Organization Contact	Topic ID	Topic	Comment	Proposed Action
Ahmad Albustami, HCA	1	General Comments	I encourage all hospital administrative teams to adopt the chief pharmacist officer as part of the senior administration team.	Comment appreciated. No action taken.
Ahmad Albustami, HCA	1	General Comments	Reward pharmacists for professional development; such as board certification, degree advancement.This is very important to encourage pharmacists to obtain more in depth knowledge and increase patient safety.	Comment appreciated. No action taken.
Barbara Corn, NAHQ	1	General Comments	Line 244- 245-Healthcare organizations are fraught with systems failures that worsen care becomes more fragmented and complex. Sentence should be reworded.#15- What if a patient refuses to have information forwarded to post discharge provider?	Comment appreciated. The problem section was updated in SP4 to reword sentence as requested. The patient has the right to refuse sharing of information, as documented in the patient chart.
Fernando Diaz, AANS	18	Update: Surgical Site Infection Prevention	The AANS fully recognizes that preventable adverse events may be serious and tragic to the patient and costly to the health care system as a whole. We share the NQFs desire to minimize such events and continue to work to provide our members with the best possible information on how to prevent these incidents and how to identify and promote "best practices."In terms of surgical site infections,	The committee gratefully acknowledges the input from AANS. It is not known whether it is possible to
Lea Anne Gardner RN, PhD (on behalf of the Performance Measurement Subcommittee), American College of Physicians	1	General Comments	The Performance Measurement Subcommittee is concerned that the scope of the document does not include any significant scientific and methodologically appropriate documentation of evidence behind these many "Safe Practices".	There is extensive documentation of the evidence for each of the updated safe practices. The full Safe Practices report will include the full list of general and specific references. In the next update, NQF will consider a specific evidence scoring schema for practices.

Christine Kaptur, FLorida Hospital	1	General Comments	SP4- Add delirium or altered mental status to RRT critieria. Eliminate Legionnaire's Disease	Delirium and Legionnaire's disease were removed from the additional specifications. However, these conditions were moved to SP 4 "Example Implementation Approaches" for organizational consideration.
Christine Kaptur, FLorida Hospital	2	New: Care of the Caregiver	Questions under Treatment is just: How many organizations suggest individuals have their own legal counsel before giving a formal statement to the healthcare what? or we to assume the healthcare is the hospital, not clear.	The Safe Practice suggests that: "All individuals should be given the advice to have their own legal counsel before giving a formal statement to the healthcare organization staff." The healthcare organization staff refers to the organization (hospital, outpatient center, nursing home) leadership.
Christine Kaptur, FLorida Hospital	19	Update: Influenza Prevention	Agree HCP should sign a declination for refusal of flu vaccine. This is done for HBV vaccination and would align to existing practice.	No action taken.
Rita Munley Gallagher, PhD, RN, American Nurses Association	1	General Comments	NQFs efforts to strengthen implementation guidance, update research recommendations, and evaluate new practices to ensure that the Safe Practices set remains current and appropriate are laudable. The revised document provides greater clarity in reducing the risk of harm to patients. The American Nurses Association (ANA)is particularly supportive of NQFs retention of Safe Practice 9: Implement critical components of a well designed nursing workforce which mutually reinforce patient safeguards.In addition, ANA offers the following comments of relevance to specific practice:Safe Practice 3: Developing Team-based Care (p. 15) Basic Teamwork Training should be revised to include involve the patient and their family	Appreciate ANA's support of the safe practices. The inclusion of patient and family involvement will be included in the full Safe Practices report.

Rita Munley Gallagher, PhD, RN, American Nurses Association	10	Update: Id. & Mitigation of Risk/Hazards	Safe Practice 4: Identification and Mitigation of Risks and Hazards (p. 17) should be revised to also state: The organisationnel culture should be framed by a focus on system (not individuel) errors, blame free reporting and use data from risk assessment to create a just culture. In addition, the following should be inserted between #5 and #6 (p. 18): Skill mix. Since the proportion and composition of highly trained and less qualified staff can have an impact on patient safety, the organisation must be aware of this fact and include in their annual or regular review. The balance should then be reordered	The proposed revision for "skill mix" was placed under "Risks and Hazard Indentification Activities."
Rita Munley Gallagher, PhD, RN, American Nurses Association	12	Update: Disclosure	Safe Practice 7 : Disclosure There is a need for clarification (p. 25) as to which takes precedence... insurance company policy or hospital policy.	This language has been clarified within the practice to ensure LIPs are given the hospital disclosure policy with the expectation that the LIPs will provide this information about these full disclosure programs to their individual medical malpractice liability carriers in the event the LIP is provided liability coverage from an entity outside the organization.
Rita Munley Gallagher, PhD, RN, American Nurses Association	2	New: Care of the Caregiver	Safe Practice 8: Care of the Caregiver: While the American Nurses Association (ANA) applauds the inclusion of this recommended new practice (pp. 25-26), it could be strengthened by adding the phrase : Implement a care of the caregiver approach that aims to prevent adverse events related to fatigue, stress, burn-out and low motivation by providing supportive and positive practice environment and other incentives	Please refer to implementation approaches for the addition of this recommendation.
Rita Munley Gallagher, PhD, RN, American Nurses Association	13	Update: Patient Care Information	Safety Practice 12: Patient Care Information ~ The detailed chapter addresses the use of technology and electronic health records as follows: Consider the use of technologies to enable the closure(p. 102)Some organizations have provided access to the entire medical record to patients online. (p. 103).Automated electronic notification of critical test results.(p. 106). However, the summary table (p. 31) does not include any specifications which address technology to facilitate patient care information and should be revised.	This recommendation was accepted by the committee and a statement of technology use was added. Please see new bullet 4 under additional specifications.

Rita Munley Gallagher, PhD, RN, American Nurses Association	17	Update: CLABSI Prevention	Safe Practice 21. Actions are taken to prevent CLABSI by implementing evidence-based intervention practices (p. 45) ~ Consideration should be given to expanding the types of antiseptics for skin preparation to include chlorhexidine, alcohol, and povidone iodine. They can be used as single agents or in combination. The preferred practice is use of a combination of alcohol and either chlorhexidine or povidone iodine. (Infusion Nurses Society. (2006). Policies and Procedures for Infusion Nursing. Boston, MA: Infusion Nurses Society and Camp Sorrell, D. (2004). Access Device Guidelines: Recommendations for Nursing Practice and Education. Pittsburgh, PA: Oncology Nursing Society).	Chlorhexidine is the preferred antiseptic per HAI compendium. Agree that many use alcohol/chlorhexdine combination. Confusion may arise if povidone iodine is added as a preferred agent. Therefore committee voted to not add at this time to the safe practice.
Rita Munley Gallagher, PhD, RN, American Nurses Association	18	Update: Surgical Site Infection Prevention	Safe Practice 22. Actions are taken to prevent SSIs by implementing evidence-based intervention practices ~ The first bullet on p. 47 should be revised to read Document education of health care workers involved in surgical procedures as well as in the on page 165.	The word "Document" was added to the education of healthcare workers involved in surgical procedures… in the SSI additional specifications bullet 1.
Rita Munley Gallagher, PhD, RN, American Nurses Association	4	New: CAUTI Prevention	Safe Practice 25. Actions are taken to prevent Catheter Associated Urinary Tract Infection (CAUTI) by implementing evidenced-based intervention practices. ~ The first bullet on p. 52 (as well as in the chapter on page 206) should be revised to read Document education of health care workers involved in the insertion.	See first bullet in additional specifications.This word "document" was added.
Rita Munley Gallagher, PhD, RN, American Nurses Association	11	Update: Pressure Ulcer	Safe Practice 27: Actions are taken to prevent pressure ulcers by implementing evidence-based intervention practices. During patient admission, should be revised to read identify individuals at-risk requiring pressure ulcer preventionâ€¦using a pressure risk assessment plan/guide to identify the specific risks.	This recommendation was accepted. Refer to Additional specifications bullet 3.
Rita Munley Gallagher, PhD, RN, American Nurses Association	21	Update: Anticoagulation Therapy	Safe Practice 29: Anticoagulation therapy (p. 54) should be revised to read is available and documented in the medication record	This recommendation aws accepted. Refer to "Additional Specifications," bullet 1 for additional Safe Practice language.

Rita Munley Gallagher, PhD, RN, American Nurses Association	22	Update: Contrast Media-induced RF Prevention	Safe Practice 30. Utilize validated protocols (pp.54-55). Should be revised to read: Documentation by a licensed clinician in the patients health record that risk assessment/stratification was completed.	Revision was accepted and placed under "Safe Practice 30: Contrast Media-induced Renal Failure." Additional specs final bullet.
Rita Munley Gallagher, PhD, RN, American Nurses Association	8	New: Falls Prevention	Safe Practice 33: Actions are taken to prevent patient falls and reduce fall-related injuries by implementing evidence-based intervention practices (p. 265) ~Falls with Injuries should be revised to include documentation of multiple injuries and injury by severity level (NQF has a rating scale for severity of injury) which would standardize severity level rating.Injury level should be identified for standardization as the following (and per NQFs endorsed Fall Injury Rate):Nonepatient had no injuries resulting from the fall;Minorâ€"resulted in application of a dressing, ice, cleaning of a wound, limb elevation, or topical medication;Moderate resulted in suturing, application of steri-strips/skin glue, or splinting;Major resulted in surgery, casting, traction, or required consultation for neurological or internal injury;Death the patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall).The fall risk assessment standard (reference on lines 4540-4543) is based on guidelines which should be cited as: American Geriatrics Society, British Geriatrics Society, and American Academy of Orthopaedic Surgeons Panel on Falls Prevention. (2001).Guideline for the Prevention of Falls in Older Persons. JAGS 49:664"672.	Comments about rating scale were incorporated into the "Outcome Measures." Citation for falls risk assessment standard was added to "Process Measures" section.

Rita Munley Gallagher, PhD, RN, American Nurses Association	6	New: Pediatric Imaging	Safe Practice 34: CT Imaging Studies in Children (pp.) should e revised to include the need to shield reproductive areas and add a notation about the principles of time, distance and shielding.	Added to Additional specs: “Decisions about shielding those radiosensitive areas outside of the scan range or those within the scan field (in-plane shielding) should be based on discussion with a qualified phycisist and incorporate local and national standards of practice.” The concept of “time and distance” would be applicable to angiography and fluoroscopy and would not be appropriate for CT imaging.
Catherine MacLean, WellPoint, Inc	10	Update: Id. & Mitigation of Risk/Hazards	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	12	Update: Disclosure	The added issue re: malpractice insurance carriers is a great addition. The last bullet notes patients wont be billed if preventable error occurs but does not mention the health plan. Recommend: include all billing parties (patient, health plan, etc.)will not be billed for preventable errors.	The comment is referring to statement: "A process should be in place to consider early remediation and waiving billing for care services provided during the care
Catherine MacLean, WellPoint, Inc	2	New: Care of the Caregiver	Approved	No action taken.

Catherine MacLean, WellPoint, Inc	13	Update: Patient Care Information	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	3	New: Order Read-back/Abbreviations	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	14	Update: Medication Reconciliation	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	15	Update: Pharmacist Leadership Systems	Unable to comment on changes due to inability to determine changes in this measure. No hilighting or underlining in the document.	No action taken. New practices or those with extensive updates did not have marked changes, as the practice was delivered back to the marketplace as new and available for comments on any section.
Catherine MacLean, WellPoint, Inc	19	Update: Influenza Prevention	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	17	Update: CLABSI Prevention	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	18	Update: Surgical Site Infection Prevention	Approved	No action taken.

Catherine MacLean, WellPoint, Inc	16	Update: Care of the Ventilated Patient	Unable to comment on changes due to inability to determine changes in this measure. No hilighting or underlining in the document.	No action taken. New practices or those with extensive updates did not have marked changes, as the practice was delivered back to the marketplace as new and available for comments on any section.
Catherine MacLean, WellPoint, Inc	5	New: Multi-drug Resistant Organism Prevention	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	4	New: CAUTI Prevention	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	11	Update: Pressure Ulcer	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	20	Update: VTE Prevention	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	21	Update: Anticoagulation Therapy	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	22	Update: Contrast Media-induced RF Prevention	Approved	No action taken.

Catherine MacLean, WellPoint, Inc	9	New: Glycemic Control	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	8	New: Falls Prevention	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	6	New: Pediatric Imaging	Approved	No action taken.
Catherine MacLean, WellPoint, Inc	7	New: Organ Donation	Approved	No action taken.
Rebecca Zimmermann, AHIP	1	General Comments	AHIP has reviewed the Safe Practices for Better Healthcare: 2009 Update. We agree with the proposed recommended changes noted in the document. We recognize the practices outlined in the document would be an ambitious undertaking for any health care entity to pursue and may need to be phased in over time to ensure stable adoption.	Comment appreciated. No action taken.
Marilyn Jones, RN, MPH, CIC, on behalf of APIC	10	Update: Id. & Mitigation of Risk/Hazards	Retrospective Identification:Root Cause Analysis. The root cause analysis process for identifying the causal factors for events, including sentinel events, should be undertaken with emphasis on measuring the outcome and identifying whether the risk has actually been reduced. Rationale: Recent literature noted the lack of data to demonstrate the effectiveness of RCA to really improve the outcome. However, the actual contribution of RCA in reducing risk has not been studied. Lipshutz AKM, Pronovost Effectiveness and Efficiency of Root Cause Analysis in Medicine JAMA, February 13, 2008"Vol 299, No. 6 685-87 Mills PD, J Neily, Kinney LM, Bagian J, Weeks JB Effective interventions and implementation strategies to reduce adverse drug events in the Veterans Affairs (VA) system Qual Saf Health Care 2008;17:3746Percarpio KB.; Watts BV, Weeks, William B. The Effectiveness of Root Cause Analysis: What Does theLiterature Tell Us? Joint Commission Journal on Quality and Patient Safety, Volume 34, Number 7,July 2008 , pp. 391-398(8)	The committee recognizes this literature is evolving and added this concept and the citations requested: Revision placed in bullet 2 under "Example Implementation Approaches"

Marilyn Jones, RN, MPH, CIC, on behalf of APIC	10	Update: Id. & Mitigation of Risk/Hazards	6. Iatrogenic pneumothorax: Not specific enough to be helpful.Evidence-based guidelines simply acknowledge that IP is a known risk of certain procedures as listed by CMS. This lends itself to informed consent. Barotraumas (physical damage to body tissues caused by a difference in pressure between an air space inside or beside the body and the surrounding gas or liquid) occurs not infrequently in mechanically ventilated patients requiring high pressures to ventilate for which there is no real alternative. Carrying out these procedures requires assessing alternative risks. These statements do not provide actual guidance.	The committee agrees with the recommendation to remove iatrogenic pneumothorax from the "Additiona Specifications." Revision placed in bullet four under "Example Implementation Approaches." This condition is now listed as a consideration for organizations to address.
Marilyn Jones, RN, MPH, CIC, on behalf of APIC	10	Update: Id. & Mitigation of Risk/Hazards	7. Delirium:Not specific enough to be helpful.Delirium is associated with aging and treatment of illness requiring hospitalization, early Alzheimer patients can develop delirium just by being in unfamiliar surroundings. Delirium can occur in ICUs through utilization of necessary medications, including antibiotics, as well as through sleep deprivation common with being critically ill (vent and pump alarms, etc). These statements do not provide actual guidance.Although there may be recommended practices that can reduce the risk, evidence-based guidelines for predictive prevention do not exist. Again, the risks of alternatives must be weighed against the specific patient's needs. Delirium caused by necessary medications is not by nature something that can be predicted before the medication is given; reaction to medications is variable from patient to patient. These statements do not provide actual guidance.	The committee agrees with the recommendation to remove delirium from the "Additiona Specifications." Revision placed in bullet four under "Example Implementation Approaches." This condition is now listed as a consideration for organizations to address.
Marilyn Jones, RN, MPH, CIC, on behalf of APIC	10	Update: Id. & Mitigation of Risk/Hazards	8. Legionnaires' disease:Not particularly useful in light of other diseases priorities and existing CDC/HICPAC guidelines.This could be stated about nearly every infectious disease and as a statement is not helpful. This is already covered in greater detail in the CDC Environmental Infection Control Guidelines for Facilities and CDC/HICPAC Pneumonia Guidelines for facilities for recognition, diagnosis and treatment. Why is this picked out of all the disease prevention strategies? Recommend a reference CDC/HICPAC Guidelines if still included.	The committee agrees with the recommendation to remove LD from the "Additiona Specifications." Revision placed in bullet four under "Example Implementation Approaches." This condition is now listed as a consideration for organizations to address.

Marilyn Jones, RN, MPH, CIC, on behalf of APIC	19	Update: Influenza Prevention	20. Comply with current Centers for Disease Control and Prevention (CDC) Influenza Vaccinations for Healthcare Personnel and the yearly Advisory Committee on Immunization Practices (ACIP) for individual influenza prevention and control recommendations:-Encourage compliance with CDC guidelines with category II evidence.-Obtain a signed declination from HCP who decline influenza vaccination for reasons other than medical contraindications (category II).This is too prescriptive and reason for Category II for signed declination is due to lack of evidence that this is effective." With the recent focus on declination statements, including the passage of legislation that requires HCWs who refuse vaccination to use a signed declination form, there is a risk of distraction from the focus of the vaccination program." (Talbot, TR Improving Rates of Influenza Vaccination Among Healthcare Workers: Educate; Motivate; Mandate? Infect Control Hosp Epidemiol 2008, vol. 29, no. 2 107-10) Recommendation should be more system oriented. Recommend rather:-Individuals who decline the vaccine for other than medical reasons should be tracked separately by whatever system is adopted by the facility in order to develop vaccination improvement strategies.	Comment appreciated. The declination recommendation from "Additional Specifications" has been moved to "xample Implementation Approaches." See Example Implementation, bullet one.
Marilyn Jones, RN, MPH, CIC, on behalf of APIC	17	Update: CLABSI Prevention	21. Actions are taken to prevent CLABSI by implementing evidenced based intervention practices:This is likely language taken from the SHEA/IDSA compendium which emphasizes implementation, but should still reference back to current CDC/HICPAC Guidelines for Prevention of Intravascular Catheter-Related Infections from which these were developed. CDC/HICPAC guidelines that are the basic gold standard guideline that undergo revision periodically. There should be no confusion over the key resource.	CDC Reference was added.
Marilyn Jones, RN, MPH, CIC, on behalf of APIC	18	Update: Surgical Site Infection Prevention	22. Actions are taken to prevent SSIs by implementing evidenced-based intervention practices:This is likely language taken from the SHEA/IDSA compendium which emphasizes implementation, but should still reference back to current CDC/HICPAC Guidelines for Prevention of Surgical site Infection from which these were developed. CDC/HICPAC guidelines that are the basic gold standard guideline that undergo revision periodically. There should be no confusion over the key resource.	Please refer to the Safe Practice statement. Mangrum 1999 reference is added to this section. This reference was already listed in the additional specifications as appropriate.
Marilyn Jones, RN, MPH, CIC, on behalf of APIC	16	Update: Care of the Ventilated Patient	23. Actions are taken to prevent complications associated with ventilated patients: specifically,ventilator-associated pneumonia (VAP), venous thromboembolism (VTE), peptic ulcer disease (PUD),dental complications, and pressure ulcers:This is likely language taken from the SHEA/IDSA compendium which emphasizes implementation, but should still reference back to current CDC/HICPAC Guidelines for Preventing Healthcare-associated Pneumonia from which these were developed. CDC/HICPAC guidelines that are the basic gold standard guideline that undergo revision periodically. There should be no confusion over the key resource.	The CDC guidelines authored by Tablan 2004 reference is clearly cited in the practice.

Marilyn Jones, RN, MPH, CIC, on behalf of APIC	5	New: Multi-drug Resistant Organism Prevention	24. Implement a systematic MDRO eradication program built upon the fundamental elements of infection control, an evidence-based approach,assurance of the hospital staff and independent practitioner readiness, and a re-engineered identification and care process for those patients with or at risk for MDRO infections.Note: This practice applies to, but is not limited to, epidemiologically important organisms such as methicillin resistant Staphylococcus aureus (MRSA), Vancomycin ResistantEnterococci (VRE), and Clostridium difficile. Multidrug resistant Gram-negative bacilli (MDR GNB), such asEnterobacter species, Klebsiellaspecies, Pseudomonas species, and Escherichia coli and vancomycin-resistant Staphylococcus aureus (VRSA), should be evaluated for inclusion on a local system level based on organizational risk assessments.This is likely language taken from the SHEA/IDSA compendium which emphasizes implementation, but should still reference back to current CDC/HICPAC Guidelines for Isolation Precautions 2007 and CDC/HICPAC Management of multidrug-resistant organism in healthcare settings, 2006 from which these were developed. CDC/HICPAC guidelines that are the basic gold standard guideline that undergo revision periodically. There should be no confusion over the key resource.	CDC/HICPAC Guidelines for Isolation Precautions 2007 and CDC/HICPAC Management of multidrug-resistant organism in healthcare settings, 2006 from which these were developed. CDC/HICPAC guidelines added as references to "Additional Specifications" section. Seigel MDRO guidelines are already cited.
Marilyn Jones, RN, MPH, CIC, on behalf of APIC	4	New: CAUTI Prevention	25. Actions are taken to prevent Catheter Associated Urinary Tract Infection (CAUTI) by implementing evidenced-based intervention practices: This is likely language taken from the SHEA/IDSA compendium which emphasizes implementation, but should still reference back to current CDC/HICPAC Guidelines for Prevention of Catheter-associated Urinary Tract Infection from which these were developed. CDC/HICPAC guidelines that are the basic gold standard guideline that undergo revision periodically. There should be no confusion over the key resource. This guidelines is undergoing revision now and should be complete by the end of 2008.	CDC Reference was added.
Marilyn Jones, RN, MPH, CIC, on behalf of APIC	1	General Comments	The reference to implementing the bundles rather than a single strategy appears to be a predominant theme. However, AHRQ in its report on evidence based interventions states that there is insufficient data to support this claim (http://www.premierinc.com/quality-safety/tools-services/safety/safety-share/02-07-downloads/12-hainfgap.pdf pg 95	The committee gratefully acknowledges the input and the lack of research defining absolute, exact preventability. Please refer to the problem section last sentence for updated verbiage reflecting the suggestion.
Bernard Rosof, MD, MACP, PCPI	1	General Comments	The Physician Consortium for Performance ImprovementÂ® (PCPI) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) Safe Practices for Better Healthcare 2009 report. We support the report and the goals of the safe practices. The PCPI is especially pleased to see that each of the NQF Safe Practices includes components that strive to promote patient involvement in his or her care and the concepts of measurement integrated within each safe practice.We appreciate the opportunity to comment.	Appreciate comment. No action taken.

Nancy Nielsen, MD, PhD, AMA	1	General Comments	The American Medical Association (AMA) is pleased to have the opportunity to comment on the National Quality Forumâ€™s (NQF) Safe Practices for Better Healthcare â€“ 2009 report. While we support the report and the goals of the safe practices and are especially pleased to see that each of the NQF Safe Practices includes components that strive to promote patient involvement in his or her care, we have concerns with Safe Practice 18 as it is written and the unintended consequences of the Safe Practices 20-25 if used inappropriately to inform payment policy. These concerns are outlined below.	Appreciate comment. Specific changes noted below.
Nancy Nielsen, MD, PhD, AMA	15	Update: Pharmacist Leadership Systems	Leadership and Culture of Safety: While we agree that the pharmacist is an integral member of the medication management team, the practice specification establishes the pharmacist as the leader of the medication management process and minimizes the role of other healthcare professionals, particularly physicians. We recommend that the language on page 128, lines 1763-1764 be revised to read as follows: Pharmacists should actively participate in the medication management processes, structures and systems, including, at a minimum.	Please refer to Additional specifications bullet 2 for change to requested language: "participate in," deletion of "lead.".
Nancy Nielsen, MD, PhD, AMA	15	Update: Pharmacist Leadership Systems	Selection and Procurement:Beginning on page 130, lines 1796-1797, this section on selection and procurement implies pharmacists have the oversight of the medication formularies. Physicians are integral to therapeutic drug management and we request that the concept of physician oversight of the formulary be included within the specification.We refer the Committee to the AMA's comprehensive policy on drug formularies and therapeutic interchange. In particular, AMA Policy, H-125.991, Drug Formularies and Therapeutic Interchange, (attached) provides definitions for the following terms: formulary, formulary system, Pharmacy & Therapeutics (P&T) Committee, therapeutic alternates, therapeutic interchange, and therapeutic substitution, and outlines the standards that should be required for a formulary system including the necessity for medical staff or equivalent (ie, physician) oversight and approval of both in-patient and out-patient formularies. We request that the Committee consider a modification to the statement on line 1796 and the inclusion of an additional statement on line 1797 to ensure adequate physician oversight and approval of formulary systems. This principle would read as follows:Pharmacists work with physicians and other health professionals to select and maintain a formulary of medications chosen for safety and effectiveness. The formulary system should have a process in which the medical staff has oversight and approval of the formulary.	Please refer to Additional specifications, selection and procurement, bullet one for addition of requested language for physician oversight of formulary.

Nancy Nielsen, MD, PhD, AMA	15	Update: Pharmacist Leadership Systems	While we agree with the pharmacists role in medication selection, the AMA believes medications should be chosen based on a physicians clinical judgment and a patients preferences. We recommend additional language be included on line 1800 to read as follows: Prescriber should document the specific reason, clinical indications and/or patient preferences and why a patient is not receiving a recommended medication based on readily available, current guidelines.	Please refer to Additional specifications, selection and procurement, bullet two for addition of requested language.
Nancy Nielsen, MD, PhD, AMA	1	General Comments	Safe Practices 20 25: Influenza Prevention, Central Line Associated Blood Stream Infection (CLABSI) Prevention, Surgical Site Infection Prevention, Daily Care of the Ventilated Patient, Multi-Drug Resistant Organisms (MDRO) Prevention, and Catheter-Associated Urinary Tract Infection (UTI) Prevention:While the practices that are proposed here are important and worthwhile practices that can improve patient care and safety and should be implemented by caregivers to the extent feasible, the AMA is very concerned about the unintended consequences presented if this list is inappropriately used by policy makers and payers to inform payment policy. As we noted in our August 2008 comment letter to the NQF on the National Priorities Partnership document, we are concerned that NQF endorsement of such practices implies that all such conditions are one hundred percent preventable and that their incidence can be eliminated.	
Corrie Fierstein, American Geriatrics Society	1	General Comments	While the main focus of the document is on the inpatient setting, it does demonstrate from its content the awareness that geriatric issues are major safety concerns. This is exhibited in the inclusion of topics of- Falls reduction; Prevention of pressure ulcers; Preventing catheter associated infections; Medication reconciliation; Health care workers use of influenza immunization; Risk assessment and mitigation activities for delirium; Opportunities for patient and family involvement in assessment and care planning;	Comment appreciated. No action taken.
Corrie Fierstein, American Geriatrics Society	14	Update: Medication Reconciliation	SP 17 Medication Reconciliation - it notes that a complete list of medications be created and documented. At no time does it discuss the approach of review of the actual medication bottles. We have found lists to be incomplete, outdated and not understood by the patient or family. The approach that is recommended results in a complete list of what you ordered rather than what they are actually taking.	The language for review of bottles was added. Refer to example implementation approach bullet 8.

Corrie Fierstein, American Geriatrics Society	16	Update: Care of the Ventilated Patient	SP 23 Care of the Ventilated Patient - notes the importance of preventing pressure ulcers but that section does not refer to SP 27 which is devoted to Pressure Ulcer prevention.	Safe Practice 27: Pressure Ulcer Prevention is referenced in the "Other Relevant Safe Practices" section and now in the additional spec to refer to practice 27.
Corrie Fierstein, American Geriatrics Society	4	New: CAUTI Prevention	SP 25 Cather associated UTI -the focus on healthcare workers education should specifically include physician education since they are the ultimate controller of when a catheter is used and for how long.	The requested language for physician education was added. See bullet under additional specs.
Corrie Fierstein, American Geriatrics Society	21	Update: Anticoagulation Therapy	SP 29 - Anticoagulation therapy calls out the importance of dietary interaction but should also include clinical pharmacy review of drug-drug interactions	Refer to "Additional Specifications," bullet 2 for addition to Safe Practice language.
Nancy Nielsen, MD, PhD, AMA	1	General Comments	Recent actions by healthcare organizations, including the Center for Medicare and Medicaid Services (CMS) and private health insurers, to brand certain conditions as a never events show a clear misconception that most healthcare-associated infections or serious reportable events can be reasonably prevented. These actions have raised significant concerns across the provider community. To be reasonably preventable, there should be solid evidence, published in peer-reviewed literature, that by following certain guidelines, the occurrence of an event can be reduced to zero, or near zero, among a typically broad and diverse patient population, including high risk patients. This is not the case for many of the conditions adopted by CMS and private payers in their policies.The AMA continues to work aggressively to improve quality, safety and efficiency for patients, but simply not paying for complications or conditions that are not entirely preventable is not good for patients or our healthcare system. In the race to improve health care quality, CMS and private payers have confused events that should never happen in a hospital, like wrong-patient surgery, with often unavoidable conditions, like surgical site infections.	The committee gratefully acknowledges the input from AMA. It is not known whether it is possible to prevent each and every adverse event, there is clear evidence that some adverse events, such as infection rates, can be reduced to levels far lower than they are today in most health care settings. These safe practices are intended to assist providers in their efforts to continually reduce and drive infections toward zero.
Nancy Nielsen, MD, PhD, AMA	1	General Comments	Given the lessons learned from the Serious Reportable Events report and its misuse by payers, the AMA strongly recommends that NQF clearly state in this report that the intent of the list of safe practices is to improve patient care and safety and that inclusion of certain practices on the list is not suitable justification for the development of payment policy by payers.We appreciate the opportunity to comment.	

Corrie Fierstein, American Geriatrics Society	22	Update: Contrast Media-induced RF Prevention	SP 30 Contrast Media-Induced Renal Failure Prevention recommends screening with a serum creatinine which is not sensitive enough when the more specific calculated GFR is more accurate	Addition of GFR was placed under "Safe Practice 30: Contrast Media-induced Renal Failure" problem section and Example Implementation Approaches per your recommendation.
Corrie Fierstein, American Geriatrics Society	9	New: Glycemic Control	SP 32 - Glycemic Control notes that there is a debate of a tight control of critically ill adults with a conclusion of no difference in hospital mortality. However, the long term cognitive implications of episodes of hypoglycemia in frail elders may have one re-consider a target range that is as low as 80-110	The committee acknowledged in the problem section that the target level of glycemic control may be less important than the controlling the extent of variability in glucose levels. Also, we defined in the measures sections the following as "out of range" glucose readings: <40mg/dL extreme hypoglycemia, <70mg/dL hypoglycemia, >300mg/dL extreme hyperglycemia and percentage of eligible patient days with mean <140 or <180 mg/d, and/or with all values <180. The practices does not define a specific range for any group of 80-110 as "normal."

Lisa Thiemann, American Association of Nurse Anesthetists	12	Update: Disclosure	Our comments concern the additional specification statement which begins, [i]n the event that the healthcare providers have different malpractice insurance carriers ...." As written this statement may have unintended consequences for healthcare professionals and the facilities in which they work. By placing the undue expectation of bringing together two dissimilar parties (i.e., an institution and a malpractice carrier) squarely on the shoulders of the healthcare provider in order to secure or retain employment within a facility, this specification statement may have unintended consequences. This requirement, although laudable in concept, may pose a challenge to employment and may result in decreased access to care should malpractice carriers choose not to enter into such an agreement. From an insurers perspective, this requirement may be cost prohibitive to implement, and may result in insurance companies walking away from insuring certain groups (i.e., those healthcare providers who are self-insured). If this were to happen on a large scale basis, institutions may be faced with a diminished healthcare professional pool, resulting in a decrease in access to care for the patient population served by the institution.	The committee reduced the rigor of the language to request that organizations have a process in place to ensure that licensed independent practitioners (LIPs) are provided with a detailed description of the organizations program for responding to adverse events, including the full disclosure of error(s) that may have caused or contributed to patient harm.
Lisa Thiemann, American Association of Nurse Anesthetists	3	New: Order Read-back/Abbreviations	The AANA agrees communication plays a vital role in patient safety, and we support NQFs efforts to improve communication across all care settings. Our comments specifically address the following specifications which begin [t]he receiver of verbal information...", "[t]he receiver reads back ...", and "[t]he receiver receives confirmation ....As written, these statements may be problematic to implement within an operating room (OR) setting. When engaged in the care of patients under anesthesia, anesthesia professionals often receive verbal orders for the administration of medications from the operating practitioner. This order may not be written down on an order sheet; however, it is recorded on the anesthesia record when the requested medication is administered. In the OR a drug is documented at the time it is given, not when it is ordered. In those clinical settings which have already transitioned to electronic anesthesia care records, entering a verbal order into the computer may signify the drug has been administered, rather than an order has been issued for the drugs administration. It is then problematic to reenter the electronic medication chart in order to adjust the actual drug administration time in order to comply with these statements as written. The AANA respectfully requests the NQF consider clarifying the above cited language in order to reflect the nuances of clinical care in various settings which may require adaptation for implementation.	Revision placed under "Additional Specifications" to allow a clinical judgement call when the order readback "written" process is not practical.

Janet Davis, Tampa General Hospital	14	Update: Medication Reconciliation	Annual education should not be required. This is a high volume practice and education should be based on data. If a problem exists education should be provided. Annual education should be required on low volume / high risk interventions.	See additional specification bullet one for requested revision. Regular eduction and frequency of such education should depend on the risk of noncompliance and adverse drug events determined by the organization.