Performance measurement

Now available: 2019 ORYX performance measurement requirements and billing changes

Key updates are now available on the Joint Commission website for 2019 ORYX® performance measurement program reporting requirements. As a reminder, the Joint Commission’s Direct Data Submission Platform (DDSP) is available for submitting electronic clinical quality measure (eCQM) data directly to The Joint Commission. This reduces the reporting burden and expense, as well as empowers organizations with valid data for measurement evaluation and analysis for quality improvement purposes. Organizations are required to use the DDSP for calendar year (CY) 2019 eCQM data.

The Joint Commission continues to align its performance measure reporting requirements with the Centers for Medicare & Medicaid Services (CMS), which published its fiscal year (FY) 2019 Inpatient Prospective Payment System (IPPS) final rule in August. The rule includes CY 2019 Hospital Inpatient Quality Program reporting requirements. In the final IPPS rule:

- CMS maintained its CY 2018 eCQM reporting requirements and currently available eCQMs for CY 2019; hospitals are required to report on four eCQMs for one self-selected calendar quarter.
- CMS removed three chart-abstracted measures in common with The Joint Commission effective for the CY 2019 reporting period — emergency department (ED) measure ED-1, immunization (IMM) measure IM-2 and venous thromboembolism (VTE) measure VTE-6.

For 2019, the ORYX reporting requirements for hospitals are:

- A minimum of four eCQMs, and a minimum of one self-selected calendar quarter. (For CY 2019 eCQM data and forward, all hospitals will be transitioned to and utilize the DDSP.)
- Monthly chart-abstracted measure data must continue to be reported on a quarterly basis for all four calendar quarters of 2019 utilizing an ORYX chart-based vendor.
- Hospitals with an average daily census greater than 10 (ADC > 10) must report on two required chart-abstracted measures (a reduction from five to two measures) and a choice of a minimum of four of 13 available eCQMs.
- Hospitals with at least 300 live births are required to report on all chart-abstracted perinatal care (PC) measures, including PC-06, effective with Jan. 1, 2019 discharges.
- Critical access hospitals (CAHs) and small hospitals (ADC ≤ 10) must report on a choice of three available measures (a reduction from six to three measures).
- Freestanding psychiatric hospitals must continue to report on the four required hospital-based inpatient psychiatric services (HBIPS) measures.
- Suspension of requirements continues for freestanding children’s hospitals, long-term acute care hospitals and inpatient rehabilitation facilities.

ORYX® performance measurement billing changes

With the removal of the ORYX vendor requirement for eCQM data submission, The Joint Commission has adjusted and simplified the billing structure for ORYX reporting requirements. Historically, the ORYX data submission process for eCQMs and chart-based measures incurred costs covered by The Joint Commission’s
required data transmission fees, which were billed to ORYX vendors. In 2017, the transmission fee structure was changed to a flat fee model for both eCQMs and chart-based measures submission. ORYX vendors typically pass on these fees to health care organizations along with any additional fees for using their software and/or platform. Through market research, The Joint Commission determined some organizations were paying $20,000 to $50,000 for their eCQM data submission.

Beginning this January, organizations with ORYX requirements will be directly billed an annual rate based upon organizational weighted volumes for both eCQMs and chart-based submissions. Although some ORYX vendors continue to support 2019 chart-based measures submission, our billing structure will provide for an annual rate for all organizations with ORYX requirements. There will no longer be any transmission fees.

Learn more about these updates, including:
- 2019: ORYX Performance Measure Reporting Requirements
- 2019: What You Need to Know — ORYX FAQs
- The Joint Commission Measures Effective January 1, 2019

Pioneers in Quality webinar: 2019 measure reporting requirements
A Pioneers in Quality™ webinar on Oct. 23, from 9-10 a.m. (PT) / 10-11 a.m. (MT) / 11 a.m.-noon (CT) / noon-1 p.m. (ET), will answer questions from hospital quality and information technology (IT) staff and leaders regarding electronic clinical quality measures (eCQMs) and chart-based measure reporting requirements for 2019. Participants will also learn about The Joint Commission’s continued alignment with the Centers for Medicare & Medicaid Services’ (CMS) data reporting requirements.

During the webinar — “Pioneers in Quality™ 2019 Joint Commission ORYX Reporting Requirements: Your Questions Answered” — Joint Commission staff will:
- Provide key updates to the 2019 ORYX performance measure reporting requirements.
- Describe the data collection and reporting requirements for accredited hospitals and critical access hospitals for both eCQMs and chart-based measures.
- Explain the Joint Commission’s Direct Data Submission (DDS) platform and the new billing model starting in January 2019 for hospitals with ORYX requirements.

Register for the webinar.

Quality and safety

New Quick Safety hones in on ways to ensure accurate patient identification
The latest issue of Quick Safety — “People, processes, health IT and accurate patient identification” — delves into the patient identification process, which is ubiquitous in health care. It occurs every time a health care professional has a conversation with a patient, as well as any time information about a patient is recorded or accessed. Because of this, the process can be fraught with risk for wrong-patient errors and can lead to:

- Providing treatment to the wrong patient.
- Delays in treatment.
- Serious harm or death.

Safe care begins with proper identification, and that requires the timely transfer of correct information, as well as making it an area of continuous focus for patient safety efforts — as evidenced by the first National Patient Safety Goal: “Improve the accuracy of patient identification.”

Read the latest issue of Quick Safety.
Center launches project to address hospital-acquired pressure injuries

The Joint Commission Center for Transforming Healthcare has collaborated with teams at The Johns Hopkins Hospital, Kaiser Permanente South Sacramento Hospital and Memorial Hermann Southeast Hospital to identify root causes of hospital-acquired pressure ulcers and injuries (HAPU/I) and solutions for reducing HAPU/I rates.

Through the “Reducing hospital-acquired pressure injuries” project, the hospitals will work with a Center for Transforming Healthcare team to apply Robust Process Improvement (RPI) to measure HAPU/I incidences at their organizations and analyze the root causes. Teams will then test and implement targeted solutions to address their unique root causes.

Following the project’s completion in summer 2019, the Center for Transforming Healthcare will analyze findings to determine whether targeted solutions identified and tested by the three participating hospitals can be replicated at other organizations.

Every year in the U.S., these injuries result in significant patient harm, including:

- Pain
- Expensive treatments
- Increased length of institutional stay
- Premature mortality for some patients

More than 2.5 million patients in U.S. acute-care facilities annually are estimated to suffer from pressure ulcers and injuries, and 60,000 die from their complications.

The Agency for Healthcare Research and Quality found that HAPU/I rates have risen by 10 percent from 2014-2016 despite an 8 percent decrease in all other hospital-acquired conditions during the same time period. Additionally, the cost of treating a single pressure ulcer/injury can reach $70,000 — leading to an estimated cost of $11 billion for treating pressure ulcers/injuries in the U.S. every year.

“Health care’s toughest problems to tackle are those with myriad root causes and widespread impact on patients and the entire industry, such as a lack of consistent handwashing among hospital staff and the rising rate of hospital-acquired pressure ulcers/injuries,” said Klaus Nether, D.H.Sc., MMI, MT (ASCP) SV, executive director, High Reliability Product Delivery, The Joint Commission Center for Transforming Healthcare. “These are complex health care problems that require very specific targeted solutions due to their multiple root causes. As a result, each root cause requires its own strategy for improvement, and the set of root causes differ from one organization to the next.

“I commend the teams at The Johns Hopkins Hospital, Kaiser Permanente and Memorial Hermann for their commitment to working with us to identify and test solutions that hopefully will benefit millions of patients across the country — and ultimately help hospitals attain zero harm in their delivery of care.”

October Journal: Study finds support for adoption of health care innovations

Learning communities can provide a rich, collaborative environment that supports the adoption of health care innovations and motivates organizational change. A new study in the October 2018 issue of The Joint Commission Journal on Quality and Patient Safety details how three learning communities — sponsored by the Agency for Healthcare Research and Quality (AHRQ) and focused on adopting health care innovations — were established and supported.

The study — “Using Learning Communities to Support Adoption of Health Care Innovations,” by Deborah Carpenter, RN, MSN, CPHQ, CPPS, PMP, senior study director, Westat, Rockville, Maryland, and co-authors — describes how the learning communities focused on three high-priority areas:

- Advancing the practice of patient- and family-centered care (PFCC) in hospitals.
- Promoting medication therapy management for at-risk populations.
• Reducing non-urgent emergency services.

Members of each learning community worked collaboratively in facilitated settings to adapt and implement strategies featured in the AHRQ Health Care Innovations Exchange. The Innovations Exchange was a web-based repository of more than 900 evidence-based service delivery and policy innovations, as well as 1,500 tools for improving quality and reducing disparities.

All three learning communities achieved significant improvements:

• Learning Community 1 (Advancing the Practice of PFCC in Hospitals): The PFCC Learning Community consisted of 11 Florida-based acute care hospitals that worked together over an 18-month period to establish or enhance a patient and family advisory council (PFAC). The number of participating hospitals with a PFAC increased from 4 to 11, and the total number of active patient and family advisors increased from 56 to 129.

• Learning Community 2 (Promoting Medication Therapy Management for At-Risk Populations): Spring Branch Community Health Center, Texas, enrolled 57 at-risk patients into the MyRx pilot program and retained 38 of those patients throughout the entire 6-month pilot test period. During the program, pharmacists provided more than 230 interventions. Patients who received one-on-one counseling from a pharmacist had greater changes in blood glucose levels compared to those who did not.

• Learning Community 3 (Reducing Non-Urgent Emergency Services): A protocol was developed to enable Detroit emergency medical services (EMS) personnel to make real-time referrals to community organizations; identify and work with the top 25 EMS users; and intervene at local “hot spots” where there was significant EMS activity. In a 12-month period, EMS made 288 referrals to community organizations and preliminary results showed fewer 911 calls and shorter EMS response times.

The improvements indicate that the learning community model of group learning can serve as an effective method to support dissemination and implementation of innovations, as well as achieve desired outcomes in local settings. The study is open access through Oct. 17.

Also featured in the October issue:

• “Use of Lean and Related Transformational Performance Improvement Systems in Hospitals in the United States: Results from a National Survey” (1,222 U.S. hospitals)

• “Epidemiology of and Risk Factors for Harmful Anti-Infective Medication Errors in a Pediatric Hospital” (Montefiore Medical Center, Bronx, New York)

• “Effect of Hospital-Wide Quality Improvement Initiative to Promote High-Value Care” (Boston Medical Center, Boston)

Access the Journal.

Resources

Don't miss this: Webinar replay now available for latest Pioneers in Quality™ webinar

A webinar replay — including presentation slides and questions and answers — is now available for a recent Pioneers in Quality™ Proven Practices Collection program webinar.

“Pioneers in Quality™ 2018 eCQM Proven Practices: An evolutionary approach and a model of collaboration” featured expert contributors from Vail Health Hospital and Texas Health. They were selected for the overall strength of their electronic clinical quality measure (eCQM) processes and practices, and the applicability and replicability for other organizations to improve their implementation of eCQMs, as well as their use of eCQM data to improve patient care.

View the webinar replay.
FDA webinar: Learn about effectiveness of duodenoscope reprocessing instructions
If you are interested in participating in an ongoing study that is designed to evaluate the real-world effectiveness of duodenoscope manufacturer’s reprocessing instructions, you can learn more from a webinar recording from the U.S. Food and Drug Administration’s MedSun program. The webinar is intended for health care professionals who work in endoscopy processing units or who are responsible for duodenoscope reprocessing at their facility, and infection control practitioners at facilities where endoscopic retrograde cholangio-pancreatography (ERCP) procedures are performed.

The webinar, which took place Oct. 3, featured speakers from the FDA:

- Lauren J. Min, PhD, epidemiologist, Center for Devices and Radiological Health, Office of Surveillance and Biometrics
- Shani Haugen, PhD, microbiologist, Center for Devices and Radiological Health, Office of Device Evaluation

The program was recorded for those who were unable to attend. For a link to the recording, email medsun@fda.hhs.gov. Interested health care professionals should include the following in the email:

- In the subject line, type “Attention 10/3 Webinar – C.”
- Provide your name, position/title, email address and phone number.

Second of 3-part podcast series gives guidance on closing the loop on diagnostic errors
ECRI Institute’s Partnership for Health IT Patient Safety — a multistakeholder collaborative — has released the second of a three-part podcast series, which takes a deeper look into what factors impact closing the loop on diagnostic errors and who is responsible to monitor the loop.

The 15-minute podcast — featuring Dr. Christoph Lehmann, Dr. Hardeep Singh, Mark Segal, Dr. Dean Sittig and Patricia Giuffrida — includes expert tips. Listen to the podcast.

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