AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

AMERICAN COLLEGE OF CHEST PHYSICIANS

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October 20, 2010

Steering Committee on Patient Outcome Measures
National Quality Forum
601 13th Street NW
Suite 500 North
Washington, D.C. 20005

To the Steering Committee:

The American Association of Critical-Care Nurses, the American College of Chest Physicians, and the American Thoracic Society would like to appeal the National Quality Forum's (NQF) recent decision to endorse Intensive Care Unit Length of Stay and In-Hospital Mortality for Intensive Care Unit Patients as patient outcome measures. As professional societies with expertise in critical care medicine, we represent approximately 100,000 critical care practitioners in the United States. We believe that these quality measures carry significant potential for adverse consequences that may ultimately harm patients and increase health care costs.

These measures reflect process of care that are independent of quality and can be easily manipulated. Both measures can be altered by transferring ICU patients early in their course of treatment to post-acute care facilities such as skilled nursing facilities or long-term acute care hospitals. Research demonstrates that transferring patients "sicker and quicker" out of the hospital can shorten length of stay and improve a hospitals risk-adjusted mortality profile, but not improve patient care.[1,2] Furthermore, encouraging earlier transfer out of the ICU to the floor could increase the risk of patient harm and increase the rate of unscheduled readmission to the ICU.[3]

Adoption of these measures could unfairly reward hospitals that transfer a large number of patients to post-acute care facilities and encourage overuse of post-acute care, potentially increasing health care costs. This effect could result in unfair penalties to safety-net hospitals that are unable to transfer out patients due to lack of health insurance. Additionally, these measures could discourage hospitals from providing time-consuming yet important end-of-life care for ICU patients. Indeed, prior research shows that benchmarking based in-hospital mortality simply delays death or shifts the site of to a post-acute care facility, without actually reducing overall mortality.[4]

We are well aware that concern about the potential of harm caused by "gaming" could potentially apply to any measure. However, particularly in the case of an ICU LOS measure, we feel that the risk of unintended negative patient consequences is quite high and the scientific underpinnings are particularly weak, given the lack of availability of well validated risk adjustment for this outcome.[5] We strongly suggest the NQF not endorse ICU length of stay. As an alternative to in-hospital mortality, we suggest that the NQF consider 30-day mortality, which is much less susceptible to discharge bias. Indeed, all of the risk-adjusted mortality measures adopted by the Centers for Medicare and Medicaid Services such as pneumonia mortality and acute myocardial infarction mortality use 30-day mortality, not in-hospital mortality.

Respectfully,

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