

**Washington State**  
**Safety Net Assessment: Quality Incentive Measure Guidelines**  
**December 23, 2010** (Updated 02/17/11)

This document provides the measure guidelines for the Hospital Safety Net Assessment Quality Incentive. The measures, clinical rationale, data definitions, data reporting process, and time lines are included.

In selecting the measures, clinical experts from across the state for each topic were used to identify potential measures which are evidence based and significant for Medicaid patients. Final selection was done by the Medicaid Purchasing Administration in collaboration with the Health Care Authority, Washington State Department of Health, the Washington State Hospital Association, the Puget Sound Health Alliance, and the Forum. Where possible, the definitions from national organizations were used. For measures where data was available for prior years, hospital data were arrayed in quartiles based on prior performance in order to set performance thresholds for the upcoming year.

Hospitals wishing to earn the quality incentive will report on measures for their inpatient units. The data reported by hospitals for the quality incentive will be available upon request from the state. For questions regarding definitions or data collection contact from the Health Care Authority staff Jeff Thompson at [ThompJ@dshs.wa.gov](mailto:ThompJ@dshs.wa.gov) or 360-725-1630 or Washington State Hospital Association staff Ken Rudberg at [kenr@wsha.org](mailto:kenr@wsha.org) or (206) 577-1851.

**For acute care, rehabilitation, and pediatric services:**

Reduce Hospital Acquired Infections

- Healthcare Worker Influenza Immunization (pg. 2)

Safe Discharges (Reduce Rehospitalizations) (except Children's hospitals)

- Patient Discharge Information (pg. 5)

Safe Deliveries (hospitals with obstetrical programs only)

- Elective Delivery Prior to 39 Weeks (pg. 8)

Reducing Emergency Room Cost

- Reducing Preventable Emergency Room Visits (pg. 12)

**For behavioral health services:**

Reduce Hospital Acquired Infections

- Healthcare Worker Influenza Immunization (pg. 2)

Safe Medications

- Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (pg. 14)

## **Reduce Hospital Acquired Infections: Healthcare Worker Influenza Immunization**

### **Clinical Rationale**

The influenza virus is a contagious disease that kills 36,000 people each year. The virus spreads from person to person through respiratory droplets or from touching contaminated surfaces. The Centers for Disease Control and Prevention (CDC) states that the single best way to prevent the flu is to get a flu vaccine each season. Immunizing healthcare workers is a safe and effective method to prevent hospital acquired influenza infections and deaths among patients (Carman, Elder, Wallace, McAulay, Walker, Murray, et al., 2000).

The immunization rate of healthcare workers in the United States is 42 percent (Parekh, 2008). Of those healthcare workers who get the flu, over 70 percent continue to work with high-risk patients despite being ill. Up to 50 percent of people infected with the flu have no symptoms, yet can be infectious (Stott, Kerr, & Carman, 2002). Outbreaks in healthcare settings have caused deaths including newborn children in neonatal intensive care units (CDC, 1992; Cunney, Bialachowski, Thornley, Smaill, & Pennie, 2000).

National organizations are calling for healthcare workers to be immunized:

### **Society for HealthCare Epidemiology of America (SHEA)**

[http://www.shea-online.org/Assets/files/policy/083110\\_Vaccination\\_Release.pdf](http://www.shea-online.org/Assets/files/policy/083110_Vaccination_Release.pdf)

<http://www.journals.uchicago.edu/doi/pdf/10.1086/656558>

“This paper from October 10, 2010 states that influenza vaccination is the professional and ethical responsibility of healthcare professionals and that non-compliance with healthcare facility policies regarding vaccination should not be tolerated. It is endorsed by IDSA.”

“SHEA views influenza vaccination of Health Care Practitioner (HCP) as a core patient and HCP safety practice with which noncompliance should not be tolerated. It is the professional and ethical responsibility of HCP and the institutions within which they work to prevent the spread of infectious pathogens to their patients through evidence-based infection prevention practices, including influenza vaccination. Therefore, for the safety of both patients and HCP, SHEA endorses a policy in which annual influenza vaccination is a condition of both initial and continued HCP employment and/or professional privileges.”

### **Association for Professionals in Infection Control and Epidemiology (APIC)**

[http://www.apic.org/AM/Template.cfm?Section=Search&section=News\\_Release&template=/CM/ContentDisplay.cfm&ContentFileID=11932](http://www.apic.org/AM/Template.cfm?Section=Search&section=News_Release&template=/CM/ContentDisplay.cfm&ContentFileID=11932)

“Washington, DC, October 9, 2008 – In response to the low rates of influenza immunization among healthcare personnel, the Association for Professionals in Infection Control and Epidemiology (APIC) supports requiring flu immunization for healthcare workers who have direct patient contact as well as ancillary staff.”

### **American Academy of Pediatrics (AAP)**

<http://www.aap.org/advocacy/releases/sept-flu.htm>

“Mandatory influenza immunization for all health care personnel is "ethically justified, necessary and long overdue to ensure patient safety," according to the statement.”

## **Centers for Disease Control and Surveillance (CDC)**

<http://www.cdc.gov/flu/professionals/index.htm>

2010 recommendations have been updated to state that “routine influenza vaccination is recommended for all persons aged 6 months and older. Vaccination is the primary measure to prevent infection or development of illness from influenza, and thereby limit transmission of influenza and prevent complications from influenza.”

### **Definition – Modification of National Quality Forum (NQF)**

This definition includes all employed staff regardless of their job or the location where they work. Employed physicians, direct care providers, and indirect overhead departments are included in the definition of staff. This definition is consistent with the NQF except it excludes non-employed staff, vendors, contractual, and other non-hospital workers. These workers were excluded this first year as obtaining their status is difficult.

#### *Definition:*

*Numerator:* Number of employed healthcare workers (as defined above) hospital-wide who were vaccinated between June 1, 2010 through April 15, 2011 or reported having received influenza vaccination elsewhere.

- Employees are counted regardless of location.
- An employee verbally stating they got an immunization is not adequate to be counted.
- Starting January 1, 2011, in order to count an employee having influenza vaccination received elsewhere, authentication must come from a receipt, a practitioner note stating they gave the immunization to the employee, or an employee signature.

*Denominator:* Number of employed healthcare workers (as defined above) hospital-wide who were employed on April 1, 2011. (Note: This is not the number of FTEs).

In the event that the Washington State Health Officer determines that an FDA approved flu vaccine is not available in adequate supply in hospitals or in a form that can be readily used without allergy or other concern by January 1st, use of this measure will not be used that year for incentive payment.

This measure is calculated hospital-wide with acute care, pediatrics, behavioral health, and rehabilitation earning incentive points based on what the hospital as a whole achieves.

*Sampling:* None

### **Data Source – Washington State Hospital Association (WSHA)**

Data are to be reported annually.

#### *Fields to be reported:*

- Number of employed healthcare workers hospital-wide who were vaccinated (numerator)
- Number of employed healthcare workers (denominator)

*Data collection period:* June 1, 2010 – April 15, 2011

*Reporting deadline:* Reported once a year by May 1, 2011

*Data collection system:* Data will be submitted to WSHA

*Audits and validation:* Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

Healthcare Worker Influenza Immunization Award Table:

Threshold	0-60 percent	61-69 percent	70-79 percent	80 percent or more
Point Award	0	3	5	10

This measure is used in the quality incentive for acute care, pediatric, behavioral health hospitals, and rehabilitation hospitals or units. Points are awarded based on results of entire hospital.

## **Safe Discharges (Reduce Rehospitalizations): Patient Discharge Information**

### **Clinical Rationale**

Discharge information is necessary for patients to understand how to take care of themselves and coupled with good follow up can reduce rehospitalizations. Discharge from a hospital is a time of high risk because patients have often experienced significant changes in health status, little energy, and commonly have difficulty remembering. The Institute for Healthcare Improvement recommends that strategies such as setting an early discharge date, coordinated discharge education, and teach back are important to ensure patients have adequate patient discharge information to prevent costly readmissions.

A meta-analysis of randomized controlled trials (RCTs) evaluated the effect on heart failure patients. Specific patient education coupled with post-discharge follow-up assessment found a 21% reduction in the relative risk of rehospitalization (pooled RR 0.79; 95% CI 0.68-0.91;  $p < 0.001$ ) over 3 to 12 months of follow up (Gwadry-Sridha et al. Archives of Internal Medicine. 2004;164(21):2315-2320) Jovicic A, Holroyd-Leduc JM, Straus SE. Effects of self-management intervention on health outcomes of 34. A systematic review of RCTs examining self-management interventions in which patients retain the primary role of self-monitoring and determining when medical attention is needed was associated with a reduced risk of rehospitalization for heart failure by 56% (OR 0.44; 95% CI 0.27-0.71), reduced all-cause rehospitalization by 41% (OR 0.59; 95% CI 0.44-0.8;  $p = 0.001$ ), and lower per patient costs (Jovicic, et al., BMC Cardiovascular Disorders. 2006;6:43. 36).

### **Definition (Provided Discharge Information): Modification of CMS - HCHAPS**

Patients are surveyed following discharge about the discharge instructions they were given. Patients report whether hospital staff discussed the help they would need at home. Patients also report whether they were given written information about symptoms or health problems to watch for during their recovery.

This data are gathered as the percent of patients at each hospital who respond “yes”, to these two questions. CMS then adjusts scores for mode of survey administration (e.g., mail, phone). Responses in telephone surveys tend to be higher compared to by mail. The data are also adjusted for patient mix. The resulting percentages are then averaged to create a “Provided Discharge Instructions” composite score for the hospital.

Data for the quality incentive will use information from all payors and use the same calculations except the adjustment for patient mix. If feasible, these adjustments will be made using the CMS adjustments published by October 1, 2010. This measure uses results calculated hospital-wide with rehabilitation unit receiving “credit” based on what the hospital as a whole achieved.

The most up to date measure definition from CMS for the data collection period will be used in calculations. Data will include information from applicable patients regardless of payor.

Definition:

*Numerator:* Patients who responded YES to the following HCAHPS questions:

Q19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?

Q20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

*Denominator:* Patients who answered HCAHPS questions 19 and 20.

Population included in the sample:

- 18 years or older at the time of admission
- At least one overnight stay in the hospital as an in-patient
- Non-psychiatric MS-DRG/principal diagnosis at discharge
- Alive at the time of discharge

Populations excluded from the sample:

- Patients discharged to hospice care
- Court/Law enforcement patients (i.e. prisoners)
- Patients with a foreign home address (excluding U.S. territories—Virgin Islands, Puerto Rico, and Northern Mariana Islands)
- “No-Publicity” patients - patients who request that they not be contacted
- Patients who are excluded because of rules or regulations of the state in which the hospital is located

*Sampling:* Patients must be randomly selected for the survey based on a monthly sample. Each hospital must have 300 completes within the given year. Sampling should be performed based on the HCAHPS Quality Assurance Guidelines found at: <http://bit.ly/cK10Hm>

**Data Source: Washington State Hospital Association**

Data are to be submitted to WSHA by the hospital or the hospital’s HCAHPS vendor. Data will be collected quarterly.

*Fields to be reported:*

- Response to HCAHPS Q19
- Response to HCAHPS Q20
- Education score
- Self-health rating score
- ER admissions
- Response percentile
- Age
- Non-English primary language
- Service line

*Data collection period:* January 1, 2011 – September 30, 2011

*Reporting deadline:* 90 days following the end of a quarter and final data in by January 1, 2012

*Data collection system:* Data sent directly to WSHA from hospital and/or hospital’s HCAHPS vendor

*Audits and validation:* Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

Patient Discharge Instructions Award Table:

Threshold	0-81 percent or less	82-83 percent	84-85 percent	86 percent or more
Point Award	0	3	5	10

This measure is used in the quality incentive for acute care and rehabilitation hospitals or units. Points are awarded based on results of entire hospital.

## Safe Deliveries: Elective Delivery Prior to 39 Weeks

### Clinical Rationale

For almost three decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have had in place a standard requiring 39 completed weeks gestation prior to *elective* delivery, either vaginal or operative (ACOG, 1996). A survey conducted in 2007 of almost 20,000 births in HCA hospitals throughout the U.S. carried out in conjunction with the March of Dimes at the request of ACOG revealed that almost 1/3 of all babies delivered in the United States are electively delivered with 5% of all deliveries in the U.S. delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13- 21%) (Clark et al., 2009).

According to Glantz (2005), compared to spontaneous labor, elective inductions result in more cesarean deliveries and longer maternal length of stay. The American Academy of Family Physicians (2000) also notes that elective induction doubles the cesarean delivery rate. Repeat elective cesarean sections before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis and hypoglycemia for the newborns (Tita et al., 2009). In Washington, the rate of elective delivery prior to 39 weeks was 17.8 percent in 2008.

The focus on elective deliveries prior to 39 weeks is the first step in an effort to reduce the rate of C-sections in Washington State. Next year's goal will focus more directly on C-sections after more discussion with key groups on goal setting and measures.

### Selected references:

- American Academy of Family Physicians. (2000). Tips from Other Journals: Elective induction doubles cesarean delivery rate, 61, 4. Retrieved December 29, 2008 at: <http://www.aafp.org/afp/20000215/tips/39.html>.
- American College of Obstetricians and Gynecologists. (November 1996). ACOG Educational Bulletin.
- Clark, S., Miller, D., Belfort, M., Dildy, G., Frye, D., & Meyers, J. (2009). Neonatal and maternal outcomes associated with elective delivery. [Electronic Version]. *Am J Obstet Gynecol.* 200:156.e1-156.e4.
- Glantz, J. (Apr.2005). Elective induction vs. spontaneous labor associations and outcomes. [Electronic Version]. *J Reprod Med.* 50(4):235-40.
- Tita, A., Landon, M., Spong, C., Lai, Y., Leveno, K., Varner, M, et al. (2009). Timing of elective repeat cesarean delivery at term and neonatal outcomes. [Electronic Version]. *NEJM.* 360:2, 111-120.

### **Definition – Modification of The Joint Commission Definition**

This measure is defined by The Joint Commission under PC-01. The complete definition can be found at <http://manual.jointcommission.org/releases/TJC2010B/MIF0166.html>. The most up to date definition from The Joint Commission for the data collection period will be used in calculations. Data will include information from applicable patients regardless of payor. This definition is consistent with the National Quality Forum and Leapfrog.

The modifications for the quality incentive is in the sampling. An additional sampling methodology which allows for all cases of induction patients 37 to 39 weeks is allowed.

Definition:

Numerator: Patients with elective deliveries

Included Populations: ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for one or more of the following:

- Medical induction of labor as defined by ICD-9-CM Codes:
  - 73.01 Induction of labor by artificial rupture of membranes
  - 73.1 Other surgical induction of labor
  - 73.4 Medical induction of labor
- Cesarean section as defined by the following ICD-9-CM codes while not in Active Labor<sup>1</sup> or experiencing Spontaneous Rupture of Membranes<sup>2</sup>:
  - 74.0 Classical cesarean section
  - 74.1 Low cervical cesarean section
  - 74.2 Extraperitoneal cesarean section
  - 74.4 Cesarean section of other specified type
  - 74.99 Other cesarean section of unspecified type

*Denominator:* Patients delivering newborns with  $\geq 37$  and  $< 39$  weeks of gestation completed.

Excluded Populations:

- ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for conditions justifying elective delivery as defined in The Joint Commission Appendix A, Table 11.07
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay  $> 120$  days
- Enrolled in clinical trials

<sup>1</sup> Active Labor: Documentation that the patient was in active labor with regular uterine contractions with cervical change before medical induction and/or cesarean section.

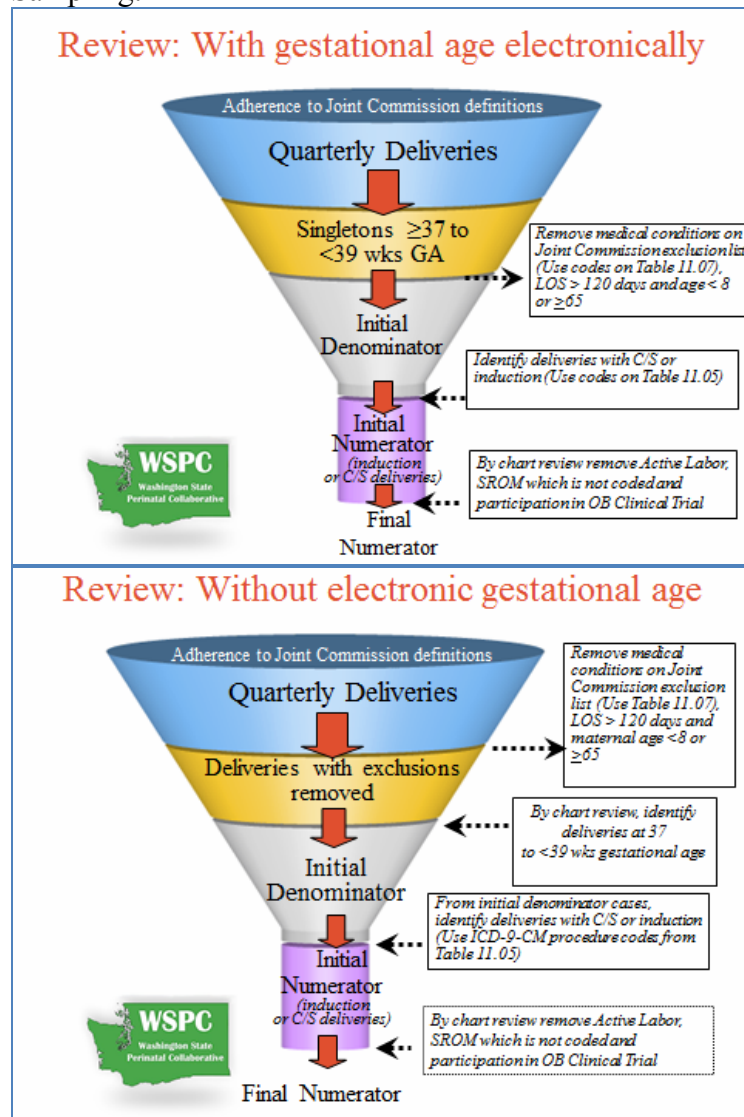
<sup>2</sup> Spontaneous Rupture of Membrane: Documentation that the patient had spontaneous rupture of membranes (SRM) before medical induction and/or cesarean section.

*Data Accuracy:* Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

*Sampling:* As defined by The Joint Commission  
<http://manual.jointcommission.org/releases/TJC2010B/SamplingChapterTJC.html>

Hospitals are encouraged to consider sampling using the following methodology. This methodology was created as it is simpler for hospitals to follow and will result in more cases reviewed supporting learning.

*Sampling:*



**Data Source - Washington State Hospital Association**

Data are to be submitted to WSHA by the hospital or vendor. Data will be collected quarterly.

*Fields to be reported:*

- Patients with elective deliveries

- Patients delivering newborns with  $\geq 37$  and  $< 39$  weeks of gestation completed

*Data collection period:* January 1, 2011 – September 30, 2011

*Reporting deadline:* 90 days following the end of a quarter and final data in by January 1, 2012

*Data collection system:* Data submitted to the Washington State Hospital Association Quality Benchmarking System

*Audits and validation:* Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

Elective Delivery Between 37 and 39 Weeks Award Table:

Threshold	31 percent or more	30 - 18 percent	17 - 8 percent	7 percent or less
Point Award	0	3	5	10

This measure is used in the quality incentive for acute care hospitals with maternity units.

## **Reducing Preventable Emergency Room Visits**

### **Clinical Rationale**

High emergency room (ER) utilization is a considerable concern for the increasing cost of health care. Frequent and inappropriate use of hospital ERs is extremely costly and care could be provided in a less expensive setting. Patients, when possible, should be treated by their primary care provider for non-emergency conditions in order to promote consistent, quality care.

### **Plan Development Expectations**

For the first year, the hospital will have a written plan to reduce preventable ER visits of Medicaid managed care clients. This plan will be approved and scored by Medicaid Purchasing Administration. The plan will have 5 sections; each section will be approved or not approved. Three points will be awarded for 3 sections approved; 5 points for 4 sections approved; 10 points for all 5 sections approved.

Final plan must be emailed to the designated Medicaid Purchasing Administration staff by September 1, 2011. Hospitals may turn plans in early to have their plan scored, and may resubmit a strengthened plan if needed to maximize points earned, no later than September 1, 2011.

#### **Section 1: Community Partnerships**

1. Documentation that infrastructure is in place which includes relevant community partners.
  - a. Hospital Name
  - b. Address(es) of Emergency Department(s), both on and off campus
  - c. Primary Contact (name, position and contact information) responsible for supervising the execution of the plan at the hospital.
  - d. Names and positions of hospitals and community partners in workgroup.
    - i. Include names and positions of hospital staff responsible for executing the plan at the hospital.
    - ii. Names and positions of community partners (Medicaid managed care plans participating in the county/adjacent county; community clinics; local health jurisdictions; major primary care providers) who have participated in generating the plan and those who are part of the plan (primary care referral sites, for example).
  - e. Minutes of workgroup meetings with future meeting dates. Workgroup with relevant community partners must have met at least once prior to plan approval.

#### **Section 2: Data Reporting**

- A. Evidence of collection and analysis of data upon which to create an informed plan.
  1. Data report which identifies preventable ER visits using standard methodology such as MediCal groupings, New York University groupings, or own version. Report should identify visits for Medicaid managed care clients by Healthy Options plan, at a minimum.
  2. Identification of the top five reasons for potentially avoidable ER visits.

### Section 3: Strategic Plan for Prevention of Visits

#### A. Creation of strategies to prevent patients from needless visits to the ER

1. Develop at least two strategies with community partners to help patients learn in advance of arriving in the ER how to access care in less expensive location. Must include full work plan description, who, what, where, when, how.
  - i. Examples could include community education programs, brochures in the physician offices, extended hours of primary care clinic, triage of patients.
2. Refrain from explicitly soliciting primary care visits to the hospital's ER in marketing materials such as billboards, radio, scripts, etc.

### Section 4: ER Visit Follow-up

#### A. Create strategies addressing patients who have arrived in the Emergency Department

1. Develop a minimum of two strategies with community partners addressing patients who have arrived in the Emergency Department but could be seen in less expensive location. Must include full work plan description, who, what, where, when, how.
  - i. Potential strategies could include education materials in the Emergency Department, phones to call primary care physician for appointment, managed care staff to educate patients, primary care clinic referrals.
- B. Describe method of identifying patients and notifying managed care organizations or their designated primary care clinics of the client's use of the ER in a timely way, either in-place or in process of implementation.

### Section 5: Participation in Continuing Education

- A. Evidence of at least one hospital team member attending educational programs by the state, such as web conference for CEOs, ER Directors and key administrators or an in-person meeting on best practices.

Reducing Preventable Emergency Room Visits Award Table:

Threshold	2 sections or less approved	3 sections approved	4 sections approved	5 sections approved
Point Award	0	3	5	10

This measure is used in the quality incentive for acute care hospitals with emergency departments.

## **Prudent Medication Prescription: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification**

### **Clinical Rationale**

Studies have shown that as many as 50 percent of inpatients treated with antipsychotic medication concurrently receive two or more antipsychotics (Stahl & Grady, 2004). This is significant because the use of multiple antipsychotic drugs has been linked to greater side effects often without improving clinical outcomes. This has led to multiple parties, including the National Association of State Mental Health Program Directors (2001), to call for reductions in the use of multiple antipsychotic medications unless absolutely necessary. The American Psychiatric Association Practice Guidelines (2004) urges the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate. It is important to document these failed trials of single antipsychotic therapy as evidence of justification for increased medication. Justification shows a facility's commitment to adherence to the APA's Practice Guidelines.

Selected references:

- American Psychiatric Association (APA). (2004). Steering Committee on Practice Guidelines. Practice guideline for the treatment of patients with schizophrenia, second edition. *Am J Psychiatry*. 161(2 Suppl):1-56.
- Centorrino, F., Gören, J.L., Hennen, J., Salvatore, P., Kelleher, J.P., & Baldessarini, R.J. (2004) Multiple versus single antipsychotic agents for hospitalized psychiatric patients: a case control study of risk versus benefit. *Am J Psychiatry*. 161 (4):700-706.
- Jaffe, A.B. & Levine, J. (2003). Antipsychotic medication co-prescribing in a large state hospital system. *Pharmacoepidemiol Drug Saf*.12:41-48.
- National Association of State Mental Health Program Directors (NASMHPD). (2001). Technical report on psychiatric polypharmacy. Alexandria, VA.
- Stahl, S.M. & Grady, M.M. (2004). A critical review of atypical antipsychotic utilization: comparing monotherapy with polypharmacy augmentation. *Curr Med Chem*.11:313-327.
- Tranulis, C., Skalli, L., Lalonde, P., & Nicole, L. (2008). Benefits and risks of antipsychotic polypharmacy. An evidence based review of the literature. *Drug Saf*.31(1):7-20
- University HealthSystem Consortium. (2006). Mental health performance measures field brief. Oakbrook, IL.

### **Definition – The Joint Commission**

This measure is defined by The Joint Commission under HBIBPS-5 “overall rate”. The complete definition can be found at <http://manual.jointcommission.org/releases/TJC2010B/MIF0120.html>.

The most up to date definition from The Joint Commission for the data collection period will be used in calculations. Data will include information from applicable patients regardless of payor.

Definition:

*Numerator:* Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification<sup>1</sup>

*Denominator:* Psychiatric inpatients discharged on two or more routinely scheduled 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
- Patients with a length of stay  $\leq 3$  days

*Sampling:* As defined at:

<http://manual.jointcommission.org/releases/TJC2010B/SamplingChapterTJC.html>

<sup>1</sup> Appropriate Justification for Multiple Antipsychotic Medications: documentation in the medical record of appropriate justification for discharging the patient on two or more routine antipsychotic medications. Data elements include:

- The medical record contains documentation of a history of a minimum of three failed multiple trials of monotherapy.
- 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.
- The medical record contains documentation of augmentation of Clozapine.
- The medical record contains documentation of a justification other than those listed in above. (This is not considered appropriate justification by the Joint Commission).
- 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. (This is not considered appropriate justification by the Joint Commission).

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.

**Data Source - Washington State Hospital Association**

Data are to be submitted to WSHA by the hospital or vendor. Data will be collected quarterly.

*Fields to be reported:*

- *Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification (numerator)*
- *Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications (denominator)*

*Data collection period:* January 1, 2011 – September 30, 2011

*Reporting deadline:* 90 days following the end of a quarter and final data in by January 1, 2012

*Data collection system:* Washington State Hospital Association Quality Benchmarking System

*Audits and validation:* Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification Award Table:

Threshold	0-10 percent	11-20 percent	21-30 percent	31 percent or more
Point Award	0	3	5	10

This measure is used in the quality incentive for acute care hospitals with behavioral health units and behavioral health hospitals.