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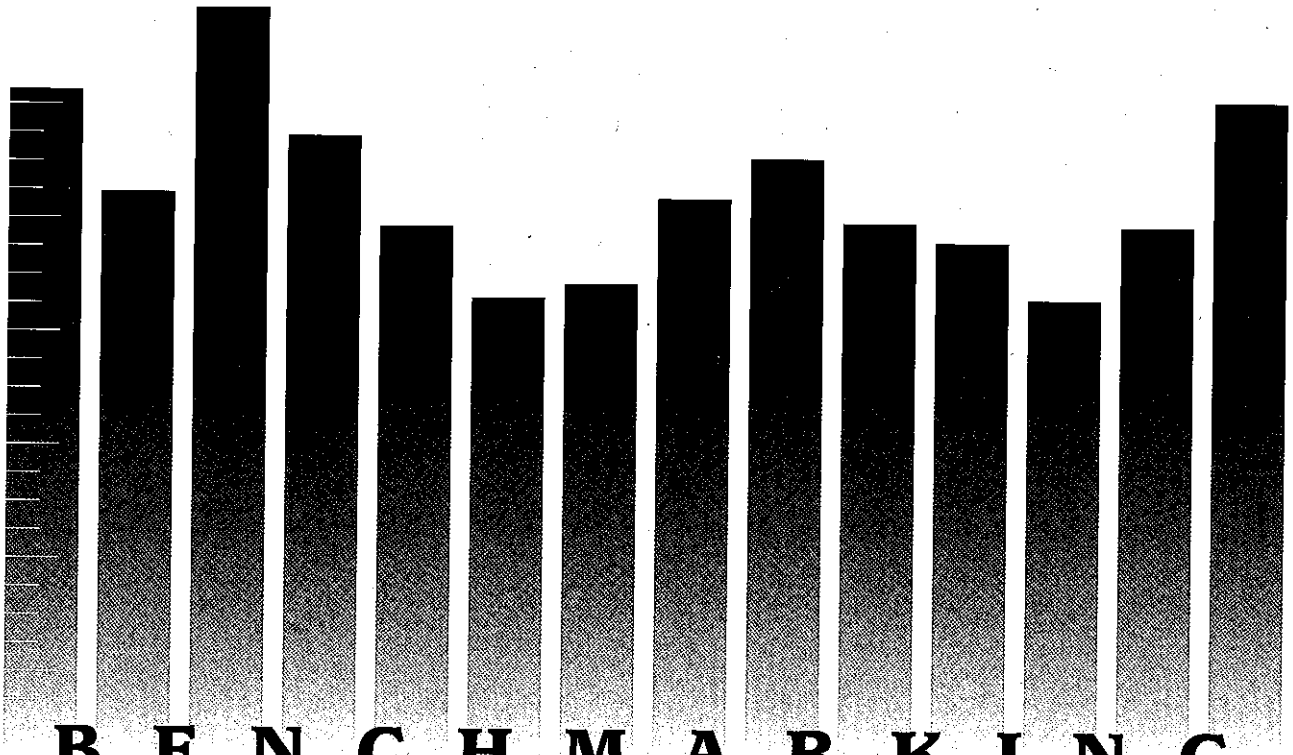
A project of the "Benchmarking Initiative"

National Association of Psychiatric Health Systems

and its partner, the Association of Behavioral Group Practices



BENCHMARKING INDICATORS

Survey Report

Prepared by the Center for Quality Innovations & Research

Naakesh A. Dewan, M.D., Director

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of the
National Association of Psychiatric Health Systems
and its partner, the
Association of Behavioral Group Practices

Benchmarking Committee

The Benchmarking Committee oversees NAPHS data-collection efforts. The committee is responsible for a variety of projects, including the NAPHS/ABGP Benchmarking Initiative.

Chair:
Peter Panzarino, M.D., Cedars Sinai Medical Center, CA

Members:
Mark Benz, Universal Health Services, Inc., PA
James M. Cole, Cleo Wallace Centers, CO
Allen S. Daniels, Ed.D., University Managed Care/University Psychiatric Services, OH
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Prepared by the Center for Quality Innovations & Research
Naakesh A. Dewan, M.D., Director
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Summer 1999

EXECUTIVE SUMMARY / KEY FINDINGS

Commentary: Behavioral healthcare providers are committed to providing high-quality care for individuals who experience mental and addictive disorders. As caregivers, providers in all types of treatment settings are always looking for ways to improve patient care. But what are the best measures of quality? Which performance measures will offer the field the best chance of not only tracking practice, but actually improving patient care? How can we identify measures that will provide maximum value without depleting the resources available (including both time and dollars)?

In an era of ever-tightening resources, identifying such measures is increasingly important. It is also important for behavioral healthcare providers to document the value of the services they provide -- whether those services are offered in inpatient, outpatient, partial hospital, or residential treatment settings. Demonstrating value is essential to counter external trends toward burdensome and costly regulation, downward pricing pressures, and erosion of behavioral health benefits.

Data collection is one important tool that helps to meet our clinical mission of continually finding ways to improve patient care. Continuous quality improvement techniques have long been part of internal systems designed to help behavioral healthcare providers monitor and improve services. As payers and others demand more data, facilities are working to begin a process of benchmarking – that is, comparing their performance not only internally, but across systems. This can only happen when there is a common language for data collection, when indicators provide data that is "meaningful, measurable, and manageable[1] ," and when there are sufficient financial resources to analyze, interpret, and act on the data.

This survey of members of the National Association of Psychiatric Health Systems and the Association of Behavioral Group Practices is an important first step toward identifying areas in which there may be – or could be – a common language, as well as potential value for future data-collection efforts. The survey, which evolved from a consensus-driven process of an expert panel, very simply sought to document which of a variety of selected performance measures were currently being used by NAPHS and ABGP members. The hope was that this first step would identify areas in which there was already a strong data collection process underway, in which there was some consistency of definitions, and in which further study may be readily possible.

Key Findings:

- All levels of care use performance measures and devote considerable resources to collection of performance measurement data.
- Facilities measure performance in a variety of multi-dimensional categories. Facilities collect data across various domains, including clinical performance, peer review, perception of care, and coordination of care.
- Measures of clinical performance and perception of care are among the most widely used measures across treatment settings.
- Measures of clinical performance and perception of care were found to be generally measurable and manageable across levels of care.
- On most measures, there was general consistency in definitions. This common language may help facilitate future comparison of data across systems.
- Member organizations have said they are willing to aggregate data and to participate in future benchmarking studies.
- Residential and outpatient levels of care are at an earlier stage in the development of organized data-collection efforts.

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[1] This phrase was first used in a benchmarking context by the American Managed Behavioral Healthcare Association (AMBHA) in its Performance Measures for Managed Behavioral Healthcare Programs (PERMS).

INTRODUCTION / HISTORY

Purpose of the "Benchmarking Initiative"

The survey described in this report is a project of the "Benchmarking Initiative" of the National Association of Psychiatric Health Systems (NAPHS) and its partner, the Association of Behavioral Group Practices (ABGP). It is the first report of its kind to attempt to document which of a set of performance measures (selected for their potential value through a consensus process) are currently in widespread use among behavioral healthcare providers offering services along a continuum of care – including inpatient, residential, partial hospitalization, outpatient, and behavioral group practice services.

As rapid technical advances occur on many fronts – from practice guidelines to outcomes research to report cards – and as resources become ever more scarce, the behavioral healthcare field must reevaluate its data needs. Recognizing this, NAPHS and ABGP began the Benchmarking Initiative in 1998 as an effort to begin to identify performance indicators that would be relevant for behavioral health services throughout the continuum of care. It was felt that benchmarking is critical to:

- improve patient care
- shape the direction of the behavioral health profession
- fight commodification and the downward pressure on price
- better support behavioral health's interests in the regulatory arena (e.g., with JCAHO, NCQA, HCFA, etc.)

The overall Benchmarking Initiative is designed to provide a forum to begin to bring together theory and practice to help behavioral health organizations implement data-collection strategies that will provide the information needed to advance patient care and quality. This survey is the first step toward understanding current performance measurement practices in the field.

Benchmarking Committee Develops *"Benchmarking Indicators Survey"*

In 1998, the National Association of Psychiatric Health Systems established a Benchmarking Committee (described in detail in the "Acknowledgments" section). The committee, which included representation from the Association of Behavioral Group Practices, developed a strategy and action plan designed to allow the associations to speak with authority on the complex issues involved in benchmarking behavioral healthcare services.

With the support of the Center for Mental Health Services, the Benchmarking Committee held a number of meetings and conference calls throughout 1998 to:

1) define the issues, problems, and opportunities facing the field

2) broadly review existing performance measurement instruments developed by providers, consumers, managed care, and other constituencies

3) select a set of indicators with important benchmarking potential *for behavioral health providers* – whatever the treatment setting (group practice, partial hospital, residential treatment, psychiatric unit, specialty hospital, etc.) and levels of care. Through a consensus process, the Benchmarking Committee identified a set of indicators for further analysis. An extensive literature review was brought to bear on the discussions of the committee and facilitated the selection of indicators used in this survey from literally hundreds of possibilities.

4) design a survey instrument to gather important information about whether the selected indicators are, in fact, already being used by behavioral healthcare provider organizations. It was felt that it would be essential to gather the baseline information requested through this survey to help the committee identify performance indicators with potential to be "meaningful, measurable, and

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manageable" for the field. For example, were these indicators being used routinely? Was there any consistency in definitions used? The results of that survey form the content of this "Benchmarking Indicators Survey Report."

What the *Benchmarking Indicators Survey* Studied

The study was designed to provide a snapshot at a moment in time of performance measures being systematically assessed by behavioral healthcare provider organizations. The survey was sent to members of the National Association of Psychiatric Health Systems and the Association of Behavioral Group Practices. These organizations were asked to identify which measures (pre-determined by the Benchmarking Committee through discussion and an extensive literature review) were currently being tracked by their organizations using formal data-collection mechanisms. The intent was to identify which performance measures were widely used throughout the field. This is an analysis that had not been undertaken by the field as a whole. The Committee felt it essential to identify areas in which there may be sufficient common language (and a history of value in the data-collection effort) to allow for exploration of next steps, such as designing mechanisms that would allow facilities to compare data with their peers (that is, to truly "benchmark"). The report:

- selected a variety of performance measures as being potentially valuable to behavioral healthcare systems
- asked for information on which of these selected performance measures were being systematically analyzed internally by members of NAPHS and ABGP
- asked for information on which levels of care were using these selected performance measures
- asked for definitions (e.g., what age group constitutes "child"?) and examples of instruments used (e.g. for symptom function measures, etc.)

What the Study Is Not

This study described in the following pages:

- does not collect or report any performance measure data. The study asks *only* whether selected performance measures are tracked within behavioral healthcare organizations and within which levels of care.
- does not necessarily indicate that *information* related to these performance measurement areas is not being collected. The survey looks only at whether a *formal data-collection system* is in place for collecting and reporting specific performance measures within the organization. For example, physicians may routinely contact their patients' primary care physicians but not formally report that information to a central data-collection site. This survey would not capture that information because the survey would indicate "no" -- no formal *data base or data collection* mechanism in place on tracking primary care contacts.
- does not indicate these are the *only* or even the best performance measures for each identified area. The selected performance measures were chosen as *examples* of areas that a consensus panel of experts identified as having potential for being of value to behavioral health providers across all levels of care. The specific examples of indicators given here are not intended to be comprehensive. Many indicators could be substituted to address other important aspects of the broad concepts identified as potentially useful to clinical care.
- does not discuss the *use* of the data for quality improvement. Collecting data alone – without a system for analyzing and *using* the data – is not enough. Behavioral healthcare organizations have extensive quality improvement programs in place. Description of these is beyond the scope of this report.

Benchmarking Indicators Survey Distribution

The 1998 NAPHS *Benchmarking Indicators Survey Instrument* – which evolved from multiple meetings and edits by the Benchmarking Committee – was sent in September 1998 to the CEOs of organizational

members of the National Association of Psychiatric Health Systems as well as to each ABGP group practice. Of the 297 organizations receiving the survey:

- 249 were hospital-based systems providing a full range of services (who responded in all appropriate categories of the survey for the services they offer, including inpatient, residential, partial hospitalization, and outpatient care)
- 6 were partial hospital systems or companies
- 25 were behavioral group practices
- 3 were management companies
- 9 were youth services organizations or companies
- 3 were residential treatment centers
- 2 were community based service organizations

In addition to the core systems surveyed above, an additional 98 facilities / sites / organizations operated by the core systems also received surveys. These facilities include outpatient clinics, schools, satellite service centers, and other divisions offering a range of treatment settings.

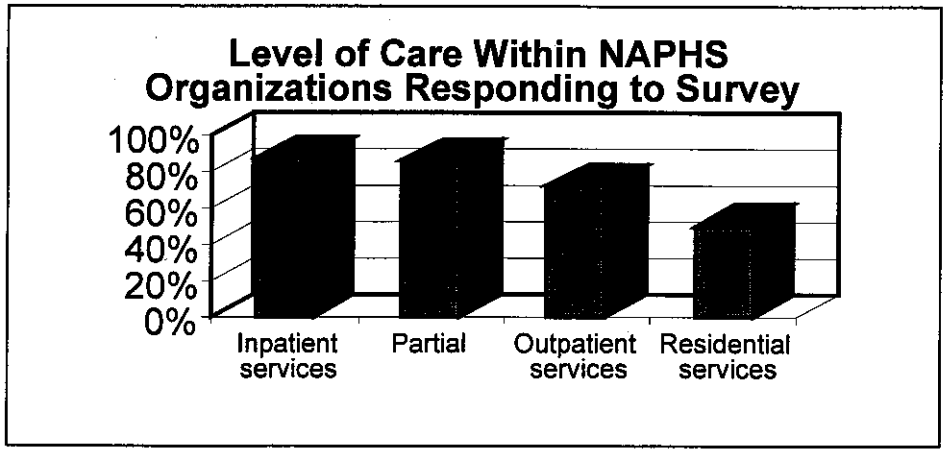
Completed surveys were sent to external data-collection experts at the University of Cincinnati's Center for Quality Innovations & Research, led by Naakesh A. Dewan, M.D., for analysis and coding. The Center was not aware of the identification of research sites to protect confidentiality.

Survey Respondents

A total of 127 surveys were returned by organizational members (for a 43% response rate). The respondents were broadly representative of the membership and included:

Types of Organizations	(n)
Specialty Inpatient & Psychiatric Unit in Medical Hospital	105
Freestanding Residential	9
Behavioral Group Practice	10
Other	3

The survey respondents provide a variety of services, including inpatient (87%), outpatient (72%), partial (86%), and residential services (50%). Most are hospital-based services that provide multiple levels of care. Percentages in the report were calculated based on the following breakdown of levels of care.



Level of Care Within NAPHS Organizations Responding to Survey	(n)	Percent
Inpatient services	111	87%
Partial hospitalization services	110	86%
Outpatient services	92	72%
Residential services	63	50%

ABOUT THE ORGANIZATIONS

About NAPHS

The National Association of Psychiatric Health Systems (NAPHS) represents behavioral healthcare systems that are committed to the delivery of responsive, accountable, and clinically effective treatment and prevention programs for children, adolescents, and adults with mental and substance use disorders. NAPHS members are behavioral healthcare provider organizations, including 400 specialty hospitals, general hospital psychiatric and addiction treatment units, residential treatment centers, partial hospital services, behavioral group practices, youth services organizations, and other providers of care. In 1997, the Association of Behavioral Group Practices (ABGP) also joined NAPHS as a system member, further expanding NAPHS's representation of the continuum of care. In April 1999, ABGP merged with NAPHS, becoming a special-interest section committed to advocating for a marketplace in which behavioral group practices can deliver effective, quality behavioral healthcare services and thereby improve the lives of individuals, families, and communities.

Founded in 1933, NAPHS today concentrates on three key areas: strengthening advocacy for behavioral health services; building strategic alliances; and collecting and disseminating information to help members understand, respond to, and manage change.

About ABGP

The Association of Behavioral Group Practices (ABGP) has been formed to advocate for a marketplace in which behavioral group practices can deliver effective, quality behavioral healthcare services and thereby improve the lives of individuals, families, and communities. ABGP works:

- to serve as the national advocacy voice for behavioral group practices
- to communicate the role, benefits, value, and effectiveness of behavioral group practices in the healthcare delivery system
- to strengthen the advocacy voice for behavioral healthcare through collaboration, coordination, and communication with delivery system providers along the continuum of care

About the Center for Quality Innovations & Research

CQIR is a research and development organization affiliated with the Department of Psychiatry at the University of Cincinnati. The Center is dedicated to discovering answers and solutions for improving quality and cost-effectiveness in healthcare. It achieves its mission through collaborations with the private and public sector. It is a national leader in benchmarking and conducts pharmacoeconomics research, software research and development, and health services research through a variety of funding resources.

Involved in this study was Naakesh A. Dewan, M.D., who serves as the Director for CQIR overseeing the National Outcomes Management Project, Medical Director for Quality for Alliance Behavioral Care, and Assistant Professor, University of Cincinnati College of Medicine. Ron Bramlage, M.S.W., CQIR's Quality Research Analyst, is a clinician and educator with a decade of experience in quality improvement and outcomes. As Program Coordinator, Mary Behle organized and managed the collection and entry of the survey data. Peter Dillon, Ph.D. conducted a number of analyses for the preliminary report..

PERFORMANCE MEASURES

Introduction

Traditional evaluations of healthcare quality usually involve the measurement of the structure, process, and outcome of care. Most quality initiatives involve a cycle that includes setting of goals, measurement of either process or outcomes, and real-time or retrospective feedback of the results. This information is then used to drive action or intervention at the program or individual clinical level. Continual measurement and feedback occur and result in ongoing quality improvement within a system.

Within this framework, organizations are constantly challenged to choose measures of performance which are most effective and efficient in assessing progress toward the goals they have set. The NAPHS/ABGP Benchmarking Initiative Project is a first step toward helping the field identify performance measures that: a) are currently in use by their peers; and b) hold promise for providing meaningful, measurable, and manageable data.

Commentary: Current performance measurement choices reflect medicine's historic traditions of measurement. This 2,000-year tradition is firmly rooted in the overarching goal of preventing adverse events, as expressed in the premise: "First, do no harm." In addition, the historic tradition of peer review undergirds professional practice. The willingness of individual practitioners to allow their work to be reviewed by their peers is a hallmark of such practice.

In more recent times, in addition to assessment of adverse events and peer review, systems have recognized the essential role of the patient and family as partners in care. Perception of care has emerged as a fundamental dimension of measurement as has greater emphasis on outcomes. And as systems of care become more complex, a new era of performance measurement is beginning to focus on coordination of care.

The overall evolution of healthcare measurement is clearly reflected in the results of this benchmarking report. The most frequently and widely used performance measures today are those that monitor adverse events (measures such as "attempted suicide" or "adverse drug reactions"). Morbidity and mortality (traditional outputs of a healthcare delivery system) are a regular part of performance measures for NAPHS and ABGP members. Peer review mechanisms are solidly in place for the vast majority of organizations. Assessment of perception of care, sometimes referred to as measures of satisfaction, are performed by virtually all respondents. Measures of coordination of care (such as tracking of post-discharge care, contact with primary care physicians, and readmission rates) are a part of the operation of most organizations.

DISCUSSION OF SURVEY RESULTS

To understand how various treatment settings use the performance measures described in the following section, this Benchmarking Survey ranked the current use of performance measures by four treatment settings (inpatient, residential, partial, and outpatient) and by behavioral group practices (who participated from both the membership of the National Association of Psychiatric Health Systems and the Association of Behavioral Group Practices). These rank orders appear in the following pages.

These rankings provide a sense of the measures – by virtue of their routine use -- that treatment providers in various settings have identified as most pertinent in that setting. What is striking is the routine use of performance measures by all treatment settings. The measures in the first quartile of each ranking below are almost universally used in these settings. Performance measures are well-established.

Facilities measure performance in a variety of multi-dimensional categories. Facilities collect data across various domains, including clinical performance, peer review, perception of care, and coordination of care.

While there may be variation in the tools used to assess each of these areas (for example, see typical instruments used to measure symptom change in the following section), the process of collecting and reviewing data on critical issues impacting clinical performance, perception of care, and peer review are well-established.

Measures of health status and techniques for coordinating care with primary care physicians, for example, are less routinely used – given the complexity of tracking these types of measures which cut across treatment settings.

Behavioral healthcare managers and clinicians looking to determine which performance measures they should study in their own setting may find the following rankings useful guides as a starting point for self-assessment.

Inpatient performance measures

Inpatient Performance Measurement Activities	Rank Order	Percent Using This Measure
Track adverse drug reaction **(CLINICAL PERFORMANCE)**	1	96%
Patient satisfaction surveys conducted **(PERCEPTION OF CARE)**	2	95%
Track seclusion **(CLINICAL PERFORMANCE)**	2	95%
Track restraints **(CLINICAL PERFORMANCE)**	3	95%
Policy to document medication use in chart **(CLINICAL PERFORMANCE)**	4	95%
Policy requires peer review feedback to clinicians **(PEER REVIEW)**	5	92%
Established standards for peer review **(PEER REVIEW)**	6	92%
Track completed suicide **(CLINICAL PERFORMANCE)**	7	88%
Track attempted suicide **(CLINICAL PERFORMANCE)**	8	86%
Track readmission **(COORDINATION OF CARE)**	9	81%
Measure symptom/function at admission/discharge **(CLINICAL PERFORMANCE)**	10	70%
Measure family satisfaction **(PERCEPTION OF CARE)**	11	62%
Measure health status **(HEALTH STATUS)**	12	61%
Measure satisfaction with medication and explanation of side effects **(CLINICAL PERFORMANCE)**	13	57%
Track signature of family/legal guardian on treatment plan **(CHILD/ADOLESCENT)**	14	51%
Post-discharge treatment appointment tracking **(COORDINATION OF CARE)**	15	50%
Confirm attendance at appointment after discharge **(COORDINATION OF CARE)**	16	32%
Track contact with primary care provider in treatment **(COORDINATION OF CARE)**	17	30%

NOTE: Some indicators may have different rank orders due to the rounding off of the percentages.

Residential treatment performance measures

Residential Performance Measurement Activities	Rank Order	Percent Using This Measure
Track adverse drug reaction **(CLINICAL PERFORMANCE)**	1	86%
Policy to document medication use in chart **(CLINICAL PERFORMANCE)**	2	85%
Track completed suicide **(CLINICAL PERFORMANCE)**	3	82%
Established standards for peer review **(PEER REVIEW)**	4	77%
Track attempted suicide **(CLINICAL PERFORMANCE)**	4	77%
Policy requires peer review feedback to clinicians **(PEER REVIEW)**	5	75%
Patient satisfaction surveys conducted **(PERCEPTION OF CARE)**	6	71%
Track seclusion **(CLINICAL PERFORMANCE)**	7	70%
Track restraints **(CLINICAL PERFORMANCE)**	8	69%
Track readmission **(COORDINATION OF CARE)**	9	52%
Measure symptom/function at admission/discharge **(CLINICAL PERFORMANCE)**	10	51%
Track signature of family/legal guardian on treatment plan **(CHILD/ADOLESCENT)**	11	49%
Measure family satisfaction **(PERCEPTION OF CARE)**	12	48%
Measure health status **(HEALTH STATUS)**	13	48%
Measure satisfaction with medication and explanation of side effects in treatment **(CLINICAL PERFORMANCE)**	14	40%
Post-discharge treatment appointment tracking **(COORDINATION OF CARE)**	15	37%
Track contact with primary care provider in treatment **(COORDINATION OF CARE)**	16	22%
Confirm attendance at appointment after discharge **(COORDINATION OF CARE)**	17	14%

Partial hospital performance measures

Partial Hospitalization Performance Measurement Activities	Rank Order	Percent Using This Measure
Policy to document medication use in chart **(CLINICAL PERFORMANCE)**	1	83%
Track completed suicide **(CLINICAL PERFORMANCE)**	2	81%
Established standard for peer review **(PEER REVIEW)**	3	77%
Patient satisfaction surveys conducted **(PERCEPTION OF CARE)**	4	77%
Policy requires peer review feedback to clinicians **(PEER REVIEW)**	4	76%
Track attempted suicide **(CLINICAL PERFORMANCE)**	5	75%
Track adverse drug reaction **(CLINICAL PERFORMANCE)**	6	66%
Measure symptom/function at admission/discharge **(CLINICAL PERFORMANCE)**	7	61%
Measure family satisfaction **(PERCEPTION OF CARE)**	8	49%
Measure health status **(HEALTH STATUS)**	9	48%
Measure satisfaction with medication and explanation of side effects in treatment **(CLINICAL PERFORMANCE)**	10	44%
Track readmission **(COORDINATION OF CARE)**	11	43%
Track signature of family/legal guardian on treatment plan **(CHILD/ADOLESCENT)**	12	39%
Post-discharge treatment appointment tracking **(COORDINATION OF CARE)**	13	33%
Confirm attendance at appointment after discharge **(COORDINATION OF CARE)**	14	23%
Track contact with primary care provider in treatment **(COORDINATION OF CARE)**	15	21%

NOTE: Some indicators may have different rank orders due to the rounding off of the percentages.

Outpatient performance measures

Outpatient Performance Measurement Activities	Rank Order	Percent Using This Measure
Track completed suicide **(CLINICAL PERFORMANCE)**	1	70%
Established standards for peer review **(PEER REVIEW)**	2	66%
Policy to document medication use in chart **(CLINICAL PERFORMANCE)**	3	65%
Policy requires peer review feedback to clinicians **(PEER REVIEW)**	3	65%
Patient satisfaction surveys conducted **(PERCEPTION OF CARE)**	4	64%
Track attempted suicide **(CLINICAL PERFORMANCE)**	5	58%
Measure symptom/function at admission/discharge **(CLINICAL PERFORMANCE)**	6	40%
Track adverse drug reaction **(CLINICAL PERFORMANCE)**	7	39%
Measure family satisfaction **(PERCEPTION OF CARE)**	8	35%
Measure health status **(HEALTH STATUS)**	9	32%
Track signature of family/legal guardian on treatment plan **(CHILD/ADOLESCENT)**	10	30%
Measure satisfaction with medication and explanation of side effects in treatment **(CLINICAL PERFORMANCE)**	11	29%
Track contact with primary care provider in treatment **(COORDINATION OF CARE)**	12	24%
Track readmission **(COORDINATION OF CARE)**	13	24%

NOTE: Some indicators may have different rank orders due to the rounding off of the percentages.

Average Rank Across All Levels of Care

NOTE: "1" = highest percentage of respondents using this measure. Measures with higher (e.g. "1," "2") rank order averages are most consistently collected by inpatient, residential, partial hospital, and outpatient services.

Rank Order is derived from the mean percentage use of the measure across all levels of care.

Measurement Activities	Rank Order Average	Overall Rank Order
Track completed suicide **(CLINICAL PERFORMANCE)**	1	2
Policy to document medication use in chart **(CLINICAL PERFORMANCE)**	2	1
Established standards for peer review **(PEER REVIEW)**	3	3
Policy requires peer review feedback to clinicians **(PEER REVIEW)**	4	5
Patient satisfaction surveys conducted **(PERCEPTION OF CARE)**	5	4
Track attempted suicide **(CLINICAL PERFORMANCE)**	6	6
Track adverse drug reaction **(CLINICAL PERFORMANCE)**	7	3
Track seclusion **(CLINICAL PERFORMANCE)**	8	7
Track restraint **(CLINICAL PERFORMANCE)**	9	8
Measure symptom/function at admission/discharge **(CLINICAL PERFORMANCE)**	10	9
Track readmission **(COORDINATION OF CARE)**	11	11
Measure family satisfaction **(PERCEPTION OF CARE)**	12	10
Measure health status **(HEALTH STATUS)**	13	12
Measure satisfaction with medication and explanation of side effects in treatment **(CLINICAL PERFORMANCE)**	14	13
Track signature of family/legal guardian on treatment plan **(CHILD/ADOLESCENT)**	15	14
Post discharge treatment appointment tracking **(COORDINATION OF CARE)**	16	15
Track contact with primary care provider in treatment **(COORDINATION OF CARE)**	17	16
Confirm attendance at appointment after discharge **(COORDINATION OF CARE)**	18	17

In addition to the core performance measures examined in this survey, an additional set of questions were provided specifically for behavioral group practices. Group practices were asked to identify which of the following elements are documented in the initial assessment for routine office visits. The following chart indicates the percentage of group practices that indicated the following documentation policies:

Group Practice Documentation Policies

Group practice documents in the initial assessment for routine office visits:	(yes)	(%)
Presenting problems	10	100%
Personal and family psychiatric history	10	100%
Imminent risk of harm, lethality, and suicidal ideation	10	100%
Substance abuse/use	10	100%
DSM diagnosis	10	100%
Feedback to referral source/primary care physician	10	100%
Mental status	9	90%
Formulation and treatment plan	10	100%
Statement of functionality, including any limitations within the last 30 days	9	90%
Policies regarding confidentiality	10	100%
Tobacco use	6	60%
Preventive services and patient education activity	4	40%

The Performance Measures Studied

In the following section are the specific performance measures studied in this *Benchmarking Survey*. They are grouped into several key categories (health status, perception of care, coordination of care, clinical performance, child/adolescent, and peer review).

Appearing first under each measure studied is the intent statement that was provided as part of the survey itself to help those participating understand how and why these measures were selected.

In addition to numerous meetings supported by the Center for Mental Health Services, a detailed literature review (*see Bibliography/Reference List at the conclusion of this report*) was conducted. This literature review supported activities and the knowledge base that allowed the Benchmarking Committee to develop the performance measures to be studied.

Patient Perception of Health Status

Use of a patient-administered health status questionnaire on admission.

Intent Statement:

The Benchmarking Committee selected this indicator believing that it is important for treatment service providers to understand an individual patient's health status at admission. It is a measure that is important to consumers and also helps providers document the severity of the impairments of the patients they treat. This question asked in this survey was designed to determine whether organizations were using any of a variety of *valid and reliable* health measures. By *valid and reliable* we meant a generally accepted, standardized measure. Examples of frequently-used measures include, but are not limited to, instruments such as SF-36, SF-12, and the General Health Questionnaire (GHQ). The Benchmarking Committee was not attempting to prescribe or recommend any particular set of health status measures, but rather to evaluate whether facilities were systematically using a valid and reliable health status measure.

Survey Findings:

Patient-Administered Questionnaire of Health Status on Admission *[Do you measure health status on admission?]*	**(yes)**	**(%)**
Inpatient facilities that measure health status	66	61%
Residential	30	48%
Partial	51	48%
Outpatient	30	32%

The predominant instrument used to measure health status was the SF 36 (38%).

Clinical Performance

Evaluation with a symptom/function measure on admission and prior to discharge.

Intent Statement:

The Benchmarking Committee selected this indicator believing it is important that treatment services track individual patient's progress over time. This question asked in this survey was designed to determine whether organizations use any of a variety of *valid and reliable* symptom/function measures at two points – at admission and again at an appropriate point prior to discharge. By *valid and reliable* we mean a generally accepted, standardized measure. Examples of frequently used measures include, but are not limited to, instruments such as Psychiatric Symptom Assessment Scale, Symptom Checklist-90,

(SCL-90), Beck Depression Inventory (BDI), BASIS-32, and Brief Psychiatric Rating Scale (BPRS). The Benchmarking Committee was not attempting to prescribe any particular set of symptom/function measures, but rather to determine whether facilities were systematically using a valid and reliable symptom/function measure and evaluating patients' change over time. It was felt that if such indicators were routinely being used, it may be possible to consider benchmarking to show that psychiatric treatment produces change.

Survey Findings:

Measurement of Symptom/Function Across Levels of Care *[Do you do a symptom/function measure BOTH at admission and prior to discharge?]*	**(yes)**	**(%)**
Measure symptom/functioning at **inpatient** admission *and* discharge	77	70%
Measure symptom/functioning at **residential** admission *and* discharge	32	51%
Measure symptom/functioning at **partial** admission *and* discharge	66	61%
Measure symptom/functioning at **outpatient** admission *and* discharge	36	40%

The majority of respondents assessed patient symptom/function change with the following instruments: Global Assessment of Functioning (GAF), Brief Psychiatric Rating Scale (BPRS), Psychiatric Symptom Assessment Survey (PSAS), Basis 32.

Medication review.

Intent Statement:

The Benchmarking Committee selected this indicator to explore -- in all treatment settings (including group practices) – whether the appropriate use of medication was considered in the treatment planning process and documented in the medical record. Medication management and adherence/compliance to treatment are seen by the Benchmarking Committee (and backed by the literature) as significant contributors to optimal health outcomes. These questions were an attempt to examine policy and documentation practices as well as whether facilities evaluate patient perception regarding medication use.

Survey Findings:

Policy Regarding Documentation of Initial Medication Usage *[Do you have a written policy that all medications used by an individual entering your program are documented within their chart?]*	**(yes)**	**(%)**
Inpatient policy is to document use in chart *(...within first 24 hours).*	105	95%
Residential policy is to document use in chart *(...within first 24 hours).*	54	85%
Partial hospital policy is to document use in chart *(...within 48 hours of enrollment).*	90	83%
Outpatient policy is to document use in chart. *(...by the conclusion of the first outpatient appointment).*	60	65%

The majority of all respondents documented in the medical record.

Organization Assesses Patient Satisfaction with Medication and Explanation of Side Effects *[Do you assess patient satisfaction with medication and explanation of side effects?]*	(yes)	(%)
In **inpatient** setting	61	57%
In **residential** setting	25	40%
In **partial hospital** setting	46	44%
In **outpatient** setting	25	29%

Attempted suicide.

Intent Statement:

The Benchmarking Committee selected this question to see if there were common data-collection processes and definitions relating to attempted suicides that may allow for future industry-wide discussions on this issue. Having a system in place to identify those situations that should trigger a closer internal examination is a step, it was felt, many organizations have taken. There is currently no database that can be used by individual organizations for comparison. For purposes of this survey, the Benchmarking Committee selected an operational definition intended to focus on suicide attempts that were actually or potentially life-threatening or resulted in the need for urgent intervention rather than all actions that could possibly be defined as suicide attempts. It was felt that working toward use of this specific definition will allow for more reliable and valid comparisons across institutions.

Survey Findings:

Tracking of Suicide Attempts *[Do you collect data on attempted suicide?]*	(yes)	(%)
Track attempted suicide in **inpatient** setting	96	86%
Track attempted suicide in **residential** setting	49	77%
Track attempted suicide in **partial hospital** setting	82	75%
Track attempted suicide in **outpatient** setting	53	58%

Suicide attempts were tracked via medical records, incident reports, and in the patient history.

Completed suicide.

Intent Statement:

Mental illnesses can be life-threatening diseases. The Benchmarking Committee felt that it would be important to identify what type of tracking was currently in place in member organizations related to completed suicides – one of the most deadly results of mental illness. The data, while not currently collected centrally by the field, is already part of larger data efforts. For example, suicide rates are public health measures that are tracked by a number of federal agencies.

Survey Findings:

Tracking of Completed Suicide *[Do you collect data on completed suicide?]*	**(yes)**	**(%)**
Track completed suicide in **inpatient** setting	95	88%
Track completed suicide in **residential** setting	51	82%
Track completed suicide in **partial hospital** setting	88	81%
Track completed suicide in **outpatient** setting	64	70%

Completed suicides were reported to be a rare event, and, if there were a completed suicide, it was reviewed in Risk Management.

Serious adverse drug experience.

Definition:

Resulting in any of the following:

- Death
- A life-threatening reaction (immediate risk of death). For example, include neuroleptic malignant syndrome (NMS)
- Persistent or significant disability/incapacity (substantial disruption of one's ability to conduct normal life function). This is not intended to include experiences of relatively minor medical significance such as headache, nausea, vomiting, diarrhea, etc.
- Hospitalization or extension of an existing hospitalization.

Intent Statement:

Serious adverse experiences related to the administration of medication need to be understood by the individual organization as well as the industry as a whole. Virtually every organization reviews medication errors in some way. However, the Benchmarking Committee chose to focus on serious adverse drug experiences to standardize the definition to be used for the purpose of this project (based on FDA guidelines). Recently national efforts supported by both the Department of Health and Human Services and professional organizations have highlighted the importance of monitoring serious drug reactions.

Survey Findings:

Tracking of Serious Adverse Drug Reactions *[Do you collect data on serious adverse drug experiences?]*	**(yes)**	**(%)**
Track serious adverse drug experiences in **inpatient** setting	106	96%
Track serious adverse drug experiences in **residential** setting	55	86%
Track serious adverse drug experiences in **partial hospital** setting	72	66%
Track serious adverse drug experiences in **outpatient** setting	36	39%

Seclusion and restraint.

Definition:

- Seclusion is defined as the involuntary confinement of a person alone in a room where the person is physically prevented from leaving. An episode is defined by a discrete, individual order written by a licensed independent practitioner.
- Restraint is defined as the involuntary restriction of a person's freedom of movement, physical activity, or normal access to his or her body (not including temporary immobilization related to medical or diagnostic procedures, adaptive support, or therapeutic holding of a child for less than 15 minutes.)

Intent Statement:

The Benchmarking Committee selected this indicator to get a better sense of how these emergency procedures were being tracked currently by facilities. Clinically, it is important to be certain that patients are treated in least restrictive ways.

Survey Findings:

Tracking of Restraint *[Do you collect data on restraint?]*	**(yes)**	**(%)**
Track restraint in **inpatient** setting	103	95%
Track restraint in **residential** setting	44	69%

Tracking of Seclusion *[Do you collect data on seclusion?]*	**(yes)**	**(%)**
Track seclusion in **inpatient** setting	104	95%
Track seclusion in **residential** setting	45	70%

Perception of Care

Patient satisfaction.

Intent Statement:

The Benchmarking Committee selected this indicator to determine whether facilities routinely collect and analyze patient satisfaction data and, if they do, whether there is any common language in how these questions are asked. The intent was *not* to recommend or impose any particular system or instrument. In fact, the Benchmarking Committee believes that any satisfaction questionnaire may be used. However, the Committee also felt that – over time -- it will be important for the field to begin to add a single question (asked in exactly the same way and tabulated in the same way) so that patient satisfaction data can begin to be benchmarked across organizations.

Survey Findings:

Satisfaction Surveys *[Do you collect data on patient satisfaction?]*	**(yes)**	**(%)**
Inpatient patient satisfaction surveys conducted	105	95%
Residential patient satisfaction surveys conducted	45	71%
Partial patient satisfaction surveys conducted	83	77%
Outpatient patient satisfaction surveys conducted	58	64%

Among respondents, 81% attempted to survey all patients, 31% used the convenience sample method, and 21% used a random sample. Eighty-four percent of patient surveys were completed while in treatment, 29% were completed via mail, and 9% were completed via phone survey.

Family satisfaction (for families of child/adolescent patients).

Intent Statement:

The Benchmarking Committee selected this indicator to determine whether facilities are routinely collecting and analyzing family satisfaction data. While family satisfaction might appropriately be assessed for patients of any age, the question asked in this survey focused on child and adolescent patients. The intent was *not* to impose any particular system or instrument. The Benchmarking Committee believes any satisfaction questionnaire may be used. However, the Committee also felt that – over time – it will be important for the field to begin to add a single question (asked in exactly the same way and tabulated in the same way) so that family satisfaction data can begin to be benchmarked across organizations.

Survey Findings:

Measurement of Family Satisfaction *[Do you collect data on the satisfaction of families of child/adolescent patients?]*	**(yes)**	**(%)**
Inpatient family satisfaction surveys conducted	66	62%
Residential family satisfaction surveys conducted	31	48%
Partial family satisfaction surveys conducted	52	49%
Outpatient family satisfaction surveys conducted	31	35%

Across levels of care, 78% of respondents attempt to collect a 100% sample for family satisfaction, 29% used a convenience sample, 16% collected family satisfaction by a random sample. Seventy-five percent completed family satisfaction surveys while in treatment, 33% completed by mail survey, and 19% completed via phone survey.

Peer Review

Licensed independent practitioners who have had their care reviewed (on quarterly basis), via the medical record, by another professional and have received clinical feedback based on that review.

Intent Statement:

The Benchmarking Committee selected this indicator to determine whether behavioral health systems are currently formally tracking peer review. This was seen as an important indicator because quality care can only be delivered by qualified, competent professionals. An important way to monitor professional competence is through regular review of practice. An important way to enhance competence is through a mechanism of regular peer feedback. Peer review has a strong tradition in medical care. An important way to measure professional performance is through regular peer feedback and ongoing improvement initiatives.

Survey Findings:

Requirement for Peer Review *[Does your organization have established standards for peer and professional review of clinical practice?]*	**(yes)**	**(%)**
Inpatient policy requires peer review	97	92%
Residential policy requires peer review	49	77%
Partial policy requires peer review	84	77%
Outpatient policy requires peer review	60	66%

Requirement for Peer Review Feedback *[If yes, does your policy require that licensed independent practitioners receive feedback from the review?]*	**(yes)**	**(%)**
Inpatient policy requires peer review feedback to clinician	97	92%
Residential policy requires peer review feedback to clinician	46	75%
Partial policy requires peer review feedback to clinician	79	76%
Outpatient policy requires peer review feedback to clinician	56	65%

Peer reviews were conducted via the medical record on a quarterly basis.

Coordination of Care

Post-discharge treatment appointment tracking.

Intent Statement:

Continuity of care has potential for enhancing positive patient outcome and is essential as integrated systems of care become the norm. These questions were designed to determine whether facilities have a mechanism for determining whether a patient attends his/her first post-discharge treatment appointment.

Survey Findings:

Tracking Post-discharge Contact with Aftercare Provider *[Do you track the number of patients for whom your organization made a contact with a post-discharge source?]*	**(yes)**	**(%)**
Post-discharge treatment appointment tracking after **inpatient care**	55	50%
Post-discharge treatment appointment tracking after **residential care**	23	37%
Post-discharge treatment appointment tracking after **partial care**	40	33%

Confirmation of Post-discharge Appointment *[Do you track the number of patients who attended their first post-discharge treatment appointment?]*	**(yes)**	**(%)**
Confirm attendance of appointment after **inpatient care**	35	32%
Confirm attendance of appointment after **residential care**	9	14%
Confirm attendance of appointment after **partial care**	25	23%

Post-discharge appointments were recorded primarily in the medical record. The information was compiled in data bases, nurse manager records, CQI files, case management files, staff note books, and other logs. Confirmation of post-discharge appointment was maintained in the medical record.

Readmission rate to same organization and level of care.

Intent Statement:

Readmission rate is an indicator that is often requested by payors and regulatory bodies. The intent of this question was to determine whether facilities are formally collecting this data as a way of determining whether – in the future -- industry-wide rates could be documented. It was felt that extreme caution would be necessary in interpreting any such data gathered in the future. While readmission may indicate clinical issues that need to be examined, it may also indicate appropriate treatment of patients with chronic, recurring illnesses. This indicator is intended as a trigger to encourage greater internal evaluation of the reasons behind the readmission pattern. In addition, there may be patients who are readmitted, but to different organizations. This presents a challenge to efforts to capture all readmission data.

Survey Findings:

Tracking of Readmissions to Same Level of Care *[Do you routinely collect data on readmissions?]*	**(yes)**	**(%)**
Track **inpatient** readmissions	90	81%
Track **residential** readmissions	33	52%
Track **partial hospital** readmissions	47	43%
Track **outpatient** readmissions	21	24%

Contact with primary care physician.

Intent Statement:

The Benchmarking Committee selected this indicator to determine to what extent facilities are currently tracking contact with primary care physicians. It was felt that, if this data can be collected, it could be a valuable measure. Coordination and continuity of care are critical elements in the long-term success of any treatment program. Virtually everyone referred for psychiatric treatment has had some point of contact with the general medical care system. Because an episode of psychiatric treatment happens in the context of a person's larger health care experience, and because many psychiatric patients are prescribed psychotropic medications and have significant medical problems, the ongoing involvement of a primary care physician may be critical to long-term recovery (both to monitor the physical impact of psychotropic medications and to be a resource capable of identifying both psychiatric and physical symptoms before they escalate). This measure is designed to look at whether treatment facilities currently have a formal system to 1) determine whether a newly admitted patient has a primary care physician; 2) encourage dialogue between the primary care doctor and the treatment team; 3) ensure that all patients leaving a level of care have (or have a referral to) a primary care physician, and 4) identify the problems and issues that exist with the interface with the general health care system. Over the long term, it will be important to hold discussions with groups involved from the primary care perspective (such as members of the American Hospital Association and the medical delivery system) to see how this – or some other measure related to the relationship with primary care – can be pursued as a meaningful measure.

Survey Findings:

Tracking of Contact with Primary Care Provider *[Do you track the number of cases in which primary care contact was made?]*	**(yes)**	**(%)**
In **inpatient** treatment	32	30%
In **residential** treatment	14	22%
In **partial** hospital treatment	22	21%
In **outpatient** treatment	22	24%

This item was reported to be a very difficult task to complete. Respondents reported: "we are planning to monitor," "we struggle," "time consuming," "occurs seldom." A minimal percentage of respondents did contact the patient's primary care physician.

Child/Adolescent

Signature of family member/legal guardian on child/adolescent patients' treatment plan.

Intent Statement:

Studies indicate that a key predictor of outcome for child/adolescent psychiatric patients is the level of involvement of families in their treatment and ongoing care. The Benchmarking Committee felt that one indicator of a facility's ability to involve the family may be documentation of a formal process by which family members can participate in treatment planning. This question was *not* intended to determine whether families agree with the treatment plan. Informed discussion and dissent is considered equally important as agreement. While this question focused on the signing of the treatment plan, we recognize that there are other ways facilities may track their process for communicating with family members and engaging them in the treatment planning process.

Survey Findings:

Tracking of Family/Guardian Signature	**(yes)**	**(%)**
Track signature of family/legal guardian on treatment plan in **inpatient** setting	55	51%
Track signature of family/legal guardian on treatment plan in **residential** setting	31	49%
Track signature of family/legal guardian on treatment plan in **partial hospital** setting	41	39%
Track signature of family/legal guardian on treatment plan in **outpatient** setting	26	30%

Signatures were reported to be reviewed in the medical record; the data was collected on a monthly basis. The vast majority of respondents (77%) defined *child* as a young person age 17 or younger.

Family satisfaction (for families of child/adolescent patients).

Refer to "Perception of Care" section.

LIMITATIONS OF THE STUDY

This study represents a significant effort to ascertain the performance and quality improvement activities and practices in psychiatric delivery systems. The results, however, should be interpreted with caution. Altogether, over 100 surveys were tabulated. Only 43% of NAPHS members returned the survey. In addition, the survey used may not have contained the degree of precision required to ascertain a number of structural issues and performance improvement activities.

The constructs and meaning of health status, symptoms, and functional impairment may not have been perceived in a uniform fashion by all those who responded. A follow-up cognitive interview process with respondents may clarify their perceptions about what each question "meant," and could lead to a survey with greater precision and accuracy. Despite any confusion or lack of clarity on any particular items, missing data was minimal. Follow-up phone calls and re-administering the survey to a select number of respondents would clarify missing responses and provide a reliability test for the survey effort.

Enhancing the validity of the survey can be accomplished by conducting interviews with respondents to clarify the meaning of different questions.

A pilot chart audit form can be developed and pilot tested for use after the validity check is conducted. This pilot chart audit form would primarily assess process measures such as coordination of care, adverse events, and involvement in care. It would also allow for sites to perform a number of quality improvement activities in a cost-efficient manner.

In summary, the limitations of this study are consistent with any survey research effort. Techniques to enhance the validity and reliability should be considered and implemented prior to conducting a future benchmark effort.

NEXT STEPS

This report is being distributed to all member organizations within the National Association of Psychiatric Health Systems and the Association of Behavioral Group Practices. It will also be made available to others working in the field to provide both the findings and an example of the process used by the Benchmarking Committee to come to consensus on measures to be studied.

The Benchmarking Committee will continue to work on the issue of performance measures, using the data in this report to begin a dialogue on which indicators may be most appropriate for pilot testing. The Benchmarking Committee will use its own committee membership to begin to look at actual data on selected performance measures. This will be a first step in working to identify what, if any, pilot testing may be feasible (both from a data-collection and financial standpoint). The goal is to identify performance measures that are "meaningful, measurable, and manageable" across all levels of care.

Future Direction

The results of the *Benchmarking Indicators Survey Report* present a point-in-time description of the current state of performance measurement activities in the organizations represented in the survey. It will be used as a platform for the development of the next steps toward the NAPHS/ABGP Benchmarking Initiative's goal of bringing together theory and practice to ensure that behavioral health organizations are able to implement data-collection strategies that will provide the information needed to advance patient care and quality.

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Center for Mental Health Services

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NAPHS / ABGP membership

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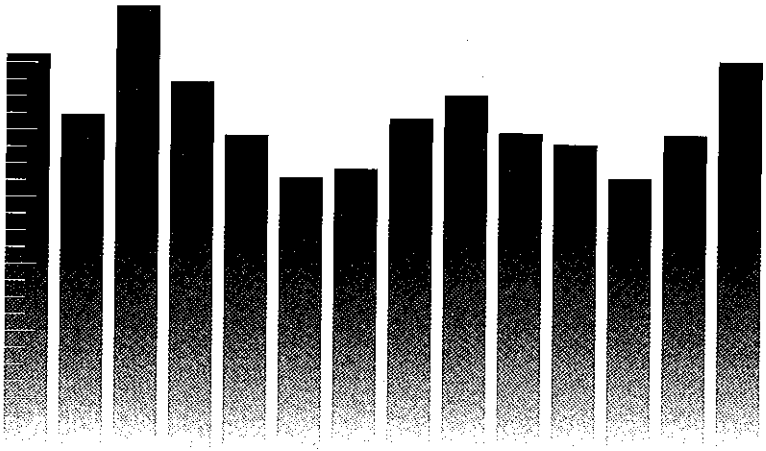

National Association of Psychiatric Health Systems
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