National Association of Psychiatric Health Systems

NAPHS special report: Performance Measurement

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PERFORMANCE MEASUREMENT PROGRESS

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Dr. Ghinassi is vice president, quality and performance improvement, Western Psychiatric Institute and Clinic/University of Pittsburgh Medical Center. The Joint Commission has also selected Dr. Ghinassi to serve as chair of the core measures project working to develop inpatient, hospital-based psychiatric core measures.

Dr. Ghinassi chaired the first meeting of the technical advisory panel on May 13, 2005.

In May it was my privilege to chair a meeting that marked a significant advance in the evolution of psychiatric service performance measures. The efforts put in motion at this meeting are likely to have significant long-term impact on our field. (See Kathleen McCann's comments in this issue for details.) The road that made it possible for me to serve this endeavor was one that illustrates both the value of personal involvement in NAPHS and the significant impact that our association has on the national stage. The fact that NAPHS is not only at the table—but also in a leadership role—as national core measures evolve is a testament to both the strategic vision of the organization and to the cumulative effect of day-to-day efforts and activities.

Core Measure Development Evolves from a History of NAPHS Member Involvement

As a faculty member and administrator who has spent much of my career helping my healthcare system address quality improvement, I was intrigued several years ago when NAPHS invited me to be part of a quality initiative that was just getting underway. The goal was to explore performance measurement across the membership. In 1998 with limited seed money from the federal government, the NAPHS committee brought together some of the most critical thinkers in the private sector to discuss this challenging issue. Our deliberations, under the leadership of then-committee Chair Peter Panzarino, M.D., gave voice to a very practical perspective that—to that point—had been absent from much of the theoretical debate. A stream of ideas was generated by people who understood the specific challenges of behavioral healthcare data collection. By surveying our members, we were able to get a sense of the measures in use, the variations in definitions, and the obstacles to advancement. NAPHS pilot-tested a select group of performance measures through our own Performance Measurement Initiative. The early work of the NAPHS committee provided a framework from which the association's Board was able to take a major step moving us to a productive next level.

Our Public-Private Partnership Built a Solid Foundation

It became clear that NAPHS would need to have partners to advocate for the behavioral healthcare providers' voice in the larger performance measurement arena. In October 2002 NAPHS signed a teaming agreement with the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI). The goal was to identify performance measures that could be useful across the behavioral health

continuum (in all settings and across all levels of care). In working to identify the principles shared in the public and private sectors, we very quickly discovered common ground—and the strong support of the boards of all three organizations. Just as NAPHS had been building a foundation from the private-sector perspective, NASMHPD and NRI had been doing the same in the public sector. We set out with the shared goals of:

- demonstrating national leadership from within the behavioral health field;
- moving toward standardization of measures, data specifications, and definitions;
- exploring the interface and interactions across and within care systems;
- focusing on improving the quality of care.

Our collaboration quickly generated enthusiasm and brought us practical experience in pilot-testing indicators—specifically, client injury, staff injury, readmission, seclusion, and restraint. Public-private collaboration became more than just an abstraction. We built a model for sharing our knowledge on performance measurement on a national level. Our initial pilot study (conducted between September 2003 and April 2004) included 22 volunteer facilities across both the public and private sectors. These facilities represent 3,329 staffed beds and contributed 16,850 unique admission records—a very solid starting point for analysis. The NRI served as the data-processing/technical assistance arm of the project.

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Representatives from the pilot test sites and our NAPHS Performance Measurement Committee debriefed in June 2004. There was a strong sense that this pilot project had already provided value both to the participants (in the form of tangible data that could be used to describe each facility's own performance) and also to the field. The pilot had helped to identify risk variables that could provide useful comparison groups. It also provided opportunities for networking across the public and private sectors—opening specific new dialogues across the states. There was clear willingness from the group to recruit other facilities to represent the diversity of clients served and to construct comparison groups. Participants suggested a phase 2 of the pilot with enhancements to the data-collection process. The goal was to increase our ability to address risk adjustment and stratification issues. Our public and private collaborators in the pilot project have continued to meet via conference calls to recommend new strategies. New data collection will include a look at residential stability and the prevalence of co-morbid conditions. Further investigation will be conducted with pilot sites to assess ease of data availability.

Practical Knowledge and Experience Have Informed JCAHO Core Measure Development

An intriguing offshoot of our longstanding public-private collaboration has been an ability to bring this experience to bear on the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) "core measure" development. When JCAHO announced in 2003 that it was planning to raise its non-core ORYX measure-reporting requirement from six to nine measures because no core measures existed for behavioral health, our public/private partnership (NASMHPD, NRI, Inc., and NAPHS) requested a meeting with JCAHO President Dennis O'Leary, M.D. This led to discussion of a potential partnership between JCAHO and our associations to jointly develop core performance measures for inpatient psychiatric services surveyed under the hospital accreditation standards. The American Psychiatric Association (APA) joined as a consulting partner on the initiative and has since been included in all discussions.

By April 2004, the Joint Commission was able to announce that it had joined with NAPHS, NASMPHD, and NRI to launch an initiative "to identify a set of standardized, core measures for hospital-based, inpatient psychiatric services." Our organizations, plus the APA, were designated as the steering committee for the project.

Since that time, the core measures project has been on a fast track toward implementation. Representatives from 24 diverse stakeholder organizations (including consumers, researchers, employers, providers, and other content experts) participated in a process to inform measure development and to help name a "technical advisory panel" charged with developing and recommending the initial measure set to the Joint Commission and its project partners. In April 2005, it was my privilege to accept an appointment as chair of the technical advisory panel. Our first meeting in May 2005 began a process that we expect will lead to preliminary measures for field review as soon as the fall.

NAPHS Provides Critical Leadership

At each step of this project, I have been impressed by a number of things.

NAPHS uses limited resources to maximum value to members. The deliberations of the NAPHS leadership have been thoughtful and focused—assessing how our association could be strategically helpful to members as performance measures loomed larger in policy debates.

NAPHS is committed to leadership. Early on, NAPHS committed to working on performance measurement (a resource-intensive undertaking)—even without outside funding. Data will drive many decisions in the future (whether core performance measures or pay-for-performance arrangements), and NAPHS is thinking ahead to help members prepare. Providers must be at the table, or measures and policies will be developed without the benefit of our perspective. Within the next 18 months, providers are likely to step up their investment in information technology. Whether we are making good investments will depend in large part on anticipating —and helping to shape—what will be required.

Reputation, follow-through, and vision all play a part in building—and maintaining—our reputation as a national leader. The experience of the NAPHS staff in building coalitions with a wide variety of potential partners and in working directly with JCAHO has been critical to the work on performance measures to date.

We have much to learn from each other. Associations are only as strong as the willingness of their members to get involved. Participating in NAPHS activities is an extraordinary opportunity to learn…and to give back to the field. Those of us who have participated in the various pilot tests for performance measurement have shared more than just the raw data. We've each had an opportunity to learn from each other, to advance our thinking on trends that will impact our facilities, and to help shape the direction that such efforts will take.

We look forward to keeping you informed on the core measures project and in using NAPHS membership to keep behavioral healthcare provider concerns on the national agenda.

CORE MEASURES IN CONTEXT

By Kathleen McCann, R.N., D.N.Sc., NAPHS Director of Clinical Services

Dr. McCann is the NAPHS director of clinical services. She is a liaison member of the Hospital and Behavioral Health Care Professional and Technical Advisory Committees of the Joint Commission on Accreditation of Healthcare Organizations. She is also a recipient of the American Psychiatric Nurses Association Excellence in Leadership Award.

Building Core Measures

Core measures are a new concept for behavioral healthcare providers. As the Joint Commission and the technical advisory panel move forward to develop core measures for hospital-based, inpatient psychiatric services (see details in Dr. Ghinassi's report above), it's instructive to look at what has evolved with core measures for general healthcare providers.

The Joint Commission began development of performance measures with the inception of the Agenda for Change in 1987. Eventually these activities were subsumed into what is now called the ORYX initiative. Organizations could meet accreditation requirements by selecting from among literally hundreds of performance measurement systems and thousands of performance measures that best served their strategic measurement goals. But with so many choices open, there was no way to compare healthcare organization data across systems and between disparate measures.

The next phase of the ORYX initiative—identification of hospital core measures—is intended to allow benchmarking comparisons using standardized, evidence-based measures. Since 1999, JCAHO has solicited input from a variety of stakeholders including clinical professionals, hospitals, consumers, state hospital associations, and medical societies about potential focus areas for an initial set of hospital core measures. To date, core measure sets exist for:

- acute myocardial infarction (AMI)
- heart failure (HF)
- community acquired pneumonia (CAP)
- pregnancy and related conditions (PR), which was evaluated with the assistance of the National Perinatal Information Center (NPIC), independent of the core measure pilot project.

Core measures for psychiatric services (when developed) would be one of the first sets of measures available—a remarkable statement about the leadership role that behavioral healthcare is playing in responding to growing demands for accountability and data.

What's Unique About the Inpatient Psychiatric Core Measures

Rather than requiring an extensive period of beta-testing, JCAHO will allow the inpatient psychiatric core measures to go "live" once identified. This will relieve early adopters from reporting the currently required nine non-core measures, which members have told us are onerous to collect and often lacking actionable data.

By providing standardization in definitions, providers will have more meaningful data that can be compared across systems. This will provide more value for the resources invested in data collection—already a Joint Commission accreditation requirement. Over time, a focus on consensus-driven measures also has the potential to change clinical practice in very positive ways.

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Core Measures Are Coming Quickly

The technical advisory panel is expected to complete the initial phase of its work by August 2005 with the posting of proposed measures for public comment in the fall. This process will be followed by synthesis of public comment and development of technical specifications for implementing the test core measure set. The goal is to have a test core measure set ready for implementation by July 2006.

We look forward to continuing to serve you and be your voice in these strategic areas. Please call NAPHS at 202/393-6700, ext. 102, with any questions.