Getting a Jump-start on The Joint Commission’s HBIPS Core Measures: Lessons learned from early adopters

A Quality Indicator Project® Executive Briefing
**New Data Requirements for Psych Providers: Seismic Shift?**

Inpatient psychiatric facilities are no strangers to data collection and transmission requirements. Since 1997, The Joint Commission (TJC) has required psych facilities to collect and submit quality of care data on a quarterly basis as part of its accreditation requirements. At present, facilities meet this requirement by contracting with a Joint Commission-listed performance measurement vendor and selecting nine measures from among that vendor’s various approved measures. Consequently, there is a wide variety of measures from which to choose, and facilities, by and large, are able to select measures that meet their specific needs or goals.

All that will soon change, as The Joint Commission is now poised to fully implement a set of standardized “core measures” for use by all hospital-based inpatient psychiatric services (HBIPS) providers.

**Evolution of the Requirement**

From the outset of implementing its ORYX requirement across its various accreditation programs, TJC intended for the requirement to evolve toward data collection on standardized, evidence-based measures. There was general, industry-wide consensus, that a uniform approach would be more meaningful from accountability, comparative analysis, and accreditation perspectives—although there was not necessarily general consensus as to the best way to go about identifying and implementing standardized measures.

Unsurprisingly, establishing core measures proved easier to achieve in the medical acute care setting, which has had core measures in place since 2002. Not so in the psych setting, where perceived challenges in data sources and definitions presented obstacles to defining and testing measures. It is fair to say that had it not been for urging of key organizations in the psychiatric services arena—the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the American Psychiatric Association (APA)—national implementation of core measures for psych services providers might still be sometime in the future, as opposed to immediately at hand.
The interests and involvement of these industry leaders and TJC’s willingness to collaborate with them confers significant benefits to the hospitals that will be subject to the requirement. With such broad industry representation on TJC’s Technical Advisory Panel (TAP) for HBIPS core measures, end users are assured that the measures were developed and refined by professionals who have practical experience in a psychiatric care setting, who have a clear sense of meaningful aspects of care in that setting, and who understand the data collection challenges particular to that setting.

This collaborative effort to develop the measures culminated in a 2007 national voluntary pilot project, in which over 100 psychiatric hospitals participated. Following the pilot, the TAP refined and narrowed the initial set of measures; the final set was announced in June of 2008. Full core measures implementation will follow National Quality Forum endorsement of the measure set, expected in 2009. Once core measures for HBIPS is implemented, hospitals will have to collect and submit those data in order to meet certain accreditation requirements.

At present, participation in the HBIPS core measures is optional. Accredited psychiatric hospitals can report on the seven HBIPS measures in lieu of submitting the nine non-core measures they are currently submitting to meet the ORYX requirement. Accredited general/medical surgical hospitals with hospital-based psychiatric units can submit the HBIPS measure set as part of their core measures reporting.

**While pilot testers studied the measures, QI Project® studied the pilot testers.**

As a pilot test vendor, the QI Project recognized it was in a unique position to observe and assess the experiences of its customers in the pilot test and pass the “lessons learned” on to others. With 44 inpatient psychiatric hospitals actively participating in the HBIPS pilot, the QI Project had a good sample of hospitals for surveying and interviewing.

The study’s intent was to identify the most common problems encountered during implementation, strategies used by quality improvement staff to address those problems, and the perceived benefits related to implementing the HBIPS core measure set. To gather this information, the study team conducted research on both sides of the equation—interviewing members of the QI Project’s own implementation team as well as quality improvement professionals at pilot test hospitals.

In interviewing members of the implementation team, the study team hoped to determine if there were common problems encountered by their customers—and common remedies to address those problems. The study team conducted semi-structured interviews with three members of the QI Project’s training and education team who had primary responsibility for HBIPS training and implementation at customer sites. The interviews focused on each step in the collection and
reporting process and on the reported volume of questions in each area from pilot hospitals.

On the hospital side, the study team conducted both a focus group and an online survey. The purpose of the focus group was to verify the feedback obtained from the implementation staff and to uncover additional details about the hospitals’ experience in the pilot. The study team used the interview and focus group findings to develop the online survey—the intent of which was to capture information about reported issues and strategies in a more structured format.

Focus group participants were facility quality improvement staff from three freestanding hospitals and two general/medical surgical care hospital-based psychiatric units, all from the mid-Atlantic region. An independent moderator led the discussion, which focused on the challenges identified during the process (e.g., setting up an XML file), strategies for success (e.g., documentation practices), and any lessons they learned through participation.

Survey invitations were sent to hospital quality improvement personnel during the first quarter of 2008 at all 44 of the QI Project’s HBIPS pilot test participants. These pilot test participants are located across 20 states and represent one-fifth of the QI Project’s 234 psychiatric hospital clients. Nearly 71% of eligible survey sites responded.

Obstacles, Solutions, Benefits: What the pilot sites said

Overall, half of the survey respondents rated their overall experience implementing the measures as somewhat successful, with another 29% rating it as either extremely or very successful, and 16% rating it as very unsuccessful.

The critical problems reported by hospitals’ quality improvement staff during the interviews and focus group related to technical challenges associated with data collection and electronic data submission. Survey respondents also cited this issue as the most problematic (58%). Additional issues mentioned include interpreting data element definitions, documentation, and limited resources for data collection, especially for hospitals without an electronic medical record. Sixteen percent of survey respondents reported having to hire new staff to implement the measures.

The most commonly-reported critical changes required to achieve implementation noted on the survey were modifications to clinical documentation to support documentation compliance and facilitate data abstraction (42%). Hospitals also noted the importance of educating staff about the initiative; convening interdisciplinary HBIPS teams with representatives from clinical staff, information technology, medical records and quality improvement; dedicating staff time; creating new data capture methods to ease the data collection burden and utilize electronic medical records; and setting up auditing processes.
Pilot sites also cited several benefits to implementing the measures, including improvements in clinical practice and documentation, awareness of critical quality improvement issues, and the development of new quality improvement processes.

**Further benefits of early adoption**

While the advantages of early experience in collecting the data may seem readily apparent, what might not be so apparent to pilot testers are the benefits of familiarity with their facilities’ performance on the measures prior to national implementation of the HBIPS core measures. As is the case with TJC’s non-core ORYX requirement, facility quality improvement staff must understand and be ready to explain to surveyors their facility’s performance on the measures using statistical process control (SPC) methodology and standard graphics. Yet, these analysis methods are not useful until a facility has accumulated several quarter’s worth of data.

In addition—and perhaps more critically—once fully implemented, facility-specific data on the measures will be publicly reported on the Joint Commission’s website (www.qualitycheck.org). While it is too early to predict the extent to which these measures will factor into public accountability, the public availability of the data necessitates facilities’ readiness to discuss and explain their performance with virtually anyone who may be interested.

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### HBIPS Core Measures: Are your data ready for public consumption?

| HBIPS 1 | Admission Screening Completed |
| HBIPS 2 | Hours of Physical Restraint Use |
| HBIPS 3 | Hours of Seclusion Use |
| HBIPS 4 | Patients Discharged on Multiple Antipsychotic Medications |
| HBIPS 5 | Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification |
| HBIPS 6 | Post-discharge Continuing Care Plan Created |
| HBIPS 7 | Post-discharge Continuing Care Plan Transmitted to the Next Level of Care Provider |
**Takeaway lessons**

Based on this research and further discussions with psychiatric care providers currently participating in the HBIPS core measures, the QI Project recommends the following steps for hospitals planning to participate in this initiative in 2009.

**Review the manual well in advance**
Download and read the HBIPS Specifications Manual from the Joint Commission’s [website](#) to become familiar with the measures and data elements.

**Allow six months for full implementation**
Hospitals report an average time of 4-6 months for effective implementation. Hospitals that begin the process before the requirement goes into effect will have adequate time to determine resources, identify process issues, and make any necessary changes before the facility’s data is subject to review by The Joint Commission and the public.

**Ensure key staff are trained on requirement and tools**
A facility’s vendor of choice must provide comprehensive training, education, and on-going support to help provide quality improvement professionals with the necessary skills and understanding to put their data to work. In this era of burgeoning public accountability, the well-armed quality improvement professional is a key team member at any hospital.

**Involve staff from multiple disciplines**
Convene an interdisciplinary team including leadership, clinical, quality, and information technology staff to review current processes and identify potential issues. Examine collection and reporting processes to strategize ways to make processes efficient and address any potential issues. Determine how to incorporate the core measures collection and reporting into the existing or revised performance improvement processes to ensure that the new measures foster performance improvement.

**Identify physician and nurse champions**
Find a physician champion and a nurse champion to facilitate clinician involvement. These champions can ensure a smoother implementation process by providing key insights on how to link the needed documentation to clinical practice, fostering buy-in for changes in practice, and encouraging clinical staff involvement.

**Get IT involved early**
Identifying all potential electronic sources of data and establishing processes for obtaining those data requires IT involvement. Representatives from IT should be involved during the initial planning stage. IT staff will also play an
important role in establishing an efficient data abstraction process and testing upload files with your facility’s vendor.

Network with peers
Talk to other psychiatric care providers who have already implemented or are in the process of implementing the HBIPS core measures. Cast a broad net in your networking activities: contact your current vendor for referrals to customers who participated in the pilot and other vendors for referral to their pilot sites.

Conclusion
The study team’s findings clearly indicate that HBIPS core measures implementation will require organizations to devote considerable resources and identify strategies to accommodate the data collection burden and address the technical challenges related to the electronic submission of data. These challenges will be even greater for hospitals lacking electronic medical records.

At the same time, it appears that hospitals can look forward to significant benefits from implementing the core measures—expanded domains of oversight and national comparative analysis among them. It also appears that use of the core measures alongside a facility’s more established domains of measurement has the potential to offer new insight into quality of care.

At present, participation in the HBIPS core measures is optional. The Joint Commission expects to implement an HBIPS core measures reporting requirement for freestanding psychiatric hospitals in 2009, with optional participation for acute medical/surgical hospital-based psychiatric units. That said, the experience of hospitals in the QI Project study points to clear advantages of early implementation.

Prepared by:
- Gayle Olano Hurt, MPA
  *Program Manager, Quality Indicator Project*
- Corey Reilly, MBA
  *Director of Communications, Quality Indicator Project*
- Nell Wood, MBA
  *Vice President for Marketing and Business Development, Quality Indicator Project*

Please direct inquiries to Ms. Hurt via ghurt@qiproject.org or 410-379-6200

The Quality Indicator Project* is operated by the Maryland Hospital Association—6816 Deerpath Road, Elkridge, MD 21075