Introduction and Background

The History of the Performance Measurement Initiative

In 1987, The Joint Commission (previously known as The Joint Commission on Accreditation of Healthcare Organizations) announced its *Agenda for Change*, which outlined a series of major steps designed to modernize the accreditation process. A key component of the *Agenda for Change* was the future incorporation of performance measurement into the accreditation process. As the performance measurement initiative evolved, the name ORYX® was chosen to represent the overall initiative. Beginning with the hospital and long term care accreditation programs, performance measurement requirements were phased in over several years. Initial requirements allowed organizations to select a performance measurement system from a Joint Commission approved list to collect aggregate health care data on individual performance measures. In March of 1999, the ORYX® initiative became operational when the performance measurement systems began transmitting data to The Joint Commission on behalf of accredited hospitals and long term care organizations. Since that time, home care and behavioral health organizations have been included in the ORYX® initiative.

The eventual development and inclusion of standardized core performance measures was a standing goal of the ORYX® initiative. The next phase of the ORYX® initiative focused on the identification of standardized sets of valid, reliable, and evidence-based "core" measures for use in the hospital accreditation program. In early 1999, The Joint Commission solicited input from a wide variety of stakeholders-clinical professionals, health care provider organizations, health care consumers, and performance measurement experts – about potential focus areas for core measures. The input of these stakeholders, together with recommendations from state hospital associations led to the identification of five initial core measurement areas:

- Acute myocardial infarction
- Heart Failure
- Community acquired pneumonia
- Pregnancy and related conditions (including newborn and maternal care)
- Surgical procedures and complications

A period of extensive work involving clinical input from expert panels, attributes and evaluation criteria for core performance measures developed with an Advisory Council on Performance Measurement and pilot testing with state hospital associations, measurement systems, and hospitals led to the final selection of hospital core measures. Implementation of data collection on the first sets of ORYX® core measures for hospitals began in July 2001.

Performance Measurement in Disease-Specific Care Certification

Since consensus-based nationally standardized performance measures do not currently exist for many disease states, The Joint Commission has initiated a two-stage process with respect to performance measurement expectations for certified programs. Stage I requires that certified programs collect and analyze data on at least four self-identified performance measures related to, or identified in, evidence-based guidelines. Stage II comprises the development by The Joint Commission of sets of standardized measures for selected disease states for implementation by certified programs. Once a standardized set is introduced, affected programs are required to replace current (Stage I) measures with the applicable standardized (Stage II) measures. For additional information on current requirements, review the Disease-Specific Care Certification at the Joint Commission web site (www.jointcommission.org).

A systematic process is used for identification of standardized measures. First, an expert panel is identified to assist in establishing a framework (see Chapter 2), the scope of the initial measure set, and to recommend the initial measures comprising the set. The framework is designed to identify delivery of care settings, key domains or aspects of care, and outcomes of care.

The expert panel discusses potential measurement opportunities within each focus area of the framework. In some cases, while a given measurement aspect is considered to be important, existing measures cannot be identified. Where existing measures are identified, the panel prioritizes them and requests additional information from measure developers to assist the panel in evaluating the measures for importance, scientific acceptability, usability/interpretability and feasibility.

After identification of a measure framework, a public call for measures is conducted. Following the call for measures and staff review of materials received, the panel evaluates and recommends a draft set of measures for stakeholder review and public comment. The results of these reviews and public comments are carefully considered and incorporated in measure specifications, which are then pilot tested before finalization of the standardized measure set.

Standardized Stroke Measures

In November 2003, The Joint Commission in collaboration with the American Heart Association / American Stroke Association (AHA/ASA) set out to develop performance measures for DSC Certification for Primary Stroke Centers, the first advanced-level certification program designed to recognize primary stroke centers that make exceptional efforts to foster better outcomes for stroke patient care. Unlike basic certification, the advanced program outlined additional clinically-specific

requirements and expectations based on the Brain Attack Coalition's Recommendations for Primary Stroke Centers and guidelines developed by the AHA/ASA and equivalent evidence-based guidelines. These guidelines provided the foundation for the identification of areas for performance measurement and the development of detailed measure specifications. Specifications for a set of ten candidate stroke measures were ultimately drafted and recommended by the Joint Commission's Stroke Advisory Panel in early 2004, followed by a 12-month pilot test (October 1, 2004 through September 30, 2005) to assess and quantify the data collection effort, evaluate the reliability of individual data elements, measure specifications, the measurement set, and identify potential measure modifications. A standardized set of ten measures for stroke patient care was finalized following the pilot test project, and data collection for four priority measures uniformly adopted by all currently certified Primary Stroke Centers, as well as programs seeking initial DSC Certification from The Joint Commission.

The pilot test project also revealed that several pilot site programs were currently participating in the American Stroke Association's *Get With The Guidelines*SM *(GWTG)-Stroke* program / patient management tool and/or the Paul Coverdell National Acute Stroke Registry sponsored by the Division of Heart Disease and Stroke Prevention, Centers for Disease Control and Prevention (CDC). Efforts to harmonize the data elements of all three measure sets were initiated in May 2006. The Stroke Performance Measure Consensus Group, comprising representatives from The Joint Commission, AHA/ASA and CDC, was established and began to identify commonalities across the three performance measurement methodologies, and to align data element definitions and guidelines for abstraction. As a result, the ten measures included in this revised implementation guide have been harmonized with the GWTG-Stroke and Coverdell measure specifications for use in all services or programs.

Stroke

Among adults age 20 and older, the prevalence of stroke in 2004 was an estimated 5,700,000. Each year about 700,000 people experience a new or recurrent stroke. The estimated direct and indirect cost of stroke for 2007 is $62.7 billion. With advances in diagnosis and treatment, the stroke death rate fell 20.4% from 1994-2004; however, when considered separately from other cardiovascular diseases, stroke remains the No. 3 cause of death in the United States and a leading cause of serious, long-term disability.

Once a stroke has occurred, all attempts should be made to decrease the time from symptom onset to stroke treatment. The underlying pathophysiology can be varied and it is important to confirm the cause of the patient's impairment, i.e., ischemic stroke, intracranial hemorrhage, or other systemic or neurological illness. Therefore initial diagnosis is important for treatment and disease management.

Research has identified and clinical practice guidelines include recommended processes of care based on the best evidence and clinical opinion available at this time. The performance measures presented in this guide have been selected with reference to the process of care described in current clinical practice guidelines. As part of an ongoing quality improvement initiative within an organization, they can help assess the processes of care and quality of services for stroke patients within a certified DSC service or program.

References

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