Facts about accountability measures

In June 2010, in order to help hospitals prepare for performance measurement in the new health care environment, The Joint Commission categorized its process 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 designed to identify measures that produce the greatest positive impact on patient outcomes when hospitals demonstrate improvement:

- **Research**: Strong scientific evidence demonstrates that performing the evidence-based care process improves health outcomes (either directly or by reducing risk of adverse outcomes).
- **Proximity**: Performing the care process is closely connected to the patient outcome; 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 or not the care process has actually been provided. That is, the measure should be capable of indicating whether the process has been delivered with sufficient effectiveness to make improved outcomes likely.
- **Adverse Effects**: Implementing the measure has little or no chance of inducing unintended adverse consequences.

Non-accountability measures 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. Going forward, The Joint Commission is only adopting accountability measures for its ORYX program. For more information about accountability measures, see the following articles:

- “Hospital performance trends on national quality measures and the association with Joint Commission accreditation,” in the October 2011 issue of the “Journal of Hospital Medicine.”

Effective January 1, 2012, four of the six non-accountability measures that were common to the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission were retired by both organizations. The four non-accountability measures that were retired are smoking cessation advice (heart attack, heart failure and pneumonia care); and antibiotic within six hours of arrival (pneumonia care). There are two remaining non-accountability measures: discharge instructions and LVS function assessment (heart failure care). The Joint Commission will continue to support those measures that are in common with CMS and will work with CMS to consider retiring the two remaining non-accountability measures.

The Joint Commission evaluated additional process measures (excluding the perinatal care test measures) and has categorized a total of 45 measures as accountability measures. The Joint Commission will continue to re-examine all process (i.e., proportion and ratio) measures categorized as accountability measures to ensure they continue to meet the accountability criteria. Also, accountability criteria are being developed for outcomes measures. An example of an outcomes measure is mortality (heart attack); an example of a process measure is fibrinolytic therapy within 30 minutes (heart attack). The Joint Commission will continue to evaluate process performance measures against the accountability criteria.
Integrating accountability measures into accreditation
The Joint Commission has integrated accountability measures into the accreditation process in the following ways:

**Standard establishes 85 percent compliance rate for accountability measures:** Effective January 1, 2012, Joint Commission accredited hospitals (not critical access hospitals) were required to meet a new performance improvement requirement (standard PI.02.01.03 element of performance 1) that established an 85 percent composite compliance target rate for performance on ORYX accountability measures. Compliance with the EP, which has been identified as a direct impact requirement, is based on performance on a single composite measure rate for all reported accountability measures. The target rate is based on research of past ORYX performance data that shows increasing levels of compliance with accountability measures. An organization that is not in compliance with the target rate at the time of the triennial survey would receive a Requirement for Improvement (RFI) in its accreditation report.

**Launched Core Measure Solution Exchange™:** A free online tool that became available in May 2011, the Solution Exchange facilitates the sharing of success stories regarding how accredited hospitals attained excellent performance on core measures so they can learn from each other. Through the Solution Exchange, Joint Commission accredited hospitals that are seeking to improve their performance – especially on accountability measures – can learn how their peers have attained and maintained their high ratings.

**Added accountability measures to Quality Check™:** Starting with the March 2010 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).

**Priority Focus Process (PFP) and Strategic Surveillance System (S3):** Accountability measures have been integrated into the PFP and S3 Performance Risk Assessment. In these tools, accountability measures are weighted 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.