**Definition:** The total minutes recorded in the medical record that a patient was held in Event Type 2 (seclusion) during the associated Event Date.  

**Suggested Data Collection Question:** What was the total number of minutes recorded in the medical record that the patient was held in Event Type 2 (seclusion) during the Event Date?  

**Format:**  
- **Length:** 4 or UTD  
- **Type:** Alphanumeric  
- **Occurs:** 1  

**Allowable Values:**  
- 1-1440  
- UTD= Unable to Determine  

**Notes for Abstraction:**  
- Event Type 2 (seclusion(s)) should be reported in whole minutes. Events less than or equal to 60 seconds should be reported as 1 minute (i.e., event duration of 2 minutes 5 seconds is reported as 3 minutes).  
- For each patient enter the Minutes of Seclusion that corresponds with the Event Date and Event Type.  
- Select unable to determine when either the start or stop time OR the total number of minutes of Event Type 2 (seclusion) event is missing from the medical record and the total Minutes of Seclusion can not be calculated for the associated Event Date.  
- See guidelines for abstraction for definition of an Event Type 2 (seclusion).  
- When an Event Type 2 (seclusion) starts at school or during an off-campus outing; this event should be reported.  

**Suggested Data Sources:**  
- Licensed independent practitioner orders  
- Nursing flow sheet  
- Nursing notes  
- Observation sheets  
- Physician orders  
- Progress notes  
- Psychiatrist notes  
- Seclusion monitoring form  
- Therapist notes  

**Additional Notes:**
### Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
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</thead>
</table>
| Seclusion is the involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving. This includes but is not limited to ¹: | • Time-out
• Quarantine due to infectious disease
• Physical restraints while not in seclusion                                |
| • Manually or electronically locked doors                                |                                                                 |
| • One-way doors                                                          |                                                                 |
| • The presence of staff proximal to the room preventing exit or the threat of consequences if the patient leaves the room |                                                                 |

¹ 42 CFR Part 482, Medicare and Medicaid Programs; Hospital Conditions of Participation: Patient’s Rights
Data Element Name: National Provider Identifier

Collected For: HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC PC PC PC PC PC, Transmission, Optional for All Records

Definition: All Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered healthcare providers must obtain a National Provider Identifier (NPI). The NPI may be provided in addition to the Medicare provider number.

Suggested Data Collection Question: What is the NPI for this provider?

Format: Length: 10
Type: Character
Occurs: 1

Allowable Values: Any valid 10 digit NPI number.

Notes for Abstraction: None

Suggested Data Sources: UB-04, Field Location: 56

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Number of Antipsychotic Medications Prescribed at Discharge

Collected For: HBIPS-4, HBIPS-5,

Definition: The number of routinely scheduled antipsychotic medications prescribed to the patient at discharge as documented in the medical record.

Suggested Data Collection Question: What is the documented number of antipsychotic medications prescribed for the patient at discharge?

Format: Length: 2 or UTD  
Type: Alphanumeric  
Occurs: 1

Allowable Values:  
0-99  
UTD= Unable to Determine

Notes for Abstraction: An antipsychotic medication is defined as any of a group of drugs, such as the phenothiazines, butyrophenones or serotonin-dopamine antagonists, which are used to treat psychosis. An antipsychotic medication is also called neuroleptic (refer to Appendix B, Table 10.0- Antipsychotic Medications).

If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.

If the patient is on two forms of the same medication i.e., po and IM, this would be counted as one antipsychotic medication.

Only use “Antipsychotic NOS” in the following situation:

- For new antipsychotics that are not yet listed in Table 10.0 in Appendix B.

Suggested Data Sources:

- Aftercare discharge plan  
- Continuing care plan  
- Discharge plan  
- Final discharge summary  
- Interim discharge summary  
- Medication reconciliation form  
- Physician discharge orders  
- Physician progress notes  
- Referral form
Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Refer to Appendix B, Table 10.0-Antipsychotic Medications</td>
<td>• PRN antipsychotic medications</td>
</tr>
<tr>
<td></td>
<td>• Short-acting intramuscular antipsychotic medications (refer to Appendix B, Table 10.1- Short-Acting Intramuscular Antipsychotic Medications)</td>
</tr>
</tbody>
</table>

Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
### Data Element

**Name:** Patient Referral to Next Level of Care Provider

**Collected For:** HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7,

**Definition:** Documentation in the medical record that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting.

**Suggested Data Collection Question:** Is there documentation in the medical record that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting?

**Format:**

- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

### Allowable Values:

1. The medical record contains documentation that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting.

2. The medical record contains documentation that the patient or guardian refused the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting OR refused to authorize release of information.

3. The medical record contains documentation that the patient eloped OR failed to return from leave and was discharged OR that the patient has not yet been discharged from the hospital OR discharged from the hospital to another level of care outside of the hospital system from a setting other than a Psychiatric Care Setting.

4. The medical record contains documentation that the patient was not referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting for a reason other than above.

5. The medical record does not contain documentation that the patient was referred to the next level of care provider upon discharge from a hospital-based inpatient psychiatric setting OR unable to determine from medical record documentation.

### Notes for Abstraction:

If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.

### Suggested Data Sources:

- Aftercare discharge plan
- Continuing care plan
- Discharge plan
The next level of care providers include the follow-up prescribing inpatient or outpatient clinician, prescribing inpatient or outpatient entity, the treating inpatient or outpatient clinician or the treating inpatient or outpatient entity as described below:

- The follow-up prescribing inpatient or outpatient clinician is the clinician who is responsible for managing the patient’s medication regime after hospital discharge.
- The prescribing inpatient or outpatient entity is the hospital or clinic that is responsible for managing the patient’s medication regime after hospital discharge.
- The treating inpatient or outpatient clinician is the clinician who is responsible for the primary treatment of the patient in the absence of medications.
- The treating inpatient or outpatient entity is the hospital or clinic that is responsible for the primary treatment of the patient in the absence of medications.
- Some examples of inpatient or outpatient clinicians include, but are not limited to: primary care physician, psychiatrist, advanced practice nurse (APN), physician assistant (PA) Master of Social Work (MSW) and psychologist. Titles of qualified psychiatric practitioners vary from state to state.

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Patient Strengths

Collected For: HBIPS-1

Definition: 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.

Suggested Data Collection Question: Is there documentation in the medical record that the patient was screened for a minimum of two patient strengths within the first three days of admission?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) Documentation in the medical record includes a screening for a minimum of two patient strengths performed within the first three days of admission.

N (No) Documentation in the medical record does not include a screening for a minimum of two patient strengths OR the screening was not performed within the first three days of admission OR unable to determine from medical record documentation.

X (Unable to complete admission screening) Documentation in the medical record that a screening for a minimum of two patient strengths cannot be completed due to the patient’s inability or unwillingness to answer screening questions within the first three days of admission OR patient has a previous admission to the psychiatric unit during a single hospitalization.

Notes for Abstraction: A screening for patient strengths must be completed by a qualified psychiatric practitioner, e.g., psychiatrist, psychologist, registered nurse (RN), physician’s assistant (PA) or Master of Social Work (MSW) within the first three days of admission. The titles of qualified psychiatric practitioners may vary from state to state.

If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, select the first admission to the psychiatric unit.

The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The ay after admission is defined as the first day.
Suggested Data Sources:

- Biopsychosocial assessment
- Emergency department record
- Functional skills assessment
- History and physical
- Individual plan of service
- Initial assessment form
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form
- Referral packet
- School report
- Social worker assessment

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples of adult and older adult patient strengths may include but are not limited to:</td>
<td>• None</td>
</tr>
<tr>
<td>• Assessment of patient optimism that change can occur</td>
<td></td>
</tr>
<tr>
<td>• Motivation and readiness for change</td>
<td></td>
</tr>
<tr>
<td>• Setting and pursuing goals</td>
<td></td>
</tr>
<tr>
<td>• Attempting to realize one’s potential</td>
<td></td>
</tr>
<tr>
<td>• Managing surrounding demands and opportunities</td>
<td></td>
</tr>
<tr>
<td>• Exercising self-direction</td>
<td></td>
</tr>
<tr>
<td>• Vocational interests, i.e., hobbies</td>
<td></td>
</tr>
<tr>
<td>• Interpersonal relationships and supports, i.e., family, friends, peers</td>
<td></td>
</tr>
<tr>
<td>• Cultural/spiritual/religious and community involvement</td>
<td></td>
</tr>
<tr>
<td>• Access to housing/residential stability</td>
<td></td>
</tr>
<tr>
<td>• Steady employment</td>
<td></td>
</tr>
<tr>
<td>• Financial stability</td>
<td></td>
</tr>
<tr>
<td>• Awareness of substance use issues</td>
<td></td>
</tr>
<tr>
<td>• Knowledge of medications</td>
<td></td>
</tr>
</tbody>
</table>

Examples of children and adolescent patient strengths may include but are not limited to:

- Stable and supportive family
- Presence of friends
- School engagement
- Parent involvement in school
- Favorable relationships with teachers
- Assessment of self-esteem, motivation
<table>
<thead>
<tr>
<th>and achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Refrain from alcohol, drugs, sexual activity</td>
</tr>
<tr>
<td>• Engagement in hobbies, sports, arts and clubs</td>
</tr>
</tbody>
</table>
Data Element Name: Payment Source

Collected For: All Records, Optional for HBIPS-2 and HBIPS-3

Definition: The source of payment for this episode of care.

Suggested Data Collection Question: What is the patient's source of payment for this episode of care?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
1 Source of payment is Medicare.
2 Source of payment is NonMedicare.

Notes for Abstraction:
• If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list or payers, select "1".
• If the patient has Medicaid only or Medicaid and another insurance type, other than Medicare, select "2". If the patient has Medicaid and Medicare, select "1".
• If the patient is an Undocumented Alien or Illegal immigrant select "1". Undocumented Alien: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled into a United States port of entry and Mexican citizens permitted to enter the United States on a laser visa.

Suggested Data Sources:
• Face sheet
• UB-04, Field Location: 50A, B or C

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare includes, but is not limited to:</td>
<td>• None</td>
</tr>
<tr>
<td>• Medicare Fee for Service (includes DRG or PPS)</td>
<td></td>
</tr>
<tr>
<td>• Black Lung</td>
<td></td>
</tr>
<tr>
<td>• End Stage Renal Disease (ESRD)</td>
<td></td>
</tr>
<tr>
<td>• Railroad Retirement Board (RRB)</td>
<td></td>
</tr>
<tr>
<td>Medicare Secondary Payer</td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td></td>
</tr>
<tr>
<td>Medicare HMO/Medicare Advantage</td>
<td></td>
</tr>
<tr>
<td>Data Element Name:</td>
<td>Point of Origin for Admission or Visit</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Collected For:</td>
<td>All Records, Optional for HBIPS-2, HBIPS-3; Used in algorithm for PC-04, PC-05</td>
</tr>
<tr>
<td>Definition:</td>
<td>A code indicating the point of patient origin for this admission.</td>
</tr>
<tr>
<td>Suggested Data Collection Question:</td>
<td>What was the point of origin for this admission?</td>
</tr>
<tr>
<td>Format:</td>
<td>Length: 1, Type: Alphanumeric, Occurs: 1</td>
</tr>
</tbody>
</table>

**Allowable Values:**

1. **Non-Health Care Facility Point of Origin**
   - The patient was admitted to this facility upon order of a physician.
   - Usage Note: Includes patients coming from home, a physician’s office, or workplace

2. **Clinic**
   - The patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic.

3. **Reserved for assignment by the NUBC**
   - (Discontinued effective 10/1/2007.)

4. **Transfer From a Hospital (Different Facility)**
   - The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or outpatient.
   - Usage Note: Excludes Transfers from Hospital Inpatient in the Same Facility (See Code D).

5. **Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)**
   - The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.

6. **Transfer from another Health Care Facility**
   - The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list.

7. **Emergency Room**
   - The patient was admitted to this facility after receiving services in this facility’s emergency room. Usage Note: **Excludes** patients who came to the emergency room from another health care facility.

8. **Court/Law Enforcement**
The patient was admitted to this facility upon the direction of court of law, or upon the request of a law enforcement agency. **Usage Note:** Includes transfers from incarceration facilities.

9 Information not Available
The means by which the patient was admitted to this hospital is unknown.

A **Reserved for assignment by the NUBC** (Discontinued effective 10/1/2007.)

D **Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer**
The patient was admitted to this facility as a transfer from hospital inpatient within this hospital resulting in a separate claim to the payer. **Usage Note:** For purposes of this code, “Distinct Unit” is defined as a unique unit or level of care at the hospital requiring the issuance of a separate claim to the payer. Examples could be include observation services, psychiatric units, rehabilitation units, a unit in a critical access hospital, or a swing bed located in an acute hospital.

E **Transfer from Ambulatory Surgery Center**
The patient was admitted to this facility as a transfer from an ambulatory surgery center.

F **Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program**
The patient was admitted to this facility as a transfer from hospice.

**Code of Structure for Newborn (Used For PC-04 Only)**
1-4 Reserved for assignment by the NUBC. (Discontinued effective 10/1/2007)

5 Born Inside the Hospital
A baby born inside this Hospital

6 Born Outside this Hospital
A baby born outside this Hospital

**Note:** The Joint Commission is aware that there are additional UB-04 allowable values for this data element; however, they are not used for the national quality measure sets at this time.

**Notes for Abstraction:**
- The intent of this data element is to focus on patients' place or point of origin rather than the source of a physician order or referral.
- The point of origin is the **direct** source for the particular facility.

**Example 1:**
A SNF patient has chest pain is taken to the emergency department of Hospital A where it is determined that she is suffering an acute myocardial infarction. The patient is then transferred to Hospital B for admission as an inpatient. The Point of Origin for Hospital A would be 5 – Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF); the point of origin code for Hospital B would be 4 – Transfer from a Hospital.

Example 2:
An auto accident victim was taken to the emergency department of Hospital A by EMTs, stabilized, then transferred to Hospital B where he receives additional treatment in the ED, and then is admitted as an inpatient to Hospital B. The Point of Origin code for Hospital A is 7 - Emergency Room; the point of origin for Hospital B would be 4- Transfer from a Hospital.

- The emergency room code is limited to patients who receive unscheduled emergency services in the ER not originating from another health care facility. As in the auto accident example above, a victim brought to the ER would be coded as 7 since the patient was not previously at any other kind of health care facility. Code 7 also includes self-referrals in emergency situations that require immediate medical attention.

Usage Notes/Cases:

I. Transfers – From an Another Facility

**Overall Scenario** While at another acute care hospital/facility, the patient is seen by the emergency room physicians. The patient is then transferred to our facility through the emergency room.

- The Point of Origin code would be Code 4 – Transfer from a Hospital (Different Facility) due to the patient being seen at the other acute care facility’s emergency room.
- If the decision to admit was not made by the other facility’s emergency room personnel and instead was made by our facilities emergency doctor, the Point of Origin code would still be 4. Even though the decision to admit was not made by the other facility, the patient was still seen by the other facility’s emergency room personnel and a decision to transfer was made by them.
- The patient is seen by the other facility’s emergency room physician; the patient arrives at our emergency room, but receives no additional emergency room care at our facility. Instead, the patient is transferred immediately to the Heart Catheterization Department of our facility the Point of Origin code would still be 4. Since the patient is seen by a different hospital’s emergency room personnel, the decision to transfer the patient is first made by the other facility. The arrival of the patient at the receiving hospital’s emergency room and subsequent transfer to the Heart Catheterization Department is secondary to the transfer from the previous facility transfer.

II. Transfers – Skilled Nursing Facility

**Overall Scenario** A resident from a skilled nursing facility is taken to an
acute care hospital for medical care.

- The Point of Origin code would be Code 5 – Transfer from a Skilled Nursing Facility.
- The patient’s family stopped by to pick-up the patient for a routine doctor’s office visit (regularly scheduled); but while at the doctor’s office the doctor sends the patient to the emergency room from the acute care hospital. The Point of Origin code would be a 5 as the original Point of Origin is the skilled nursing facility. The subsequent visit to the doctor’s office (or even the emergency room of the hospital) is secondary to the events that took place earlier that day.

### III. Transfer by Law Enforcement or Court

**Overall Scenario** A patient arrives at the health care facility accompanied by police.

- The Point of Origin code would be Code 8 – Court/Law Enforcement as the patient is under the supervision of law enforcement.
- If the patient was simply transported by law enforcement to our facility, the patient is neither under arrest nor serving any jail time, then the Point of Origin code would be 7 – Emergency Room. Law enforcement is simply transporting the patient for emergency/urgent care treatment. The patient is not incarcerated (that is, neither under arrest nor serving any jail time).

#### Suggested Data Sources:

- Emergency department record
- History and physical
- Face sheet
- Progress notes
- Nursing admission notes
- UB-04, Field Location 15

#### Additional Notes:

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Psychiatric Care Setting

Collected For: All Records

Definition: 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.

Suggested Data Collection Question: Did the patient receive care in an inpatient psychiatric setting?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

- Y (Yes)  The patient received care in an inpatient psychiatric setting.
- N (No)   The patient did not receive care in an inpatient psychiatric setting.

Programming Note: The allowable value for Psychiatric Care Setting may be determined electronically using a source such as an Electronic Record (EHR/EMR) or hospital billing system. Hospitals must document the specific data source (field and application) that is used and make this information available to their vendor. This information must be made available to The Joint Commission upon request.

Notes for Abstraction:

Example 1 - Chemical Dependency Units that treat patients primarily for substance use disorders and occasionally psychiatric diagnoses are excluded from the BHIPS measures.

Example 2 - Psychiatric Units that treat dual diagnosis patient (patients with both substance use disorders and psychiatric diagnoses) are included in the BHIPS measures.

Suggested Data Sources:

- Emergency department record
- Face sheet
- Physician orders
- Discharge summary
- Registration form

Additional Notes:
Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• None</td>
<td>• Patients with a psychiatric diagnosis who received care in an inpatient unit other than a psychiatric unit within an acute-care hospital or a free-standing psychiatric hospital.</td>
</tr>
</tbody>
</table>
Data Element Name: *Psychiatric Inpatient Days - Medicare Only*

Collected For: HBIPS-2, HBIPS-3,

Definition: 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).

This data element is used to calculate the Initial Patient Population Size –Medicare Only data element and the denominator for HBIPS-2 and 3. ORYX vendors can refer to the Joint Commission’s ORYX Technical Implementation Guide for more information.

Suggested Data Collection Question: What is the sum of the number of days each Medicare patient was included in the psychiatric inpatient census during the month?

Format: Length: 6
Type: Numeric
Occurs: 5 (Overall rate and once per sub-strata)

Allowable Values: 0-999999

Programming Note: The value of the Initial Patient Population Size –Medicare Only may be determined electronically using a source such as an Electronic Record (EHR/EMR) or hospital billing system. Hospitals must document the specific data source (field and application) that is used and make this information available to their vendor. This information must be made available to The Joint Commission upon request.

Notes for Abstraction:
- For the purposes of calculating inpatient days, the admission day (*Admission Date*) but not the discharge day (*Discharge Date*) should be counted. The only exception will be for patients who are admitted and discharged on the same day. Such patients will contribute one inpatient day to the calculation.
- If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list of payers, the patient should be counted in the Medicare inpatient days.
- If the patient is an Undocumented Alien or Illegal immigrant, the patient should be counted in the Medicare inpatient days: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled a United States port of entry and Mexican citizens to enter the United States on a laser visa.
**Data Element Name:** Psychiatric Inpatient Days-Non-Medicare Only

**Collected For:** HBIPS-2, HBIPS-3,

**Definition:**
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).

This data element is used to calculate the Initial Patient Population Size – Non-Medicare Only data element and the denominator for HBIPS-2 and 3. ORYX vendors can refer to the Joint Commission’s ORYX Technical Implementation Guide for more information.

**Suggested Data Collection Question:**
What is the sum of the number of days each Non-Medicare patient was included in the psychiatric inpatient census during the month?

**Format:**
- **Length:** 6
- **Type:** Numeric
- **Occurs:** 5 (Overall rate and once per sub-strata)

**Allowable Values:**
0-999999

Programming Note: The value of the Initial Patient Population Size – Non-Medicare Only may be determined electronically using a source such as an Electronic Record (EHR/EMR) or hospital billing system. Hospitals must document the specific data source (field and application) that is used and make this information available to their vendor. This information must be made available to The Joint Commission upon request.

**Notes for Abstraction:**
- For the purposes of calculating inpatient days, the admission day (Admission Date) but not the discharge day (Discharge Date) should be counted. The only exception will be for patients who are admitted and discharged on the same day. Such patients will contribute one inpatient day to the calculation.
- If Medicare is **not** listed as the primary, secondary, tertiary, or even lower down on the list of payers, the patient should be counted in the Non-Medicare inpatient days.

**Suggested Data Sources:**
- Admissions/ discharges/transfers (ADT) system
- Daily census log that is completed on the same time each day

**Additional Notes:**
Discharges 04-01-10 (2Q10) through 09-30-10 (3Q10)
### Guidelines for Abstraction:

<table>
<thead>
<tr>
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<th>Exclusion</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>• Discharge date</td>
</tr>
</tbody>
</table>
Data Element Name: Psychological Trauma History

Collected For: HBIPS-1,

Definition: Documentation in the medical record that an admission screening for a psychological trauma history was performed within the first three days of admission.

Suggested Data Collection Question: Is there documentation in the medical record that the patient was screened for a psychological trauma history performed within the first three days of admission?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
Y (Yes) Documentation in the medical record includes a screening for a psychological trauma history performed within the first three days of admission.

N (No) Documentation in the medical record does not include a screening for a psychological trauma history OR the screening was not performed within the first three days of admission OR unable to determine from medical record documentation.

X (Unable to complete admission screening) Documentation in the medical record that a screening for a psychological trauma history can not be completed due to the patient’s inability or unwillingness to answer screening questions within the first thee days of admission OR patient has a previous admission to the psychiatric unit during a single hospitalization.

Notes for Abstraction:
A screening for a psychological trauma history must be completed by a qualified psychiatric practitioner e.g., psychiatrist, registered nurse (RN), physician’s assistant (PA) or Master of Social Work (MSW) within the first three days of admission. The titles of qualified psychiatric practitioners may vary from state to state.

If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, select the first admission to the psychiatric unit.

Traumatic life experiences are defined as those that result in responses to life stressors characterized by significant fear, anxiety, panic, terror, dissociation, feelings of complete powerless or strong emotions that have long term effects on behaviors and coping skills¹.

¹American Psychiatric Association. (1994). Diagnostic and statistical manual
The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day.

**Suggested Data Sources:**
- Biopsychosocial assessment
- Emergency department record
- Functional skills assessment
- History and physical
- Individual plan of service
- Initial assessment form
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form
- Referral packet
- School report
- Social worker assessment

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Examples of psychological trauma may include but are not limited to:</td>
<td>None</td>
</tr>
<tr>
<td>• physical abuse</td>
<td></td>
</tr>
<tr>
<td>• sexual abuse</td>
<td></td>
</tr>
<tr>
<td>• emotional abuse</td>
<td></td>
</tr>
<tr>
<td>• Severe childhood neglect</td>
<td></td>
</tr>
<tr>
<td>• victimization, e.g., disasters, criminal activities, crime stigma, identity theft</td>
<td></td>
</tr>
<tr>
<td>• combat experiences</td>
<td></td>
</tr>
<tr>
<td>• witnessing others being harmed or victimized</td>
<td></td>
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<tr>
<td>• any significant injury or life-threatening disease</td>
<td></td>
</tr>
<tr>
<td>• significant psycho/social loss, e.g., bankruptcy, traumatic family loss</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Sample

Collected For: HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC PC PC, Transmission, Aggregate Data File, Hospital Clinical Data File, (Used in transmission of the Joint Commission’s aggregate data file and the Hospital Clinical Data file.)

Notes:

- Required for transmission of aggregate data to The Joint Commission. Refer to the ORYX Technical Implementation Guide for more information.

Definition: Indicates if the data being transmitted for a hospital has been sampled, or represent an entire population for the specified time period.

Suggested Data Collection Question: Does this case represent part of a sample?

Format:

<table>
<thead>
<tr>
<th>Length</th>
<th>Type</th>
<th>Occurs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alphanumeric</td>
<td>1</td>
</tr>
</tbody>
</table>

Allowable Values:

- **Y** (Yes) The data represents part of a sample.
- **N** (No) The data is not part of a sample; this indicates the hospital is performing 100 percent of the discharges eligible for this topic.

Notes for Abstraction:

When *Sampling Frequency* equals '3' (No, the hospital is not sampling) or '4' (N/A, submission of patient level data is not required), then abstract Sample as "No".

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>• None</td>
<td>• None</td>
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</table>
**Data Element**

**Name:** Sample Size – Medicare Only

**Collected For:** HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC PC, Transmission, Patient Population Data File, Used in transmission of the Hospital Initial Patient Population Data file.

**Note:**
For more information refer to the Population and Sampling Specifications section and Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

**Definition:** Indicates the number of episode of care (EOC) records identified for a hospital with Medicare listed as a payment source for a hospital to perform data abstraction on. This count is after the appropriate sampling methodology, if any, has been applied for the specific time period.

**Notes for discharge measures (eg. HBIPS-1, 4, PC-01):**

- If the hospital is sampling the discharge measures, then the Sample Size – Medicare Only will be less than the Initial Patient Population Size – Medicare Only for the set, stratum, or sub-population.
- If the hospital is not sampling the discharge measures, then the Sample Size – Medicare Only will equal the Initial Patient Population Size – Medicare Only for the set, stratum, or sub-population.

**Notes for HBIPS event measures (HBIPS-2 and 3):**

- Hospitals may not sample the HBIPS event measures. For these two measures, the Sample Size – Medicare Only equals the Initial Patient Population Size – Medicare Only for the set, stratum, or sub-population.

**Suggested Data Collection Question:** Not Applicable

**Format:**

- **Length:** 6
- **Type:** Numeric
- **Occurs:** Non-stratified Measure Sets:

One Sample Size – Medicare Only per hospital’s measure set (e.g., AMI, HF, PN, and STK).
Stratified Measure Sets:

One Sample Size – Medicare Only per measure set stratum or sub-population the hospital is participating in:
* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

Note:
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the CAC, VTE, and SCIP measure sets.

Allowable Values:
0 through 999,999

Notes for Abstraction:
For Discharge measures (eg. HBIPS-1,PC-01), when Sampling Frequency = 'N/A' because the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data, Sample Size – Medicare Only equals zero.

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

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</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
Data Element Name: Sample Size – Non-Medicare Only


Note:

- For more information, refer to the Population and Sampling Specifications section and Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

Definition: Indicates the number of episode of care (EOC) records identified for a hospital with Medicare NOT listed as a payment source for a hospital to perform data abstraction on. This count is after the appropriate sampling methodology, if any, has been applied for the specific time period.

Notes for discharge measures (eg HBIPS-1, 4, PC-01):

- If the hospital is sampling the HBIPS discharge measures, then the Sample Size – Non-Medicare Only will be less than the Initial Patient Population Size – Non-Medicare Only for the set, stratum, or sub-population.
- If the hospital is not sampling the discharge measures, then the Sample Size – Non-Medicare Only will equal the Initial Patient Population Size – Non-Medicare Only for the set, stratum, or sub-population.

Notes for HBIPS event measures (HBIPS-2 and 3):

- Hospitals may not sample the HBIPS event measures. For these two measures, the Sample Size – Non-Medicare Only equals the Initial Patient Population Size – Non-Medicare Only for the set, stratum, or sub-population.

Suggested Data Collection Question: Not Applicable

Format:

- Length: 6
- Type: Numeric
- Occurs: Non-stratified Measure Sets:
One Sample Size – Non Medicare Only per hospital's measure set (e.g., AMI, HF, PN, and STK).

Stratified Measure Sets:

One Sample Size – Non Medicare Only per measure set stratum or sub-population the hospital is participating in:
* The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
* The HBIPS measure set has four occurrences, one for each age stratum.

Note:
Refer to the appropriate version of the Specifications Manual for National Quality Inpatient Measures for the number of occurrences for the CAC, VTE, and SCIP measure sets.

Allowable Values: 0 through 999,999

Notes for Abstraction: For Discharge measures (e.g. HBIPS-1, 4, PC-01), when Sampling Frequency = 'N/A' because the hospital has five or fewer discharges (both Medicare and non-Medicare combined) in a quarter and has decided to not submit patient level data, Sample Size – Non-Medicare Only equals zero.

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

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<tbody>
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</table>
### Data Element Name: Sampling Frequency

### Collected For: HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, HBIPS, PC, PC, PC, PC, PC, PC, Transmission, Patient Population Data File, Used in transmission of the Hospital Initial Patient Population Data file.

### Note:
Refer to the Population and Sampling Specifications section and Hospital Initial Patient Population Data XML File Layout in the Transmission section of this manual.

### Definition:
Indicates if the data being transmitted for a hospital has been sampled (either monthly or quarterly), or represents an entire population for the specified time period.

### Suggested Data Collection Question:
Not Applicable

### Format:
- **Length:** 1
- **Type:** Character
- **Occurs:**
  - **Non-stratified Measure Sets:**
    - One Sample Size – Medicare Only per hospital's measure set (e.g., AMI, HF, PN, and STK).
  - **Stratified Measure Sets:**
    - One Sample Size – Medicare Only per measure set stratum or sub-population the hospital is participating in:
      * The PC measure set has three occurrences, one for the mother sub-population and two for the newborn sub-populations.
      * The HBIPS measure set has four occurrences, one for each age stratum.

### Allowable Values:
- 1 Yes, the hospital is sampling data monthly.
2 Yes, the hospital is sampling data quarterly.
3 No, the hospital is not sampling.
4 N/A, submission of patient level data is not required.

Notes for Abstraction:

- Sampling Frequency must be consistent across a discharge time period.
  Example:
  If the Sampling Frequency for April is monthly, then the Sampling
  Frequency for May and June must be monthly.

- For Discharge measures (e.g., HBIPS-1, 4, PC-01): Hospitals with five
  or fewer discharges (both Medicare and Non-Medicare combined) in a
  quarter are not required to submit patient level data.

- For Event measures (eg., HBIPS-2 and 3): This data element will
  always be equal to ‘3’ (No, the hospital is not sampling) for the HBIPS
  event measures (HBIPS-2 and 3).

Suggested Data Sources: Not Applicable

Additional Notes:

Guidelines for Abstraction:

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<tbody>
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<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Sex

Collected For: All Records

Definition: The patient's documented sex on arrival at the hospital.

Suggested Data Collection Question: What is the patient’s sex?

Format: Length: 1
Type: Character
Occurs: 1

Allowable Values:
- M = Male
- F = Female
- U = Unknown

Notes for Abstraction:
- Collect the documented patient’s sex at admission or the first documentation after arrival.
- Consider the sex to be unable to be determined and select “Unknown” if:
  - The patient refuses to provide their sex.
  - Documentation is contradictory.
  - Documentation indicates the patient is a Transexual.
  - Documentation indicates the patient is a Hermaphrodite.

Suggested Data Sources:
- Consultation notes
- Emergency department record
- History and physical
- Face sheet
- Progress notes
- UB-04 Field Location: 11
- Nursing admission notes

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
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<th>Exclusion</th>
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<tbody>
<tr>
<td>None</td>
<td>None</td>
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</tbody>
</table>
Data Element Name: Substance Use

Collected For: HBIPS-1,

Definition: Documentation in the medical record that an admission screening for alcohol and substance use which occurred over the past twelve (12) months was performed within the first three days of admission.

Suggested Data Collection Question: Is there documentation in the medical record that the patient was screened for alcohol and substance use which occurred over the past twelve (12) months within the first three days of admission?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) Documentation in the medical record includes a screening for alcohol and substance use which occurred over the past twelve (12) months performed within the first three days of admission.

N (No) Documentation in the medical record does not include a screening for alcohol and substance use which occurred over the past twelve (12) months OR the screening was not performed within the first three days of admission OR unable to determine from medical record documentation.

X (Unable to complete admission screening) Documentation in the medical record that a screening for alcohol and substance use can not be completed due to the patient’s inability or unwillingness to answer assessment questions within the first three days of admission OR patient has a previous admission to the psychiatric unit during a single hospitalization.

Notes for Abstraction:
A screening for alcohol and substance use must be completed by a qualified psychiatric practitioner e.g., psychiatrist, registered nurse (RN), physician’s assistant (PA) or Master of Social Work (MSW) within the first three days of admission. Titles of qualified psychiatric practitioners vary from state to state.

If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, select the first admission to the psychiatric unit.

The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day.

Substance use is defined as the use of psychoactive or mood altering...
substances, i.e., prescription medications, over the counter medications, inhalants, organic substances, illegal substances and street drugs.

**Suggested Data Sources:**
- Biopsychosocial assessment
- Emergency department record
- Functional skills assessment
- History and physical
- Individual plan of service
- Initial assessment form
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form
- Referral packet
- School report
- Social worker assessment

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
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<th>Exclusion</th>
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</thead>
<tbody>
<tr>
<td>• None</td>
<td>• None</td>
</tr>
</tbody>
</table>
**Data Element Name:** Total Leave Days - Medicare Only

**Collected For:** HBIPS-2, HBIPS-3,

**Definition:** Total leave days-Medicare only is the aggregate number of leave days for Medicare patients during the month. A leave day-Medicare only is defined as an authorized or unauthorized absence of a Medicare 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.

This data element is used to calculate the Initial Patient Population Size –Medicare Only data element and the denominator for HBIPS-2 and 3. ORYX vendors can refer to the Joint Commission’s ORYX Technical Implementation Guide for more information.

**Suggested Data Collection Question:** What is the sum of the number of days each Medicare patient was absent from the facility?

**Format:**
- **Length:** 6
- **Type:** Numeric
- **Occurs:** 5 (Overall rate and once per sub-strata)

**Allowable Values:** 0-999999

Programming Note: The value of the Total Leave Days-Medicare Only may be determined electronically using a source such as an Electronic Record (EHR/EMR) or hospital billing system. Hospitals must document the specific data source (field and application) that is used and make this information available to their vendor. This information must be made available to The Joint Commission upon request.

**Notes for Abstraction:**
- If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list of payers, the patient should be counted in the Medicare inpatient days.
- If the patient is an Undocumented Alien or Illegal immigrant, the patient should be counted in the Medicare inpatient days: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled a United States port of entry and Mexican citizens to enter the United States on a laser visa.
Data Element Name: Total Leave Days-Non-Medicare Only

Collected For: HBIPS-2, HBIPS-3,

Definition: Total leave days-Non-Medicare only is the aggregate number of leave days for Non-Medicare patients during the month. A leave day-Non-Medicare only is defined as an authorized or unauthorized absence of a Non-Medicare 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.

This data element is used to calculate the the Initial Patient Population Size – Non-Medicare Only data element and denominator for HBIPS-2 and 3. ORYX vendors can refer to the Joint Commission’s ORYX Technical Implementation Guide for more information.

Suggested Data Collection Question: What is the sum of the number of days each Non-Medicare patient was absent from the facility?

Format:

- **Length:** 6
- **Type:** Numeric
- **Occurs:** 5 (Overall rate and once per sub-strata)

Allowable Values: 0-999999

Programming Note: The value of the Total Leave Days-Non-Medicare Only may be determined electronically using a source such as an Electronic Record (EHR/EMR) or hospital billing system. Hospitals must document the specific data source (field and application) that is used and make this information available to their vendor. This information must be made available to The Joint Commission upon request.

Notes for Abstraction: If Medicare is not listed as the primary, secondary, tertiary, or even lower down on the list of payers, the patient should be counted in the Non-Medicare total leave days.

Suggested Data Sources:
- Nursing notes
- Progress notes

Additional Notes: Guidelines for Abstraction:
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### Data Element Name:

Vendor Tracking Identifier

### Collected For:

HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS HBIPS, PC PC PC PC PC PC, Transmission, Hospital Clinical Data File

### Definition:

An ORYX Vendor®-generated identifier that uniquely identifies this patient’s stay or episode of care. It is a fictitious identifier generated by the ORYX Vendor to differentiate between individual patient records across hospitals.

This identifier cannot be derived from or related to information about the patient in such a way that it is possible to identify the patient via a review or manipulation of the data.

Since this identifier is transmitted to The Joint Commission, ORYX Vendors must be able to link this tracking identifier to the original record (patient and hospital) in the event that data quality issues arise. Any data that require correction and re-transmission must use the same tracking identifier as that used in the original transmission or a duplication of data within the Joint Commission’s database will occur.

This identifier is linked to a patient’s episode of care, not to a specific event that occurs during the episode of care. The Vendor Tracking ID must be the same each time data for a unique patient’s episode of care is transmitted; regardless of whether this is the second or thirty-second record being transmitted for the patient.

### Suggested Data Collection Question:

Not applicable, this data element is not data entered.

### Format:

- **Length:** 100
- **Type:** Character
- **Occurs:** 1

### Allowable Values:

The identifier cannot be a space (blank) or be the patient’s social security number, Medicare number, driver license number, medical record number, account number, or other identifier assigned to the patient for purposes other than transmission of data to The Joint Commission. In addition, this identifier cannot be a combination of data in which one portion of the data directly identifies the patient or the combination of data identifies the patient.
Notes for Abstraction: None

Suggested Data Sources: Unique ORYX Vendor generated identifier

NOTE TO PROGRAMMERS:

- An ORYX Vendor may have its own case identifier. We are not requesting that ORYX Vendors change their internal processes; rather, this tracking identifier is needed for transmission of the hospital clinical data to The Joint Commission.
- Since The Joint Commission is not receiving the Health Care Organization Identifier in the hospital clinical data, this tracking identifier identifies both the patient and the hospital. A tracking identifier cannot be reused for multiple hospitals.

Additional Notes:

Guidelines for Abstraction:

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Data Element Name: Violence Risk to Others

Collected For: HBIPS-1,

Definition: 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.

Suggested Data Collection Question: Is there documentation in the medical record that the patient was screened for violence risk to others over the past six months was performed within the first three days of admission?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
Y (Yes) Documentation in the medical record includes a screening for violence risk to others over the past six months performed within the first three days of admission.

N (No) Documentation in the medical record does not include a screening for violence risk to others over the past six months OR the screening was not performed within the first three days of admission OR unable to determine from medical record documentation.

X (Unable to complete admission screening) Documentation in the medical record that a screening for violence risk to others over the past six months can not be completed due to the patient’s inability or unwillingness to answer assessment questions within the first three days of admission OR patient has a previous admission the psychiatric unit during a single hospitalization.

Notes for Abstraction:
A screening for violence risk to others must be completed by a qualified psychiatric practitioner e.g., psychiatrist, registered nurse (RN), physician’s assistant (PA) or Master of Social Work (MSW) within the first three days of admission. Titles of qualified psychiatric practitioners vary from state to state.

If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, select the first admission to the psychiatric unit.

The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day.

Some examples of violence risk to others include but are not limited to the following: thoughts of harm to others, intentional infliction of harm on
someone else by the patient, homicidal thoughts by the patient and thoughts of harming someone else by the patient.

Suggested Data Sources:
- Biopsychosocial assessment
- Emergency department record
- Functional skills assessment
- History and physical
- Individual plan of service
- Initial assessment form
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form
- Referral packet
- School report
- Social worker assessment

Additional Notes:

Guidelines for Abstraction:

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**Data Element Name:** Violence Risk to Self

**Collected For:** HBIPS-1

**Definition:** 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.

**Suggested Data Collection Question:** Is there documentation in the medical record that the patient was screened for violence risk to self over the past six months within the first three days of admission?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- **Y** (Yes) documentation in the medical record includes a screening for violence risk to self over the past six months was performed within the first three days of admission.
- **N** (No) documentation in the medical record does not include a screening for risk to self over the past six months OR the screening was not performed within the first three days of admission OR unable to determine from medical record documentation.
- **X** (Unable to complete admission screening) documentation in the medical record that a screening for risk of violence to self over the past six months can not be completed due to the patient’s inability or unwillingness to answer assessment questions within the first three days of admission OR patient has a previous admission to the psychiatric unit during a single hospitalization.

**Notes for Abstraction:**
A screening for risk of violence to self and others must be completed by a qualified psychiatric practitioner e.g., psychiatrist, registered nurse (RN), physician’s assistant (PA) or Master of Social Work (MSW) within the first three days of admission. Titles of qualified psychiatric practitioners vary from state to state.

If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, select the first admission to the psychiatric unit.

The admission screening must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day.

Some examples of harm to self include but are not limited to: past suicide attempts by the patient, intentional cutting, burning, bruising or damaging...
of self by the patient, inappropriate substance use, suicidal thoughts in the past six months by the patient, specific suicidal plan in the past six months by the patient and past suicide attempts by anyone in patient's family.

**Suggested Data Sources:**
- Biopsychosocial assessment
- Emergency department record
- Functional skills assessment
- History and physical
- Individual plan of service
- Initial assessment form
- Nursing notes
- Physician progress notes
- Psychiatrist assessment/admission form
- Referral packet
- School report
- Social worker assessment

**Additional Notes:**

**Guidelines for Abstraction:**

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