National Committee on Vital and Health Statistics
Quality Subcommittee
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The Joint Commission

Joint Commission Accreditation and Certification Programs

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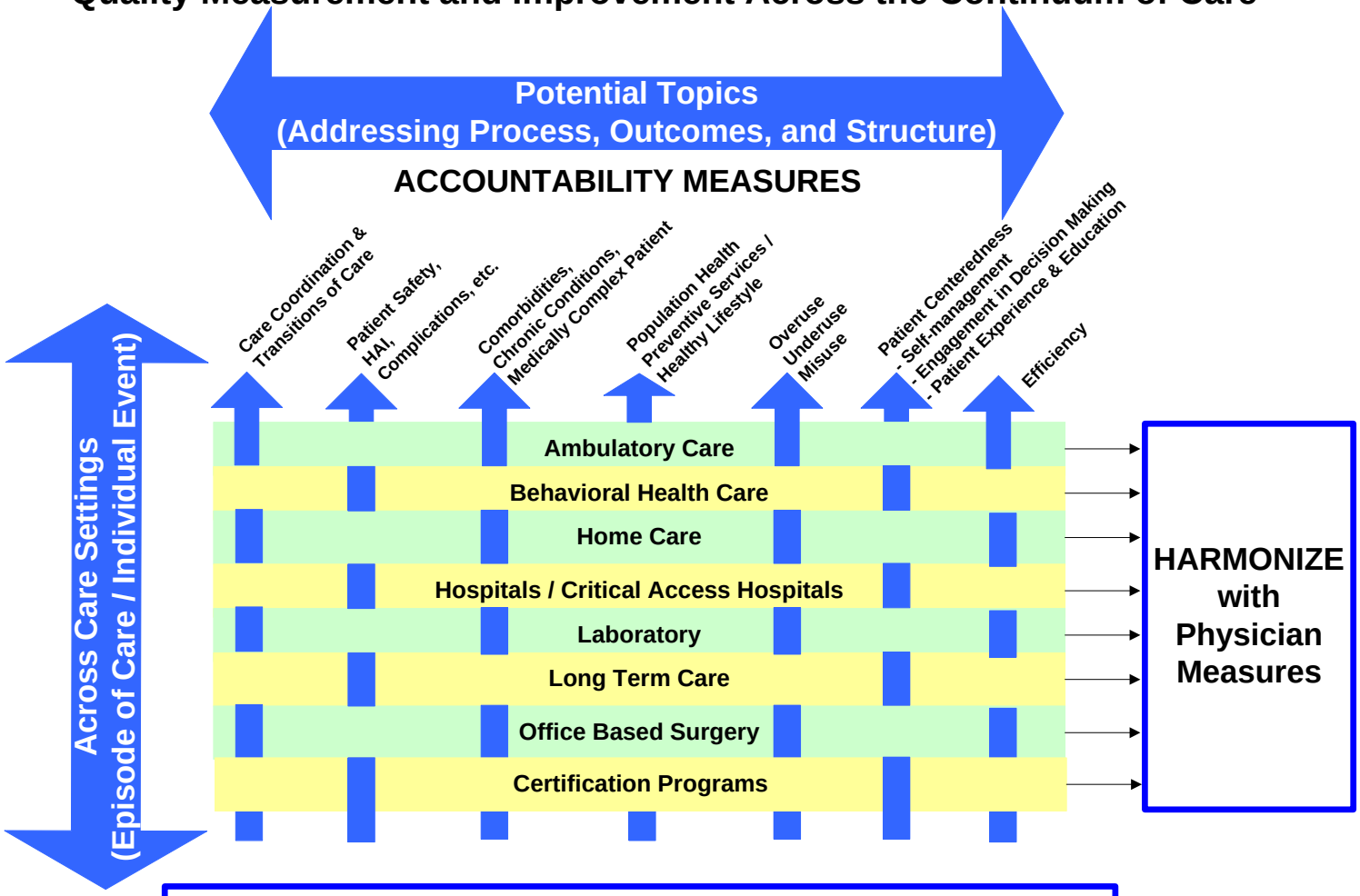
Quality Measurement and Improvement Across the Continuum of Care



INFLUENCERS

INTERNAL		EXTERNAL
- Accreditation Process	- Standards	- Legislation
- Certification Process	- Intra-cycle Monitoring	- Meaningful Use
- Center for Transforming Healthcare		- Health Information Technology

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Important Areas Continued

- Quality of care in new delivery models
  - Accountable Care Organizations
  - Primary care Homes
  - Challenge given the broad array of participants
  - Patient experiences across delivery sites
  - Management of chronic conditions
  - Cost experience across the continuum
  - Different payers, patient populations --data consistency
- Measures sensitive to failures in care transitions
  - Transitions of Care/Communication the #1 safety failure in TJC Sentinel Event Database

TJC Moving in a New Measurement Direction

- Performance measurement in “accountability programs” must meet a higher bar than internal QI efforts, guidance, etc.
- Hope that federal government, states, other stakeholders involved in accountability programs will join us.
- Does not mean less measurement
  - More cost-beneficial measurement, better results
  - Higher quality of care
- Must start now

New Direction for the Joint Commission also an Opportunity for All Stakeholders

1. National Goal should be to focus on measures that maximize health benefits to patients
2. Examine roster of current measures included in national quality programs, using established criteria to identify measures that do not improve health outcomes for patients
3. Replace poor measures with better measures
4. Suggest all quality measures used in national transparency and payment programs – both existing and proposed new measures – be vetted against specific criteria for accountability programs

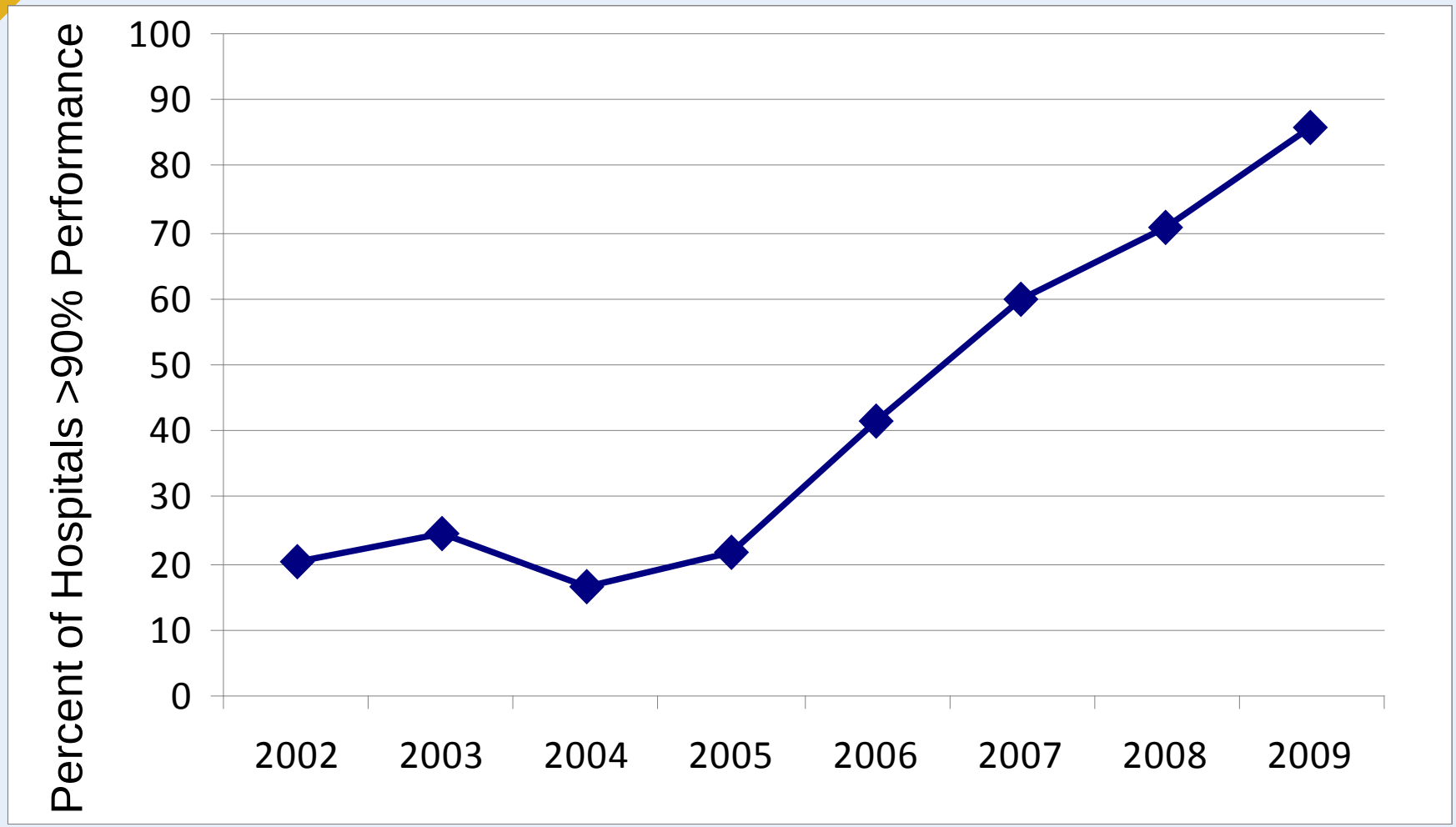
Accountability Programs Require Higher Bar for Metrics

- Accreditation and other Oversight Decisions
  - Reputation
  - Ability to participate in M/M
  - Ability to receive funds from other government or insurance programs
  - Residency programs
- Value-Based Purchasing
  - Payment updates, incentive payments, MU incentives, penalties
- Public-Reporting
  - Market share, investments

Historical View

- 1998 - TJC launched ORYX
- 2002 – TJC required standardized measures
  - Created Core Measures
- 2004 – TJC hospital public reporting
- 2005 – CMS begins public reporting using JC measures

Hospital Performance on Accountability Core Measures



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Accountability Measures and Opportunities Over Time

- Number of accountability measures and performance have increased over time
- 2002: 8 accountability measures
  - Overall performance = 81.8%
  - # opportunities = 957,000
- 2009: 22 accountability measures
  - Overall performance = 95.4%
  - # opportunities = 12.5 million

Improving Measurement to Drive Improved Outcomes

- A great deal of real-world experience
  - Many measures work well; some don’t
  - Must replace measures that don’t work
- No formal process to assess that experience, learn from it, and act on it
- Define a new approach that uses measurement to drive maximal improvement in health outcomes

Accountability Measures

The NEW ENGLAND JOURNAL of MEDICINE

SOUNDING BOARD

Accountability Measures — Using Measurement to Promote Quality Improvement

Mark R. Chassin, M.D., M.P.P., M.P.H., Jerod M. Loeb, Ph.D., Stephen P. Schmaltz, Ph.D., and Robert M. Wachter, M.D.

Measuring the quality of health care and using those measurements to promote improvements in the delivery of care, to influence payment for services, and to increase transparency are now commonplace. These activities, which now involve markably recent. In 1998, the Joint Commission launched its ORYX initiative, the first national program for the measurement of hospital quality, which initially required the reporting only of nonstandardized data on performance measures.[1] In

Accountability Framework

Accountability measures – quality (process) measures that meet criteria designed to ensure that measures produce the greatest positive impact on patient outcomes when used for improvement:

- **Research** - Strong evidence base demonstrating that given care processes leads to improved outcomes
- **Accuracy** - Measure accurately captures whether the evidence-based care process has been provided
- **Proximity** - Measure addresses a process that has very few intervening care processes that must occur before the improved outcome is realized
- **Adverse Effects** -Implementing the measure has little or no opportunity of inducing unintended adverse consequences

Measurement Drives Improvement

- Measures used for “accountability” (accreditation, public reporting, payment) cause HCOs to do major work to improve
- Measures have “clinical integrity”---Clinicians believe improving performance will lead to better health outcomes
- Lack of clinical integrity:
  - Turns clinicians away from improvement
  - Leads to workarounds and wasted effort
- Lots of good examples of both situations

Measures With Clinical Integrity: "Accountability Measures"

- Examples: Aspirin, beta blockers, and ACE inhibitors for acute MI; surgical antibiotic prophylaxis; new peri-natal measures
- Characteristics of Accountability Measures
  - Large volume of research proves relationship to improved outcomes
  - Process is closely connected to outcome
  - Measure accurately assesses process
  - No or minimal unintended adverse effects

Non-Accountability Measures

- Smoking cessation counseling (3)
- Heart failure discharge instructions
- Oxygenation
- LV function assessment
- First dose of antibiotic in 6 hrs (pneumonia)
- Pregnancy measures (old)

Joint Commission Initiatives

1. Include performance on accountability measures in accreditation standards
2. Work with other stakeholders to eliminate non-accountability measures
3. Include only accountability measures in ORYX program going forward
4. Provide evidence that improved core measures lead to improved patient outcomes
5. Help hospitals improve performance on accountability measures
   - The Center for Transforming Health Care
   - Solutions Exchange
6. Create a recognition program to further reward top performers

Next Steps

- Build accountability framework for outcome measures for clinical integrity
  - Clinical outcomes nearly always require clinical risk adjustment
  - Measure must capture the outcome
  - Minimal or no adverse effects
- Some excellent sources of outcome measures with clinical integrity
  - Patient experience measures
  - Functional outcomes (CHF, joints)

Some Outcome Measures with Clinical Integrity

- State cardiac surgery reporting systems that use clinical data (e.g., NY, PA, NJ, MA, CA)
- STS cardiac surgery registry
- American College of Surgery's National Surgical Quality Improvement Program (NSQIP)

Problematic Mortality Measures

- Comparing hospitals on mortality requires risk adjustment using data on factors that influence patients' risk of dying
  - ➔ Severity of primary illness
  - ➔ Comorbid conditions
- Many measures use data from hospital bills for these purposes, resulting in:
  - Misclassification of hospitals
  - Omission of crucial clinical factors known by clinicians to have major impact

Disagreement in hospital-level mortality measures

- When risk-adjusted mortality ratios were compared among the different vendors, agreement was relatively poor.
- In specific statistical terms, the pari-wise correlations varied from 0.36 to 0.87. (1 is perfect correlation, O is complete absence of correlation)
- There was in fact a positive correlation among the vendors; however, there were a number of outlier hospital (better than expected or lower than expected) classifications.
  - For example, the percentage of hospitals classified as outliers was large, regardless of the vendor product; approximately one-third of hospitals received the same outlier classification status by all vendor products; the vendor products identified different hospitals as outliers; and, in FY07, four hospitals were found to be higher than expected for one methodology but lower than expected for a different methodology.
  - Discharge-level mortality prediction preformed only slightly better.

Medicare's Pneumonia Model

Most important risk factors*	Included
Age	Yes
Acidosis (pH < 7.35)	
Active cancer	Yes
Serum sodium < 130	
Kidney dysfunction (BUN > 10.7)	
Respiratory rate ≥ 30	
Systolic blood pressure < 90	
Disorientation	

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*Fine M, et al. NEJM 1997;336:243-50, AHRQ-funded research

Review of E-Specifications Needed

- Threat to the integrity of JC Core Measures
  - Using only data elements from electronic records
  - Clinical integrity can be lost in attempt to simplify
- Conduct testing of the eMeasures, to fulfill NQF testing requirements and confirm an eMeasure is an accurate reflection of the derived measure, the one initially developed and then endorsed by NQF
- Create mapping and editorial fixes as needed
- Ensure steps to prevent problems during the MU Phase 2 and 3
- Resolve Questions
  - Who is the Measure Steward when e-specs are not created by originial steward?
  - Where is the locus of accountability to ensure the problems with the eMeasures are “fixed”?