

Core Measure Set Briefing for Hospital Directors and Mental Health Commissioners

Behavioral Healthcare Performance Measurement System

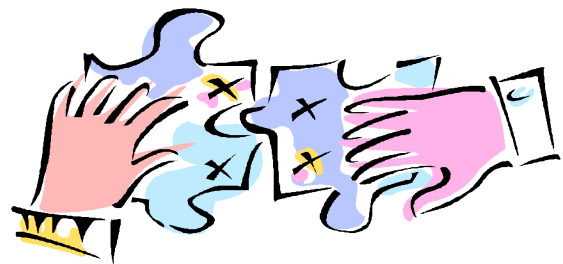
Lucille Schacht, PhD, Director of Statistical Analysis

The Hospital Based Inpatient Psychiatric Services (HBIPS) Core Measure set is an effort that has involved many partners and much hard work by hospitals to move measures into clinical relevance and consistency across hospitals. This paper will provide a brief history of the development of the final core measure set, describe each measure in the set in terms of its relevance to clinical care and its potential future directions, and provide insights from hospitals that participated in testing the original set. The paper closes with a description of the resources provided by NRI to state psychiatric hospitals.

DEVELOPMENT OF THE FINAL CORE MEASURE SET

The development of the set with the Joint Commission and partners began in 2003 with discussions on how to move this initiative forward with the involvement of the mental health field. In 2004, the Joint Commission held the first stakeholder meeting comprised of over 20 organizations to define the landscape for performance measures in inpatient psychiatric care. Following that meeting, an 18 member Technical Advisory Panel was appointed by the Joint Commission, which began meetings in 2005. A public call for measures resulted in over 100 candidate measures that the Panel reviewed and recommended a subset of 18 measures to advance to public comment. Following analysis of the public comment, the Panel recommended five measures advance to testing. Hospitals volunteered to test the set for at least calendar 2007; almost 200 hospitals participated in the evaluation using 21 different vendors.

The focus of the test phase was to evaluate the data elements, extraction processes, and measure calculation algorithms; the resulting rates for the test set would not be used as measures of performance. Following the test phase, the Panel met to review issues identified during the test and to discuss the clinical utility of measures and the comparability of measure results. The Panel revised the measure set based on findings from the test phase and supported a final set for advancement through the Joint Commission review process.



The final set is comprised of seven measures and the set is open for participation beginning with the October 2008 reporting period. Hospitals accredited by the Joint Commission under its HAP standards are eligible to use the set. Free-standing

psychiatric hospitals and distinct psychiatric units within hospitals are the primary focus of the set.

The seven measures fall into two groups: discharge measures and event measures. Discharge measures (1.1, 1.4, 1.5, 1.6, 1.7) are calculated when a client is discharged or transferred from the inpatient psychiatric services. Event measures (1.2, 1.3) are calculated for all clients served in inpatient psychiatric services. Each measure is also calculated for four age strata: children (1-12 years), adolescent (13-17 years), adult (18-64 years), and older adults (65 years and older).

HBIPS 1.1 Initial Screening

Percent of clients discharged that were screened by the 3rd day post admission for all of the following: risk of violence to self, risk of violence to others, substance use, psychological trauma history, and patient strengths.

For each screening, the Joint Commission has defined elements that must be included in the screening. The measure assesses whether the screenings were completed, not the outcomes of the screenings.

The connection to clinical care is two-fold. Certain screenings are critical for clients admitted to inpatient psychiatric care as prevalence of these conditions impact both the individual's treatment plan and the general milieu. When a screening indicates risk, inappropriate use of substances, trauma history, or limited strengths, a full assessment is warranted with development of treatment goals to address these issues.

In order to move toward measures related to treatment practices, a better understanding of the progression from screening to assessment to treatment plan development will be required. The relationship between screening and treatment planning or clinical outcomes cannot be assumed from this initial measure. However, there is a body of research to support that incorporating results from these screenings into the treatment process improves clinical outcomes.

HBIPS 1.2 Hours of Physical Restraint Use

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

A physical restraint is any manual, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a client to move his or her arms, legs, body, or head freely.

The connection to clinical care is a recognized risk that the use of restraint poses to clients and the treatment environment. While the core set only includes one measure of restraint use, most hospitals will monitor restraint in terms of proportion of clients, by units, and by other characteristics in order to target areas for improvement.

HBIPS 1.3 Hours of Seclusion Use

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

Seclusion is defined as the involuntary confinement of a client alone in a room or an area where the client is physically prevented from leaving which includes, but is not limited to: 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 client leaves the room.

The connection to clinical care is a recognized risk that the use of seclusion poses to clients and the treatment environment. While the core set only includes one measure of seclusion use, most hospitals will monitor seclusion in terms of proportion of clients, by units, and by other characteristics in order to target areas for improvement.

HBIPS 1.4 Discharge on multiple antipsychotic medications

Clients discharged on two or more antipsychotic medications as a proportion of clients discharged on one or more antipsychotic medications.

The Joint Commission further defines this measure to include the number of unique antipsychotic medications that the client will be taking on a routinely scheduled basis after discharge as documented in the medical record; including long acting depot antipsychotic medications. For purposes of reporting, one medication in two forms would count as one medication. The count excludes PRN antipsychotic medications and short-acting intramuscular antipsychotic medications.

The connection to clinical care is identifying the prevalence of prescribing multiple antipsychotic medications. The measure allows for a level of interpretation of the next measure.

HBIPS 1.5 Discharge on multiple antipsychotic medications with appropriate justification

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

Appropriate justification is defined by the Joint Commission as a history of three or more failed trials of monotherapy, recommended plan to taper to monotherapy or tapering in process (cross-taper), or augmentation of Clozapine.

The connection to clinical care is the expectation of a clear statement by the clinician of the reason for multiple antipsychotic medications, and communicating with the next care provider the plan for tapering. While the minimum required documentation for failed trials of monotherapy is the names of the medications, during the test phase it was expected that the clinician also note why the trial failed. It may be good clinical practice

to identify when and how the medication trial failed. Clinicians being tasked with documenting history of failed trials may be prompted to test new trials or test tapering.

HBIPS 1.6 Continuing care plan created

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

For each continuing care component, the Joint Commission has defined elements that must be included. The measure assesses whether the components were completed, not its specific content. In addition, the continuing care plan is defined as a “packet” which may consist of one document or several documents and details a client’s continuing care that would be transmitted to the primary next level of care provider (synonym: primary referral at discharge). It can include documents developed at any time during the hospital stay. If the client has referrals to more than one clinician or entity for follow-up, the primary next level of care provider is defined as the prescribing clinician or entity responsible for managing the client’s medication regime.

The connection to clinical care is the creation of an organized continuing care plan intended to facilitate communication between providers and be available when the client leaves the hospital.

HBIPS 1.7 Continuing care plan transmitted

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

Methods of transmitting the post-discharge continuing care plan include, but are not limited to: U.S. mail, email, fax, and EMR access. Giving a copy of the continuing care plan to the client does not comprise transmission. All components should be provided to the same identified primary next level of care provider, with a primary focus on the prescribing clinician or entity responsible for managing the client’s medication regime.

The connection to clinical care is the timely and direct hand-off of clinical information to the next provider. The goal is connecting the client to the next care provider. While an aftercare appointment is viewed as critical in this process, the ability of hospitals to collect this information and place it into the clinical record was low during the test phase. However, the proximity of the appointment to discharge is used as an indicator in other systems and therefore would be a natural extension of this measure.

INSIGHTS FROM HOSPITALS THAT PARTICIPATED IN THE TEST PHASE

Test sites indicated that the most important and resource-consuming activities were: determining the primary data source, confirming that the identified source meets the

definition, determining a mechanism to extract the data from forms, and building or restructuring data systems to input the data. These activities required the involvement of clinical staff as well as IT staff for the resulting information to have meaning to clinical care. Furthermore, leadership support is crucial to developing both the infrastructure to accomplish the data effort and to building the team environment of clinical and IT staff.

Test sites indicated that there were positive outcomes from participating in the test phase. Some hospitals had received positive feedback from the next care provider about the handoff in communication. Community mental health providers welcomed the measures on continuing care plan and wanted to see more. Clinicians engaged in evaluating the prescribing of multiple psychiatric medications, found monotherapy achievable for clients, and changed the mindset of rationale for continuing multiple antipsychotic medications.

Finally, the measure set was seen as an emphasis on performance improvement and clinical relevance. It is not just the deficiencies being evaluated but instead measures of good clinical practice. The measures are new and more relevant monitors to validate inpatient treatment practices and their connection with outcomes. They energize using data to make decisions and set a foundation for evidence-based practices.

CONTINUATION OF NON-CORE MEASURES

While the Joint Commission will be requiring the transition to the core measure set, hospitals participating with NRI also continue to have the option to participate in non-core measures relevant for their internal management and monitoring of processes. Continuing non-core measures such as percent of clients restrained, percent of clients secluded, medication error rate, client injury rate, elopement rate, and consumer satisfaction has several benefits to hospitals. The primary benefit, and the reason hospitals joined the NRI system, is the availability of comparative data not otherwise publicly available. NRI has provided nearly ten years of comparison reports based on data from state psychiatric hospitals. This rich resource allows NRI to create stratification reports relevant for state psychiatric hospitals, notably age groups and forensic status. NRI has also provided a “rank by measure” report that allows hospitals to compare their relative performance on measures that are displayed as clusters of related measures (e.g. ranking on each of the four restraint and seclusion measures are provided in one table).

Many of the initial non-core measures were defined by the state psychiatric hospital system as critical to their management of risk. Through the NRI system, they developed and adopted a single set of common definitions to allow comparison across state psychiatric hospitals. When state hospitals gather to discuss their issues, they speak a common language and rely of these benchmarks to provide the foundation for critical analysis of the risks common to their hospitals and identification of hospitals that appear to have made significant improvements in managing risk.

The non-core measures also serve clinical purposes and assist the hospital with other state and accreditation requirements. GAF and BPRS assessments provide an indication of the severity of and change in illness during the course of hospitalization. Client injury and medication error measures address safety goals of hospitals. Pharmacotherapy measures address prescribing practices. The NRI Inpatient Consumer Survey provides client satisfaction ratings on clinical, interpersonal, and environmental domains. To improve the usefulness of these measures, NRI has developed supplemental reports that “drill-down” into client characteristics, hospital characteristics, levels of severity (for risk measures), as well as variants of the measures (treatment variances per medication error, survey item specific ratings).

RESOURCES

This paper has provided only a highlight of the core measure set. Once endorsed by the National Quality Forum (NQF) and approved by the Hospital Quality Alliance (HQA), the set will become a mandatory requirement for free-standing inpatient psychiatric hospitals accredited by the Joint Commission. The Joint Commission has aligned the set with requirements of the Centers for Medicare and Medicaid Services so there is a potential for this set to be used by them as well. Individual hospital rates for core measure sets are posted publicly on the Joint Commission website along with a rating of comparison to other hospitals participating in those measures.

NRI has developed a system to meet the requirements for the core measure set and to begin assessment of future variations of these measures. To assist our hospitals with preparing for the core measure set, NRI:

- sponsors monthly conference calls
- publishes a monthly newsletter
- opened a dedicated email address for questions
- conducts annual user conferences
- created a detailed Implementation Guide (version 5)
- created a sample data abstraction form
- provides various reference materials
- provides technical assistance relating to core and non-core data reporting



Materials are posted on the secure website on a dedicated page for easy access by our hospitals. In addition, a core measures resource guide is nearing final review and will be posted on the website. This guide provides a literature review relevant to the measures and resources that may assist hospitals with both clinical and documentation practices related to the measures.

Public access to information on the core measure set can be retrieved at <http://www.nri-inc.org/projects/bhpms> then choose the link to Core Measure. For more detailed information, please feel free to email your questions to CMInfo@nri-inc.org or contact me on (703) 682-9475 or email to Lucille.Schacht@nri-inc.org.