



STRATEGY FOR PERFORMANCE MEASUREMENT DATA OUTLINED

by Dave Gourley RRT

The Joint Commission recently released a white paper on the development of a national performance measurement data strategy. This white paper is another in the Healthcare at the Crossroads series. The Joint Commission launched this Public Policy Initiative in 2001 to address issues related to providing safe, high quality health care and the health of the American people. These issues are significant in nature and require the attention of multiple stakeholders in order to achieve successful resolution.

For more than a decade, healthcare organizations have depended on performance measurement data as part of quality assessment and performance improvement programs.

Currently, there is an increased emphasis on transparency in health care information. Also, due to the increased demand for performance measurement data,

Rapid growth in performance measurement has resulted in an increase in costs and a burden to health care organizations

significant issues that impede more widespread uses of this data have been identified.

The Joint Commission notes that not enough attention has been given to the infrastructure that needs to be in place to support performance measurement activities. Multiple issues must be addressed in the framework for designing this infrastructure. These include data privacy, data sharing and linkage, and a predetermined set of rules and governance structure.

We are all well versed today on the importance of accurate collection and understandable display of quality data. This information is vital to health care organizations and practitioners, purchasers, regulators, and the general public. It is used to set quality improvement priorities and performance evaluation. For respiratory therapists, data such as ventilator length of stay and ventilator acquired pneumonia (VAP) rates have become standard quality indicators.

The recognition of the value of performance data has resulted in the development of major performance initiatives and databases. Numerous prominent organizations maintain these databases, including The Center for Medicare and Medicaid Services (CMS), American Medical Association (AMA), and The Joint Commission.

One of the problems identified is the tendency for each of these systems to operate in isolation in order to meet the needs of

their sponsor. Often, the data collection is for a specific setting, payor, or service, and data is collected and used in fragmented ways. This inhibits the ability to see overall quality for a specific clinician or organization, or the state of the public health at large.

This rapid growth in performance measurement has resulted in an increase in costs and a burden to health care organizations. In addition, it has also led to variable portrayals of performance. The Joint Commission's goal is for the ability to share or merge data, to better use system resources, and reduce confusion resulting from contradicting performance reports.

The Joint Commission's white paper includes three broad recommendations in an effort to develop a national performance measurement data strategy.

First, they recommend the creation of a framework for a national performance measurement system. This includes standardization of measure definitions and data collection processes. This is essential in order to compare data and produce data that is widely accepted. The National Quality Forum (NQF) is responsible for standardizing measures and ensuring that they have been appropriately tested prior to implementation. The funding of this initiative ideally will be a public-private partnership since collaboration is essential and funding would be needed from both sectors. The national strategy should not stifle or supersede local initiatives. It should support and complement these efforts and prevent duplication.

continued on next page



**"I'm used to big pay and no work.
I've always been a CEO."**

Secondly, The Joint Commission notes that current performance measurement activities differ in their methods for data collection, storage, and retrieval. The methodology for performance measurement used by different organizations, including The Joint Commission approved vendors, CMS, physician organizations, and disease registries, do not allow for data sharing and aggregation. The challenge will be to integrate these varied sources of data to enable data sharing. Information technology does allow for this model of data collection and analysis, but would be further enhanced by electronic medical record systems with the capability to identify, aggregate, and transmit data elements in order to produce comprehensive performance reports. One additional feature that would assist with electronic data collection is electronic personal health records (PHR). Though in its early stages of development, PHR should someday prove to be beneficial in supporting performance measurement programs.

The third principle in the development of a national performance measurement strategy is to engage stakeholders and engender trust. The most obvious obstacle to this is concerns for privacy of personal health information (PHI). Patients may be reluctant to reveal all personal health information, even to their physician, for fear of it being discovered by insurance carriers, employers, or other unauthorized persons. In fact, 15% of all patients engage in privacy protective behaviors in order to keep their PHI a secret.

To minimize these concerns regarding privacy, Connecting for Health, a foundation whose goal is a common framework for networked health information, has developed nine principles for promoting private and secure health information exchange:

1. Openness and Transparency
2. Purpose Specification and Minimization
3. Collection Limitation
4. Use Limitation
5. Individual Participation and Control
6. Data Integrity and Quality
7. Security Safeguards and Controls
8. Accountability and Oversight
9. Remedies

In conclusion, performance measurement has become a mainstay in healthcare in the United States, and is here to stay. We can expect to see an increase in the demand for data collection and public reporting of this data. As respiratory therapists, we need to remain cognizant of the role we play in this data and the results that are publicly reported. We can shine as a profession by demonstrating our expertise with positive quality data results, as the respiratory therapists in my institution did in 2007. The respiratory therapy staff at Chilton Memorial Hospital achieved 100% compliance in providing smoking cessation education to patients diagnosed with acute myocardial infarction, congestive heart failure, and pneumonia. This helps to show our value as integral members of the healthcare team. All respiratory therapists must become aware of the significance of these measures and the importance it plays to our healthcare organizations and, most importantly, our patients.

David Gourley, RRT is a veteran therapist and former Department Director. He is now Vice President of Regulatory affairs at Chilton Memorial Hospital, Pompton Plains, NJ. He can be reached at Dag29@aol.com



ON A WHOLE NEW SCALE

Introducing the revolutionary EnVe™ ventilator from Cardinal Health. The ActivCore™ gas delivery system and an active exhalation valve makes EnVe one serious ICU ventilator.

With a complete selection of modes, full graphics, spontaneous breathing trial and even pulse oximetry, EnVe sets a new standard for ICU ventilators.

Need to move your patient? No problem. EnVe can run on its internal battery for up to 4 hours. Need more time? The batteries can be hot swapped with no disruption in ventilation.

The EnVe Ventilator.....Let the revolution begin.

SLEEP 2008
Booth 223

www.cardinalhealth.com/enve
(800) 520-4368

CIRCLE READER ACTION CARD # 8