Joint Commission Announces 2015 List of Top Performer Hospitals

List Determined by January–December 2014 Data

For the fifth consecutive year, The Joint Commission has recognized hospitals that demonstrate consistently excellent performance on evidence-based process of care measures through the Top Performer on Key Quality Measures® program. This year 1,043 hospitals—that is, 31.5% of the 3,315 eligible hospitals—were recognized through the Top Performer program. Representing hospitals of all sizes and types, there is at least one Top Performer hospital in each of the United States this year.

All of the 2015 Top Performer hospitals met the following three criteria necessary for recognition for their 2014 performance:

1. Achieved cumulative performance of 95% or above across all reported accountability measures
2. Achieved performance of 95% or above on each and every reported accountability measure with at least 30 denominator cases
3. Had at least one core measure set with a composite rate of 95% or above and, within that measure set, achieved a performance rate of 95% or above on all applicable individual accountability measures

Each hospital that submits performance data to The Joint Commission through the ORYX® program is automatically eligible for recognition; no special application is required. Because the Top Performer program is based on data that organizations collect themselves throughout the year, hospitals can assess their own performance and know ahead of time whether they are meeting the 95% thresholds.

What’s New in Data Review

Top Performer hospitals for 2015 were determined by data collected during 2014

Continued on page 3
In Sight

This column informs you of developments and potential revisions that can affect your accreditation and certification and tracks proposed changes before they are implemented. Items may drop off this list before the approval stage if they are rejected at some point in the process.

Currently In Field Review

- Proposed new requirement regarding antimicrobial stewardship for ambulatory care organizations, critical access hospitals, hospitals, nursing care centers, and office-based surgery practices (field review begins November 18, 2015, and ends December 30, 2015)
- Proposed new and revised requirements for Advanced Certification for Heart Failure in the disease-specific care program (field review begins November 16, 2015, and ends December 28, 2015)

Note: Please note that field review dates are tentative and subject to change. To participate in or read more about field reviews, please visit The Joint Commission website at http://www.jointcommission.org/standards_information/field_reviews.aspx.

Currently In Development

Standards

- Proposed new requirement regarding antimicrobial stewardship for ambulatory care organizations, critical access hospitals, hospitals, nursing care centers, and office-based surgery practices
- Proposed new and revised requirements for Advanced Certification for Heart Failure in the disease-specific care program
- Proposed new Community-Based Palliative Care certification option, applicable to accredited home care organizations
- Proposed addition of National Patient Safety Goal NPSG.07.06.01 for nursing care centers and proposed modification of NPSG.07.06.01 for hospitals and critical access hospitals
- Proposed new Total Hip Replacement and Total Knee Replacement advanced certification option, applicable to accredited hospitals, critical access hospitals, and ambulatory surgery centers
- Proposed new standards addressing permanent housing support services for behavioral health care organizations
- Proposed new standards addressing eating disorders care, treatment, or services for behavioral health care organizations
- Proposed new and revised diagnostic imaging requirements for hospitals, critical access hospitals, and ambulatory care organizations
- Proposed new Comprehensive Cardiac Center advanced certification option, applicable to accredited hospitals
- Proposed new Patient Blood Management Certification program for accredited hospitals

Joint Commission Announces 2015 List of Top Performer Hospitals (continued)

Continued from page 1

On 47 accountability measures of care in 12 measure sets (shown in the list below). Seven new accountability measures were added to the program, including six measures within two new measure sets (Tobacco Treatment and Substance Use) and an additional measure for the Inpatient Psychiatric Services measure set. The Joint Commission also increased its ORYX performance measure reporting requirements from a minimum of four to at least six core measures effective January 1, 2014.*

---

**Core Measures for 2015 Top Performer Program Recognition**

1. Heart Attack Care
2. Heart Failure Care
3. Pneumonia Care
4. Surgical Care
5. Children’s Asthma Care
6. Inpatient Psychiatric Services
7. Venous Thromboembolism (VTE) Care
8. Stroke Care
9. Perinatal Care
10. Immunization
11. Tobacco Treatment—NEW to Top Performer program
12. Substance Use—NEW to Top Performer program

The specificity of the measures within each core measure set allows hospitals to target areas for improvement—the underlying goal of the Top Performer program.

---

**Data Findings**

The 1,043 hospitals earning Top Performer recognition for 2015 represent a decrease of nearly 15% over last year’s 1,224 top performing hospitals. While this decrease in recognition was to be expected—given that the increase in reporting requirements made it more difficult to meet the 95% threshold—23 hospitals submitted data on seven or more core measure sets (and achieved Top Performer thresholds on all of those sets) in 2014.

A total of 117 hospitals have achieved Top Performer recognition all five years since the program’s inception—that is, for data reported for 2010, 2011, 2012, 2013, and now 2014. The number of hospitals achieving recognition for four consecutive years is 221; for three consecutive years, 435; and for two consecutive years, 650. In addition, the results for 2015 include 249 hospitals that are being recognized as a Top Performer for the first time.

---

Of the 3,315 eligible hospitals, 665 (about 20%) missed 95% performance on only one measure and thus were identified as being “on track” for Top Performer recognition. Of the 718 on-track hospitals identified in last year’s report, 204 (28.5%) attained Top Performer status this year.

Academic medical centers and critical access hospitals are also eligible for the program. The 28 academic medical centers achieving 2015 recognition represent a decrease of nearly 24% over the previous year’s 37 academic medical centers. Of the 157 critical access hospitals eligible for recognition, 70 were named as a Top Performer—a 23% increase from last year.

Hospitals achieving Top Performer status receive a letter, a certificate of recognition, and a communications toolkit to help promote the achievement. Top Performer hospitals are additionally recognized through publications such as America’s Hospitals: Improving Quality and Safety (The Joint Commission’s Annual Report, available at [http://www.jointcommission.org/annualreport.aspx](http://www.jointcommission.org/annualreport.aspx) and on The Joint Commission’s Quality Check® site ([http://www.qualitycheck.org](http://www.qualitycheck.org)).

---

**Top Performer Program Hiatus**

As previously announced (see October 2015 Perspectives, pages 4, 6, and 15), the Top Performer program will go on hiatus during the year 2016. This means that ORYX data, which hospitals will continue to collect and submit, will not be utilized to announce Top Performer hospitals in 2016. The hiatus provides an opportunity for The Joint Commission to reevaluate the program in terms of the changing national performance measurement environment.

The Centers for Medicare & Medicaid Services (CMS) has retired a number of chart-based measures, and The Joint Commission has retired many of these measures to maintain alignment with CMS. Because the Top Performer program has compared hospitals’ performance using the results of a fixed set of designated accountability chart-based performance measures, the retirement of some of these measures varies the complement of measures and thus alters the program metrics. In 2016 CMS will also implement a requirement for hospitals to report at least four electronic clinical quality measures (eCQMs) for their Hospital Inpatient Quality Reporting Program. Because performance rates for eCQMs may not be equivalent to those for chart-based measures, this, too, results in challenges in determining Top Performers.

During the hiatus year, The Joint Commission plans to support current and future Top Performer hospitals through a new program designed to assist them on their journey toward eCQM adoption. The new program will include educational

* The expanded measure reporting requirements were discussed in the December 2012 Perspectives, pages 3–5, and the November 2013 Perspectives, page 11.
Joint Commission Announces 2015 List of Top Performer Hospitals (continued)
Continued from page 3

opportunities, a resource portal, and recognition categories and will focus on partnering with hospitals to provide the highest level of quality care for patients and their families.

For more information, e-mail topperformersprogram@jointcommission.org or visit http://www.jointcommission.org/accreditation/top_performers.aspx.

New Regulation Announced for Unlicensed California Outpatient Surgery Settings

California Senate Bill 396, signed into law in September and effective January 1, 2016, is designed to strengthen the regulation of unlicensed outpatient surgery settings. The new law builds upon existing regulatory requirements that mandate facility accreditation of ambulatory surgery centers and office-based surgery practices that are neither state licensed nor Medicare certified.

The new law affects Joint Commission–accredited ambulatory surgery centers and office-based surgery practices in the following ways.

Peer Review
The new law requires physicians and surgeons practicing in an ambulatory surgery center or office-based surgery practice to undergo a peer review evaluation every two years. The peer review must be performed by practitioners who are qualified by education and experience to perform the same or similar types of procedures. The findings of that peer review must be evaluated by the facility’s governing body; in addition, the result of the peer review(s) must be provided to The Joint Commission at the time of the organization’s on-site survey. The Joint Commission surveyor will review the process that resulted in the findings of the peer review to determine if the ambulatory surgery center or office-based surgery practice continues to maintain compliance with applicable accreditation requirements (shown in the box at right).

Unannounced Inspections
The law states that accrediting organizations may conduct unannounced surveys following an initial survey and provides specifications for doing so. Should the accrediting organization elect to conduct a routine unannounced survey, it is required to notify the outpatient setting that the survey will occur within 60 days. In accordance with Joint Commission policies, accredited office-based surgery practices and non–Medicare-certified ambulatory surgery centers are exempt from The Joint Commission’s unannounced survey policy and receive a 7-business day notification of their scheduled survey event.

In addition to the regulatory requirements that impact the accreditation process detailed above, the new law increases an organization’s ability to access information from the state medical board regarding whether or not a physician has been denied staff privileges, been removed from the medical staff, or had privileges revoked prior to granting or renewing their privileges.

Questions about the new law and Joint Commission requirements may be directed to Jennifer Hoppe, MPH, senior associate director, State and External Relations, The Joint Commission, at jhoppe@jointcommission.org.
**Appointed: Inaugural Editor-in-Chief of The Joint Commission Journal on Quality and Patient Safety®**

Joint Commission Resources, Inc. (JCR), a nonprofit affiliate of The Joint Commission, recently appointed David W. Baker, MD, MPH, FACP, as the inaugural editor-in-chief of *The Joint Commission Journal on Quality and Patient Safety*. Baker is executive vice president for the Division of Healthcare Quality Evaluation at The Joint Commission. In this senior leadership position, Baker oversees the development of The Joint Commission’s health care quality evaluation tools such as standards, survey methods, and performance measures. He also oversees The Joint Commission’s Department of Health Services Research.

“We are honored Dr. Baker is joining the Journal in this new role,” says Paula Wilson, president and chief executive officer, JCR. “As editor-in-chief, he will help shape the editorial direction of the publication to provide health care professionals with the latest innovative articles focused on the improvement of quality and patient safety at health care organizations around the world.”

Baker is internationally known for his research in health literacy, racial and ethnic disparities, the impact of language barriers, differences in health outcomes for the uninsured, and the use of electronic health records for quality measurement and improvement. He has published more than 200 original research articles and book chapters and won many awards, including the 2013 American College of Physicians’ Alvan R. Feinstein Memorial Award for research in clinical epidemiology.

Prior to joining The Joint Commission in February 2015, Baker was chief of the Division of General Internal Medicine and deputy director of the Institute for Public Health and Medicine at Northwestern University’s Feinberg School of Medicine in Chicago. Baker has served on the editorial boards for *Congestive Heart Failure* (2000–2006) and the *Journal of Cardiac Failure* (2001–2009); in addition, he was deputy editor of *Medical Care* (2005–2007). From 2011 to 2015, he chaired the American College of Physicians’ Performance Measurement Committee and served as its representative to the National Quality Forum’s Measures Application Partnership Coordinating Committee.

“I look forward to serving as editor-in-chief of the Journal and working closely with the editorial team,” says Baker. “The Journal has an outstanding reputation for publishing rigorous, real-world studies of strategies to improve quality and patient safety. As editor-in-chief, I hope to build upon this foundation and develop new ways to deliver advanced thinking, strategies, and leading practices to the health care industry.”

Published monthly, *The Joint Commission Journal on Quality and Patient Safety* is a peer-reviewed publication dedicated to providing health professionals with the information they need to promote the quality and safety of health care. *The Joint Commission Journal on Quality and Patient Safety* invites the submission of original manuscripts on the development, adaptation, and/or implementation of innovative thinking, strategies, and practices in improving quality and safety in health care. Case studies, program or project reports, reports of new methodologies or new applications of methodologies, research studies on the effectiveness of improvement interventions, and commentaries on issues and practices are all considered.


HazMat-ter of Fact
Taking a Closer Look at EC.02.02.01 and the Management of Hazardous Materials and Waste

An introduction from George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission: This column clarifies standards expectations and provides strategies for challenging compliance issues, primarily in life safety and the environment of care but also in the vital area of hazardous materials. You may wish to share the ideas and strategies in this column with your organization’s leadership. This month, I enlisted Kathy Tolomeo, CHEM, CHSP, engineer in The Joint Commission’s Department of Engineering, to further explore aspects and issues related to this topic.

Environment of Care (EC) Standard EC.02.02.01 is concerned with managing risks related to hazardous materials and waste in health care organizations. This standard is crucial, with many important elements of performance (EPs) that are often misinterpreted and improperly addressed. This standard was among the 10 most frequently cited by surveyors during the first six months of 2015, and 38% of surveyed hospitals were found to be noncompliant with it.

If not carefully inventoried and managed from the moment they enter your facility to the time they are disposed of or shipped out, these hazards can lead to serious injuries, illnesses, and code violations. From harmful vapors to blood-borne pathogens, the related threats are numerous and serious. But with proper preparation and compliance with applicable laws, regulations, and written procedures, you can better safeguard your patients, staff, visitors, and surrounding community.

This is the first of two columns focused on EC.02.02.01. This article explores Elements of Performance (EPs) 1 and 3 through 8.

EP 1 The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation.

When dealing with hazardous materials and waste (HazMats), important questions need to be asked, including the following:

* What are they?
* When did they arrive?
* What are the safety requirements?
* Where are they stored?
* What is the quantity?

A HazMat inventory should answer these questions. This inventory only needs to include HazMat items addressed by federal, state, and local regulations and laws, particularly ones specified by agencies like the US Occupational Safety and Health Administration (OSHA), the US Environmental Protection Agency (EPA), the US Drug Enforcement Administration (DEA), the US Nuclear Regulatory Commission (NRC), and the US Department of Transportation (DOT).

Several types of HazMats can be included in your inventory, among them hazardous chemicals, energy sources, medications, and gases and vapors; laboratory samples; infectious/medical waste; and radioactive materials.

Your inventory should be documented consistently, accurately, and completely on a paper form or in a database that lists essential information such as the material’s and manufacturer’s name; the safety data sheet (SDS) on file; maximum quantity on hand; Chemical Abstracts Service (CAS)/catalog number; estimated weight/volume; storage area locations; any health/safety/fire risks; any personal protective equipment (PPE) required; and any staff training required in order to handle the materials. Per OSHA, which the EPA references for chemical inventory requirements, the minimal chemical inventory should contain the following:

* Chemical name
* CAS number
* Common name
* Synonyms
* Product/mixture name (if applicable)
* Percentage of ingredients in product/mixture (if applicable)

See an example of a hazardous materials inventory form on page 7.

The DOT does not require a chemical inventory, since its focus is on the shipment of hazardous materials (for example, manifests). However, because The Joint Commission requires that hazardous waste be included on the inventory, the use of...
the DOT UN identifier would be an acceptable identifier for
this hazardous waste if no CAS Number is available.

Note that all employers need to understand their SDS
inventory in order to provide information to their employees
about hazardous chemicals they are exposed to in their
workplaces, as stated in the OSHA Hazard Communication

EPs 3 and 4 The hospital has written procedures, including
the use of precautions and personal protective equipment, that it
implements in response to hazardous material and waste spills or
exposures.

Managing HazMat risks involves following several proce-
dures—including procedures for selecting, handling, labeling,
storing, transporting, using, generating, monitoring, disposing,
documenting, and providing training—that can help your
organization decrease the danger.

Many of these recommended procedures can be found in
the related SDS, which should also include essential infor-
mation regarding its safe handling, usage, and emergency
protocol, as well as any PPE and engineering controls required
to maintain and minimize risks. (The SDS may also refer
you to further procedures or information that can be found
elsewhere, such as within OSHA regulations.)

From SDSs and other resources, organizations can create
appropriate written procedures, which should be incorporated
in your relevant EC management plan. Staff should also know
how to find and follow these written procedures. The ability
to effectively implement these procedures immediately when a
HazMat spill or exposure occurs will depend on the thorough-
ness of the aforementioned planning and documentation.

EPs 5–8 The hospital minimizes risks associated with selecting,
handling, storing, transporting, using, and disposing of hazardous
chemicals and radioactive materials; selecting and using hazard-
ous energy sources; and disposing of hazardous medications.

Reducing threats related to a particular type of HazMats
can require a unique approach such as the following:

- Hazardous chemicals, including formaldehyde, glutaralde-
  hyde, and waste anesthetic gas, need to be carefully stored
  (according to their respective SDS requirements) and
  adequately ventilated, and staff working with them must be
  properly monitored and supplied with appropriate PPE, per
  OSHA.
- Radioactive materials must be stored in a locked, secure

Continued on page 8
CLARIFICATIONS AND EXPECTATIONS: HazMat-ter of Fact (continued)
Continued from page 7

area and supervised (as mandated by the NRC), affected staff need to be routinely monitored for exposure using a dosimeter, and all radiation-producing equipment has to be carefully inventoried and tracked for service and maintenance.

- Appropriate use of, training for, and upkeep of hazardous energy sources like lasers and radiation are vital.
- Chemotherapeutic agents must be treated with special care, for example: Tubing and port connections must be properly secured, drug containers have to be transported safely to avoid leakage or spills, and staff must be carefully trained in disposing of these substances.

To more effectively minimize risks pertaining to these four types of HazMats, consider the following tips:

- Refer to the respective SDS and the regulations indicated therein.
- Implement appropriate engineering controls.
- Examine other specific regulations closely, including any issued by the EPA, NRC, OSHA, DOT, and/or DEA.
- Conduct risk assessments to identify any environment of care HazMat risks that could affect patients, staff, or other people entering the facility. When evaluating risks, consider factors such as vapors, flammability, corrosiveness, environmental impact, and security and special equipment required.

The value of conducting a risk assessment is demonstrated in this example: A staff member is concerned that the cleaning solution used by custodial workers could splatter or spill, causing eye injury. A proper risk assessment could determine whether the chemical in question is caustic and corrosive (defined by OSHA as having a pH level less than 2.5 or greater than 11.0), which should be indicated on the chemical’s SDS. If a risk for exposure is determined, installation of an eye wash station and/or emergency shower is required by OSHA federal regulation 29 CFR 1910.151(c).

Be aware that EP’s 5 and 7, pertaining to hazardous chemicals and hazardous energy sources, respectively, are currently hot topics and among the elements of performance that surveyors cite as being most problematic. To curtail risks associated with EP 5, performing additional risk assessments can ensure a higher level of compliance. And to decrease the risk of staff exposure to hazardous energy sources in EP 7, organizations should maintain a complete and accurate inventory of policies, procedures, and PPE, all of which are likely to be meticulously scrutinized during surveys.

Speaking of PPE, remember that OSHA requires your organization to provide a written “certification of hazard assessment.” This certification documents that you’ve conducted an assessment involving three steps: (1) Identify dangers related to specific hazardous materials; (2) determine specific staff job functions related to those materials; and (3) assign the appropriate PPE to mitigate hazards for those materials. OSHA mandates that your organization must (1) educate staff on how to correctly use PPE and (2) prove that staff have been properly trained prior to having contact with any HazMat sources.

Safety Requires Constant Vigilance
Protecting occupants of your facility from hazardous materials and waste takes a dedicated, consistent, and unified effort from staff. This crucial process starts with detailed documentation, continues with the creation and implementation of written procedures (including the use of PPE) to immediately address a HazMat disposer or accident, and carries on with the identification and abatement of risks related to HazMat sources.

Next month, we will round out this topic by taking a closer look at minimizing risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous gases and vapors and their proper monitoring; complying with applicable laws and regulations pertaining to HazMat threats; properly labeling HazMats; periodically checking radiation workers to gauge exposure; and creating and following procedures for routine storage and disposal of trash.

This month’s column also appears in the December 2015 issue of Environment of Care® News.
Table 1. 2016 Flexible ORYX Performance Measure Reporting Options

| Option 1: Vendor submission of quarterly data on six of nine sets of chart-abstracted measures |
| Option 2: Vendor submission of data on six of eight sets of eCQMs |
| Option 3: Vendor submission of data on six measure sets using a combination of chart-abstracted measures and eCQMs |

Updating ORYX® Measure Set Selections and Reporting Options for 2016

As noted in the October 2015 Perspectives, hospitals and critical access hospitals accredited by The Joint Commission will continue to have flexibility in meeting ORYX® performance measure reporting requirements for calendar year 2016. Measure reporting requirements can be met through the submission of data on six measure sets for hospitals (four sets for critical access hospitals) by selecting chart-abstracted measures, electronic clinical quality measures (eCQMs), or a combination of these. Table 1 below displays the three available reporting options.

### Options and Due Dates

On October 28, 2015, The Joint Commission’s Division of Accreditation and Certification Operations sent a direct communication to accredited hospitals with instructions and due dates for submitting ORYX measure set selections for 2016.

The first due date, **November 30, 2015**, applies to hospitals currently reporting on six sets of measures (four sets for critical access hospitals) for 2015 that are not required to add measure sets for 2016 and that are not electing to make any changes to their 2015 measure set selections or vendor for reporting in 2016. This date also applies to hospitals that are electing to report on a minimum of six sets of chart-abstracted measures (Option 1).

The second due date, **January 31, 2016**, applies to hospitals that are exploring vendor submission of data for the third and/or fourth quarter of 2016 on a minimum of six sets of eCQMs (Option 2) and hospitals that are considering vendor submission on a minimum of six sets of measures using a combination of chart-abstracted measure sets (monthly data submitted on a quarterly basis) and eCQM sets (third and/or fourth quarter 2016) (Option 3).

### Reporting eCQMs

Hospitals choosing Option 2 or Option 3 that are unable to report on all eCQM measures that comprise the eCQM set may now report on as few as one measure in an eCQM set—and the set will count toward meeting the six-set reporting requirement. Vendors will be invoiced for each individual eCQM measure set submitted.

Hospitals that choose Option 3 may report on both the chart-abstracted and eCQM version of the same measure set. Each version will count as an individual set of measures toward meeting the six-measure-set reporting requirement—that is, each version of the same measure set will be billed as a separate measure set.

These modifications provide closer alignment with Centers for Medicare & Medicaid Services (CMS) and support accredited organizations in their efforts to meet CMS eCQM reporting requirements for calendar year 2016. At the same time, they encourage selecting and reporting on the same eCQMs to The Joint Commission.

Please note that, for hospitals choosing Option 2 or Option 3, The Joint Commission will not publicly report the 2016 eCQM data on Quality Check®.

### ORYX Measure Changes for 2016

CMS has made multiple changes in its Hospital Inpatient Quality Reporting Program, and The Joint Commission has made changes to continue to align as closely as possible with CMS. Table 2, on page 10, shows Joint Commission measure sets effective January 1, 2016, that can be used to meet 2016 ORYX reporting requirements for accreditation purposes.

While reviewing Table 2 and making selections, hospitals should remember that measure set selections must be relevant to the services provided by the organization and the patient populations served. After determining measure set selections, hospitals should access the “2016 Flexible ORYX Reporting Options Measure Set Selection Instructions and Forms” available at [http://www.jointcommission.org/assets/1/18/2016_Measure_Set_Selection_Instructions_and_Forms_10-28-2015.pdf](http://www.jointcommission.org/assets/1/18/2016_Measure_Set_Selection_Instructions_and_Forms_10-28-2015.pdf) to proceed with submitting their selections.

### Using the Stroke Measure Set to Meet Requirements for Accreditation and/or Certification

As shown in Table 2, the chart-abstracted stroke (STK) measure set now has only a single measure—STK-4: Thrombolytic Therapy—remaining for 2016 accreditation purposes. A Joint Commission–accredited hospital that is (or is seeking to become) Primary or Comprehensive Stroke Center certi-
fied can select and report on the single chart-abstracted STK-4 measure as one of its six sets of measures or select to report on the stroke eCQMs for 2016 for accreditation purposes. However, those hospitals will still be required to report on all eight of the chart-abstracted STK measures for purposes of certification.

In addition, organizations that are (or are seeking to become) Joint Commission certified as a Comprehensive Stroke Center must also report data on all Joint Commission chart-abstracted Comprehensive Stroke (CSTK) measures.

Data may continue to be manually entered into the Certification Measure Information Process (CMIP) application accessed through the hospital’s Joint Commission Connect™ extranet site, or the data may be reported through a Joint Commission–listed vendor that supports submission of the related measure data for purposes of certification. Comprehensive Stroke Centers, in particular, are encouraged to report their STK and CSTK data through a Joint Commission–listed vendor.

Questions may be directed to Frank Zibrat, associate director, Accreditation Systems Integration and ORYX, at 630-792-5992 or via e-mail at fzibrat@jointcommission.org. Alternatively, questions may be submitted to HCOryx@jointcommission.org.

---

### Table 2. Joint Commission Measure Sets Effective January 1, 2016

<table>
<thead>
<tr>
<th>Measure Set</th>
<th>Retired/Temporarily Inactivated Chart-Abstracted Measure</th>
<th>Retained Chart-Abstracted Measure</th>
<th>Electronic Clinical Quality Measure (eCQM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack Care</td>
<td>AMI-7a (retired)</td>
<td>eAMI-7a</td>
<td>eAMI-7a, eAMI-8a</td>
</tr>
<tr>
<td>Surgical Care</td>
<td>SCIP-Inf-4 (retired)</td>
<td>eSCIP-Inf-1, eSCIP-Inf-9</td>
<td></td>
</tr>
<tr>
<td>Children’s Asthma Care</td>
<td>CAC-3 (retired)</td>
<td>eCAC-3</td>
<td></td>
</tr>
<tr>
<td>Venous Thromboembolism Care</td>
<td>VTE-1, VTE-2, VTE-3 (retired)</td>
<td>VTE-5, VTE-6</td>
<td>eVTE-1, eVTE-2, eVTE-3, eVTE-4, eVTE-5, eVTE-6</td>
</tr>
<tr>
<td>Stroke Care</td>
<td>STK-1, STK-2, STK-3, STK-5, STK-6, STK-8, STK-10 (retired)</td>
<td>STK-4</td>
<td>eSTK-2, eSTK-3, eSTK-4, eSTK-5, eSTK-6, eSTK-8, eSTK-10</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>IMM-1 (retired)</td>
<td>eED-1a, eED-2a</td>
<td></td>
</tr>
<tr>
<td>Immunization</td>
<td>IMM-2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Psychiatric Services*</td>
<td>HBIPS-4, HBIPS-6, HBIPS-7 (retired)</td>
<td>HBIPS-1,† HBIPS-2,† HBIPS-3,† HBIPS-5†</td>
<td></td>
</tr>
<tr>
<td>Tobacco Treatment</td>
<td>TOB-4 (temporarily inactivated)</td>
<td>TOB-1, TOB-2, TOB-3</td>
<td></td>
</tr>
<tr>
<td>Substance Use</td>
<td>SUB-4 (temporarily inactivated)</td>
<td>SUB-1, SUB-2, SUB-3</td>
<td></td>
</tr>
<tr>
<td>Perinatal Care‡</td>
<td>PC-1, PC-2, PC-03, PC-04, PC-05</td>
<td>eC-01, ePC-05/5a</td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>OP-1, OP-2, OP-3, OP-4, OP-5, OP-18, OP-20, OP-21, OP-23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Hearing Detection and Intervention</td>
<td></td>
<td>EHDI-1a</td>
<td></td>
</tr>
</tbody>
</table>

* HBIPS required for freestanding psychiatric hospitals
† HBIPS for each measure includes all relevant patient age groups
‡ PC required for facilities with at least 300 live births per year

Improving The Joint Commission Accreditation Process

Multiphased Project Begins with Review of Requirements

This is the first of several articles about projects in progress that are intended to improve The Joint Commission accreditation process.

The Joint Commission periodically evaluates its standards in terms of their relevance, the need to address contemporary issues, and to address feedback from customers. The Joint Commission is currently involved in an initiative designed to streamline standards and elements of performance (EPs) in the Comprehensive Accreditation Manual for Hospitals without negatively impacting quality and safety.

The project will occur in phases, the first of which involves a number of EPs that have been identified for deletion. The Joint Commission does not believe that any of these deletions will change the patient care processes that organizations currently use or affect quality and safety. For the most part, they fall into one or more of the following categories:

- No longer address contemporary quality and safety concerns
- Are similar to or duplicative of other existing EPs
- Are adequately addressed by law and regulation or other external requirements, so separate Joint Commission requirements are not needed
- Address processes that should be left up to the discretion of the organization

Please note that The Joint Commission has not removed requirements that align with Centers for Medicare & Medicaid Conditions of Participation.

The Joint Commission collected feedback from hospital customers about the deletions. The modifications for the first phase are targeted for implementation in July 2016. During the second phase, additional EPs will be evaluated and further consolidations of existing requirements will be considered. Implementation for phase two is planned for January 2017.

Questions may be directed to Maureen Carr, project director, Department of Standards and Survey Methods, The Joint Commission, at mcarr@jointcommission.org.

APPOINTED: Executive Vice President for Business Development and Marketing

The Joint Commission recently appointed Brian H. Enochs, JD, to the position of executive vice president, business development and marketing. In this senior leadership position, Enochs oversees all business development and marketing efforts for The Joint Commission and its strategic business units, including oversight of external relations and state relations. He fills the vacancy created by the retirement of Chuck Mowll, FACHE, CSSBB, in May 2015.

“Brian joins The Joint Commission as a highly accomplished, results-oriented executive with more than 20 years of extensive experience in the pharmaceutical industry,” said Mark R. Chassin, MD, FACP, MPP, MPH, president and chief executive officer, The Joint Commission. “He is a strong leader who will energize our business development efforts in The Joint Commission’s pursuit of safe, high-quality care for all patients.”

Enochs has held executive positions with Intarcia Therapeutics, Abbvie Pharmaceuticals, and Eli Lilly & Company, and he has experience in general management, marketing and sales, business development, strategic planning, alliance management, new product planning, and commercial analysis. His accomplishments include establishing Eli Lilly Malaysia as the fastest-growing pharmaceutical company in that nation for three years, as well as being commercial leader for teams that have executed more than 20 licensing and acquisition transactions. Prior to his work in pharmaceuticals, Enochs held positions in the State Department in Washington, DC, and Tokyo.

Enochs can be reached at benochs@jointcommission.org.

http://www.jointcommission.org December 2015 The Joint Commission Perspectives
For more than 60 years, The Joint Commission has inspired hospitals and health care organizations to excel in providing safe and effective care of the highest quality by earning and maintaining The Joint Commission’s Gold Seal of Approval™, a symbol of quality that is recognized nationwide and reflects an organization’s commitment to meeting demanding performance standards.

At the Joint Commission Center for Transforming Healthcare, our mission to transform health care into a high reliability industry by developing effective solutions to health care’s most critical safety and quality problems continues the quest for achieving the gold standard in health care. Why? Because, along with our participating hospitals and organizations, we believe high reliability in health care means consistent excellence in quality and safety for every patient, every time.

**Introducing Oro™ 2.0**

Oro™ 2.0 is an online organizational assessment with resources designed to guide hospital leadership throughout the high reliability journey, specifically within the areas of leadership commitment, safety culture and performance improvement. The discoveries made throughout the Oro™ 2.0 process help organizations identify their high reliability maturity level and opportunities for improvement. A detailed summary report complete with resources help further the organization’s maturity level.

The road to high reliability is an ongoing journey. It’s a commitment to patient safety and the way we deliver quality health care. So join the journey and let Oro™ 2.0 and the Joint Commission Center for Transforming Healthcare guide you every step of the way.