In this issue:
Check out 2017, 2018 ORYX reporting requirements
*Annals of Internal Medicine*: Few outcome measures meet criteria for assessing accuracy, validity
New video: Joint Commission president explains how safety culture can protect patients
*Quick Safety* discusses risks associated with noises, distractions in ORs

### Performance measurement

#### Check out 2017, 2018 ORYX reporting requirements
Earlier this month, the Centers for Medicare and Medicaid Services (CMS) published its fiscal year 2018 Inpatient Prospective Payment System (IPPS) final rule, which includes reporting requirements for calendar year (CY) 2018 and modifications to its electronic clinical quality measure (eCQM) CY 2017 reporting requirements.

In the final IPPS rule:
- CMS modified its CY 2017 eCQM reporting requirements and finalized CY 2018 reporting requirements.
- For both reporting years, hospitals are required to report on four eCQMs for one self-selected calendar quarter.
- CMS maintained its required chart-abstracted measures for both CY 2017 and CY 2018 reporting.

The Joint Commission continues to align as closely as possible with CMS, therefore:
- 2017 ORYX eCQM reporting requirements are being modified to a:
  - Minimum of four eCQMs (from six eCQMs)
  - Minimum of one self-selected calendar quarter
- 2018 ORYX eCQM reporting requirements remain the same as the 2017 requirements.

Soon, organizations that have already selected eCQMs for CY 2017 will receive additional communication, which will include instructions should an organization wish to modify the number of eCQMs selected for CY 2017.

Additionally, The Joint Commission ORYX Chart-Abstracted Reporting Requirements remain the same. This means that monthly chart-abstracted measure data must continue to be reported on a quarterly basis for all four calendar quarters of 2017 and 2018.

Questions may be emailed to HCOORYX@jointcommission.org. Information also may be found by visiting the [Performance Measurement](#) section on The Joint Commission’s website.

#### Annals of Internal Medicine: Few outcome measures meet criteria for assessing accuracy, validity
Outcome measures are intended to quantify the end results of a health care service or intervention; however, the criteria for assessing whether they are accurate and valid enough to use for public reporting, payment and accreditation are not well-defined.

The outcome measures’ criteria are:

- Strong evidence should exist that good medical care leads to improvement in the outcome within the time period for the measure.
- The outcome should be measurable with a high degree of precision.
- The risk-adjustment methodology should include and accurately measure the risk factors most strongly associated with the outcome.
- Implementation of the outcome measure must have little chance of inducing unintended adverse consequences.

These criteria were applied to 10 outcome measures currently used or proposed for accountability programs. Three measures met all four criteria, while five — including all four claims-based, 30-day mortality measures — failed to meet one or more criteria. The findings raise concerns and suggest the need for a national dialogue about how to judge outcome measures.

“The Joint Commission supports the transparency and public reporting of reliable and valid data on quality and has made such information about accredited organizations public for more than 20 years,” Dr. Baker said. “However, the nation needs to take a more critical look at outcome measures. We found that most of the national measures did not pass all of the criteria, particularly the mortality measures. If we are going to publicly report outcomes and reward providers who achieve the best outcomes, we must approach outcome measures as rigorously as we did process measures and use extreme caution to ensure that the measures are valid.”

Learn more about quality measures.

Safety culture and high reliability

New video: Joint Commission president explains how safety culture can protect patients

Mark R. Chassin, MD, FACP, MPP, MPH, president and chief executive officer of The Joint Commission, explains in a new video how years of survey and patient safety experiences led The Joint Commission to conclude that a strong safety culture can eliminate a wide variety of patient safety risks.

In the video, Dr. Chassin touches on the concepts covered in Sentinel Event Alert 57: The essential role of leadership in developing a safety culture, in order to engage health care leaders to promote and improve patient safety in their organizations.

Leadership is crucial to achieving and maintaining a safety culture in an organization, as it sets the cultural tone for the whole organization.

Dr. Chassin dove deeper into this topic in the webinar Building Your Safety Culture: A Job for Leaders.
Patient safety

Quick Safety discusses risks associated with noises, distractions in ORs
Inside operating rooms (ORs), health care team members perform high-risk, complex tasks that require situational awareness, concentration, transfer of information, and communication among team members. Given the multitude of medical equipment used and team members present, ORs also are prone to high levels of noise, which can serve as a distraction — increasing risk for error and presenting an unsafe condition for patient safety.

The latest Quick Safety focuses on the issue of noise and distractions in the OR and procedural units, and how they can make it difficult to hear and discern information or communicate effectively.

Within an OR, noise levels have been associated with:

- Ineffective communication
- Diminished signal and speech intelligibility
- Poor performance of complex tasks
- Poor cognitive function and concentration (slower time-to-task completion)
- Stress, fatigue and anxiety

Read more on this issue — including safety actions to consider — in the latest Quick Safety.

Learn more about Joint Commission Resources' offerings online or call 877-223-6866.