Joint Commission Online

A complimentary publication of The Joint Commission June 23, 2010

Special Issue for Hospitals

Focus on accountability measures: Helping hospitals meet future performance measurement expectations

In order to help hospitals prepare for performance measurement in the new health care environment, The Joint Commission is categorizing its performance measures into accountability and non-accountability measures. This approach places more emphasis on an organization's performance on accountability measures – quality measures that meet four criteria (see sidebar) designed to identify measures that produce the greatest positive impact on patient outcomes when hospitals demonstrate improvement. Non-accountability measures (for example, providing smoking cessation advice) are more suitable for secondary uses, such as exploration or learning within individual health care organizations, and are good advice in terms of appropriate patient care. The majority of The Joint Commission's core measures are accountability measures; there are six non-accountability measures (see lists below).

Criteria for accountability measures

Research: Strong scientific evidence exists demonstrating that compliance with a given process of care improves health outcomes (either directly or by reducing risk of adverse outcomes).

Proximity: The process being measured is closely connected to the outcome it impacts; there are relatively few clinical processes that occur after the one that is measured and before the improved outcome occurs.

Accuracy: The measure accurately assesses whether the evidence-based process has actually been provided. That is, the measure should be capable of judging whether the process has been delivered with sufficient effectiveness to make improved outcomes likely. If it is not, then the measure is a poor measure of quality, likely to be subject to workarounds that induce unproductive work instead of work that directly improves quality of care.

Adverse Effects: The measure construct is designed to minimize or eliminate unintended adverse effects.

Increasingly, performance measure data are being used for many purposes and, moving forward, will be the basis for much of Medicare's Value-Based Purchasing program and for public reporting purposes. The Joint Commission's new approach will help hospitals prepare for the increasing reliance on attaining high performance on quality measures.

Currently, Joint Commission-accredited hospitals deliver evidence-based treatment of heart attack **96 percent of the time** and they are making similar – and greater – gains in evidence-based treatment of heart failure, pneumonia and in surgery. The need to "raise the bar" and advance performance measures that truly improve patient outcomes has been top-of-mind for accredited hospitals and The Joint Commission for some time.

"Hospitals and physicians have embraced the measurement and reporting of robust and evidence-based quality metrics as an important mechanism to drive improvement," says Mark R. Chassin, M.D., M.P.P, M.P.H., president of The Joint Commission. "In doing so, they have achieved substantial gains that have undoubtedly saved thousands of lives."

The Joint Commission has incorporated accountability measures into its ORYX® performance measure program and is working with all stakeholders to encourage them to adopt this approach and to remove non-accountability measures. Going forward, The Joint Commission will only adopt accountability measures for its ORYX program and is reviewing all the other current core measures (e.g., perinatal care and Hospital Based Inpatient Psychiatric Services) and applying the accountability tests to them.

To learn more about accountability measures, read the June 23, 2010 online issue of the *New England Journal of Medicine* that features an article, "Accountability Measures: Using Measurement to Promote Quality Improvement," for which Mark R. Chassin, M.D., M.P.P, M.P.H., president of The Joint Commission, was the lead author.

Upcoming audioconference
Joint Commission-accredited hospitals can learn more about accountability measures during an audioconference on Wednesday, June 30, at 11 a.m. PT / noon MT / 1 p.m. CT / 2 p.m. ET. Look for information about the audioconference and how to sign-up on your hospital's Joint Commission Connect extranet. (Contact: Cathy Barry-Ipema, cipema@jointcommission.org)

How The Joint Commission is bringing accountability measures into practice
Accountability measures have already been integrated into the information reported on Quality Check™ and The Joint Commission is considering ways to integrate performance expectations on accountability measures into accreditation standards. In order to do this, it is critical that we engage hospitals in the best ways to do this. Therefore, over the next six months, The Joint Commission will be getting your input in a variety of ways, including convening focus groups and fielding online surveys. In addition, The Joint Commission is creating programs to assist hospitals to improve on these measures, including the development of a new database to share improvement interventions as well as enhanced information on the evidence demonstrating that improved performance leads to better health outcomes for patients.

Quality Check™ information derived from third quarter 2009 core measure data was posted to the Quality Check Web site in March 2010. Starting with the March report, **only accountability measures are being used to calculate the overall performance rate for each measure set**. The new calculation of measures will not affect individual measure information reported on Quality Check and has a negligible impact on measure set composite information as previously calculated and reported. However, the heart failure measure set composite (overall) rate now reflects performance on only one accountability measure – ACE Inhibitor or ARB for LVSD (left ventricular systolic dysfunction).

Accountability measures will also be integrated into the Priority Focus Process and The Joint Commission's Strategic Surveillance System (S3) Performance Risk Assessment. In these tools, accountability measures will be weighted differently (i.e., higher) than non-accountability measures. When a hospital's performance on an accountability measure is determined to be unsatisfactory, one (1) point will continue to be assigned to each of the related Priority Focus Areas (PFAs) and Clinical Service Groups (CSGs). When performance on a non-accountability measure is determined to be unsatisfactory, 0.33 point will be assigned to each of the related PFAs and CSGs. More details about changes to the PFP and S3 will be provided in the August issue of *The Joint Commission Perspectives*.

Accountability measures

Heart attack care (AMI)
Aspirin at arrival
Aspirin at discharge
ACE Inhibitor or ARB at discharge
Beta-blockers at discharge
Fibrinolytic therapy within 30 minutes
Primary PCI balloon therapy within 90 minutes

Heart failure care (HF)
ACE Inhibitor or ARB at discharge

Pneumonia care (PN)
Pneumococcal vaccination
Blood culture in Emergency Department
Antibiotics for immunocompetent patients
Influenza vaccination

Surgical care (SCIP)
Antibiotics within one hour before the first surgical cut
Appropriate prophylactic antibiotics
Stopping antibiotics within 24 hours
Cardiac patients with controlled 6 a.m. postoperative blood glucose
Patients with appropriate hair removal
Beta-blocker patients who received beta-blocker perioperatively
Prescribing venous thromboembolism prophylaxis
Receiving venous thromboembolism prophylaxis

Children's asthma care (CAC)
Relievers for inpatient asthma
Systemic corticosteroids for inpatient asthma
Home management plan of care given to patient/caregiver

Non-accountability measures

Heart attack care (AMI)
Smoking cessation advice

Heart failure care (HF)
Discharge instructions
LVS function assessment
Smoking cessation advice

Pneumonia care (PN)
Smoking cessation advice
Antibiotic within six hours of arrival