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Council/ Public	**Commenter**	**Comment**	**Topic**
Public	Submitted by Erin L. Buchanan	Data collection could be burdensome and increases the need for resources for hospitals. Not only does this increase the cost of care, but increases the demands on a hospital's Infection Control Department. Increasing infection data collection causes the Infection Preventionist to spend more time collecting data and less time on needed infection control surveillance and interventions. . For that reason, I recommend limiting data collection to measures that are already mandated by most states or required by CMS. No comments for measures PSM-001-10, PSM-002-10 and PSM-007-10. For PSM-003-10 I would recommend changing the population to the same population required by CMS; Adult and pediatric ICU.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure
Council	Submitted by Dr. Mary Jean Schumann, DNP, MBA, RN, CPNP	The Nursing Alliance for Quality Care recommends endorsement of PSM-003-10 and supports replacing NQF-endorsed measure #0138 Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients with PSM-003-10.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure
Council	Submitted by Dr. Mary Jean Schumann, DNP, MBA, RN, CPNP	The Nursing Alliance for Quality Care supports the adoption of this measure in order to expand the inclusion of patient level data for this procedure beyond the currently limited scope. It is important that we expand the reach of this measure to benefit greater numbers of patients and enhance the opportunities for quality improvement.	PSM-001-10: National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure

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Council/ Public	**Commenter**	**Comment**	**Topic**
Public	Submitted by Carrie Nagy-Marsh	Data collection could be burdensome and increases the need for resources for hospitals. Not only does this increase the cost of care, but increases the demands on a hospital's Infection Control Department. Increasing infection data collection causes the Infection Preventionist to spend more time collecting data and less time on needed infection control surveillance and interventions. . For that reason, I recommend limiting data collection to measures that are already mandated by most states or required by CMS. I would recommend changing the population to the same population required by CMS; Adult and pediatric ICU.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure
Council	Submitted by Ms. Samantha Burch	Although implementation issues are not explicitly addressed as part of the NQF measure review process, the FAH would like to note that the actual implementation of the CAUTI and CLABSI measures through the NHSN process is cumbersome because the CDC requires layers of detail beyond just the recordation of the simple infection rate. The NHSN submission form seeks additional information that is very helpful for epidemiologic purposes in terms of determining antibiotic resistant organisms, but it will require additional personnel and retraining of current personnel in LTACHs, IRFs and other care settings to implement these measures.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure

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Council/ Public	**Commenter**	**Comment**	**Topic**
Council	Submitted by Ms. Margaret Reagan	Premier recommends endorsement of PSM-001-10 and supports replacing NQF-endorsed measure #0139: Central line -associated blood stream infections rate for ICU and high-risk nursery (HRN) patients with PSM-001-10. A given facility's observed number of CLABSIs is compared to the number expected for that facility from CDC/NHSN's comparable national incidence density. The SIR accounts for length of stay, duration of use of central lines, location, and others. We agree with description from NQF, and provide comment: 1) Interfacility comparison: Premier supports the reporting of CLABSI SIRs since they are more accurate and readily available using analysis that the developer, CDC, has built into its modules for facility-specific comparison to a national, standardized frequency measure.2) NQF endorsement: Premier has always requested CMS to select only NQF-endorsed measures. Premier supports NQF endorsement of the SIR measure since it adds much value to CLABSI comparisons.3) Risk stratification: Premier supports the risk stratification currently used by CDC. Although the measure is based on unit experience there are methods to stratify patients by risk.4) No additional labor or impact on current processes- Premier supports the SIR measure since it does not add facility time or labor. CDC calculates the SIR before sending to CMS and does not add additional labor or resources for NHSN users nor impact NHSM vendors supporting NHSN.	PSM-001-10: National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure

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Council/ Public	**Commenter**	**Comment**	**Topic**
Council	Submitted by Ms. Samantha Burch	The FAH supports the use of standardized infection ratios (SIRs) to measure healthcare-acquired infections (HAIs). While we support the expansion of this measure to other care settings, we request clarification on whether this measure has been fully tested in each (or any) of the new locations added to the measure. It is unclear from the report what, if any, additional testing has taken place. The additional locations include a range of settings with varying characteristics and we believe it is important to understand how this measure functions in each of the specified locations. Some of these additional locations do not have much experience with reporting to NHSN. For example, there has been some voluntary NHSN reporting by LTCHs and IRFs, but the data has never been validated so we don't know if it's accurate.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure

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Council	Submitted by Ms. Samantha Burch	Although implementation issues are not explicitly addressed as part of the NQF measure review process, the FAH would like to note that the actual implementation of the CAUTI and CLABSI measures through the NHSN process is cumbersome because the CDC requires layers of detail beyond just the recordation of the simple infection rate. The NHSN submission form seeks additional information that is very helpful for epidemiologic purposes in terms of determining antibiotic resistant organisms, but it will require additional personnel and retraining of current personnel in LTACHs, IRFs and other care settings to implement these measures.	PSM-001-10: National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure

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Council/ Public	**Commenter**	**Comment**	**Topic**
Council	Submitted by Ms. Samantha Burch	The FAH supports the use of standardized infection ratios (SIRs) to measure healthcare-acquired infections (HAIs). While we support the expansion of this measure to other care settings, we request clarification on whether this measure has been fully tested in each (or any) of the new locations added to the measure. It is unclear from the report what, if any, additional testing has taken place. The additional locations include a range of settings with varying characteristics and we believe it is important to understand how this measure functions in each of the specified locations. Some of these additional locations do not have much experience with reporting to NHSN. For example, there has been some voluntary NHSN reporting by LTCHs and IRFs, but the data has never been validated so we don't know if it's accurate.	PSM-001-10: National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure
Council	Submitted by Ms. Samantha Burch	While the FAH appreciates that CDC and ACS worked to harmonize their SSI measures, we do not believe the new measure truly represents a "harmonized measure." It is unclear from the report what has been gained by the harmonization of these measures. Instead of two separate measures, we now have one measure that allows for providersto choose between two distinct reporting mechanisms, either NHSN or NSQIP. Therefore, we have not achieved a single data source for this information.	PSM-002-10: American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

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Council/ Public	**Commenter**	**Comment**	**Topic**
Council	Submitted by Ms. Samantha Burch	The Federation of American Hospitals (FAH) appreciates the opportunity to comment on the harmonized ACS-CDC SSI measure and the two NHSN measures (CLABSI and CAUTI) significantly revised by the CDC. Hospitals are committed to providing safe care to patients and the availability of scientifically valid, well-specified patient safety measures is critical to measuring safety and informing provider improvement efforts. To that end, it is important the we develop a standard portfolio of safety measures that can be used across the public and private sectors in order to avoid duplicative data collection and confusion among providers by measuring the same areas in slightly different ways.	General Draft
Council	Submitted by Sharon M. McCauley, MS,MBA,RD,LDN,FADA	The American Dietetic Association requests to add to Safe Practice #27: Pressure Ulcer Prevention. The American Dietetic Association recommends to address the following under Additional Specifications and in the section - Plans in place for the risk assessment, prevention, and early treatment of pressure ulcers: "Maintain and improve nutrition status in order to reduce risk for pressure ulcer development". We thank you for the opportunity to comment on this essential safe practice implementation in all care settings.	Not Recommended

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Council	Submitted by Ms. Margaret Reagan	Premier does not support PSM-007 This is a risk-adjusted, case-mix adjusted urinary tract infection outcome measure of adults 18+ years after surgical procedures. This measure is currently used in the ACS NSQIP surveillance system. The developer (ACS) reiteratedthat the measure assesses UTIs within 30 days of surgical procedure but is not necessarily catheter-associated. Non-Device-relatedAlthough no changes are offered, Premier does not support endorsing this measure. It is interesting that the justification for this measure reference catheter-associated UTIs. We believe this measure is unnecessary given the CDC/NHSN CAUTI measure as the current NQF-endorsed SCIP measure, requiring removal of the urinary catheter in surgical patients one or two days post-op and removes a primary risk factor for CAUTI – the indwelling urinary catheter. We're not sure of the proportion of UTIs identified under this outcome measure that are attributable to the catheter. There is also uncertainty as to the preventability of these UTIs in absence of an indwelling device. We note the barriers to this measures raised by NQF TAP and Committee as well. We have concerns for its adoption by other 3rdparty payors who may not appreciate its inability to develop strategies for prevention. Finally since it is not associated with catheter devices it simply adds a collection burden without much practical value.	Not Recommended

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Council	Submitted by Dr. Thomas James, III, MD	Humana appreciates the opportunity to comment. This measure should be in concert with the patient safety measures of hospital readmission. CAUTI is a major cause of hospital readmission among those patients discharged from the acute care facility to the LTAC or SNF. We would expect that the language in this measure that includes "Long Term actue care hospitals, rehabilitation hospitals" is also encompassing of skill nursing facilities and long term acute care facilities, whether they are deemed to be "hospitals" or not.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure

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Council/ Public	**Commenter**	**Comment**	**Topic**
	Submitted by Ms. Margaret	Premier recommends endorsement of PSM-003-10 and supports replacing NQF-endorsed measure #0138 Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients with PSM-003-10. This measure utilizes a SIR to calculate a given healthcare facility's observed number of CAUTIs to the number of CAUTIS expected as derived from a national standard contained in NHSN and accounts for length of stay, length of urinary catheterization, location, and other factors. Interfacility comparisons.Premier supports the reporting of CAUTI SIRssince they are far more accurate for interfacility comparisons. CMS IPPS eligible facility using NHSN will be adding this CMS required CAUTI as of January 2012. NQF endorsement: Premier has always requested CMS to select only NQF-endorsed measures. Although the current CAUTI definition is NQF endorsed, Premier supports NQF endorsement of the new SIR measure since it adds much value to CAUTI comparisons. Risk stratification: Premier supports the risk stratification currently used by CDC. Although the measure is based on unit experience there are methods to stratify patients by risk. No additional labor or impact on current processes: Premier supports the SIR sinceit does not add facility time or labor.SIR calculations do not add additional labor for NHSN users nor impact NHSN vendors supporting NHSN since CDC generates the SIR from the CAUTI data	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection

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Council	Submitted by Ms. Margaret Reagan	Premier recommends endorsement of PSM-002-10. Premier had earlier supported having only one procedure-specific SSI measure and supported the CDC/NHSN SSI SIR measure and support this harmonized measure. We agree with NQF introductory remarks and offer additional comment: 1)Specifications:Premier fully supports applying the measure only toorgan/space and deep incisional infections. These categories have serious consequences for patient morbidity and mortality, which is not the usual case for superficial skin infections.We expect expansion of the prototype using the 30 day post-discharge time frame will be modified for post-discharge of implant type procedures requiring a year follow-up. 2) NQF endorsement: Premier has always requested CMS use NQF endorsed measures CMS has selected and requires reporting of these same two procedures to CMS via NHSN starting January 2012. Therefore Premier supports endorsement of SSI PSM 002-10 outcome measure which focuses on twoprocedures at this time, and isreported as an SIR. 3) SIR not a burden: Premier also supports the use of the prototype SIR since it will not impose a burden on NHSN users nor impact the vendors supporting NHSN. CDC calculates SIRs before sending to CMS.	PSM-002-10: American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

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Council/ Public	**Commenter**	**Comment**	**Topic**
Council	Submitted by Dr. Thomas James, III, MD	Humana appreciates the opportunity to comment on this harmonized measure. We note that abdominal hysterectomy and colon surgeries are high volume procedures with significant variations in rates of post-operative infections. We are hopeful that this time-limited measure will produce useful information so that the concept may be enlarged to encompass the majority of surgical procedues in the future.	PSM-002-10: American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure
Public	Submitted by Mr. Jeff J. Maitland	Approve with comment. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. The QIC is concerned that this measure is moving away from what The Joint Commission is currently measuring. While the QIC understands the need for risk adjustment, it does not agree with having two separate metrics for measuring one outcome. The QIC would recommend harmonizing this measure with The Joint Commission CAUTI measure.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure

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Public	Submitted by Mr. Jeff J. Maitland	Approve with comment. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. The QIC notes that the measures should only be bundled, if: · doing so would create a more valuable measurement than reporting the measures separately, · all of the measures included in the bundle have been found to be valid, and · the individual measure rates are shown along with the overall bundle rate. The QIC would also like to note its concern with potential unintended consequences of the measure bundle. For example, a physician could meet five out six measures, 90 percent of the time, and would have a poor bundle rating. This is why the QIC recommends reporting the individual measure rates along with the bundle rate.	PSM-001-10: National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure
Council	Submitted by Dr. Thomas James, III, MD	Humana is delighted to have the opportunity to comment. We are pleased to see the expansion of the measure from ICU only to all areas within facilities where patients with central lines may be spending the night. Our on-site nurses have antecdotally noted that in many facilities that there are differences in the protocols for management of central lines with guidelines that are less strict in general med-surg floors than in many ICUs.	PSM-001-10: National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure

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Public	Submitted by Narda Clark, RN	Data collection could be burdensome and increases the need for resources for hospitals. Not only does this increase the cost of care, but increases the demands on a hospital's Infection Control Department. Increasing infection data collection causes the Infection Preventionist to spend more time collecting data and less time on needed infection control surveillance and interventions. . For that reason, I recommend limiting data collection to measures that are already mandated by most states or required by CMS. No comments for measures PSM-001-10, PSM-002-10 and PSM-007-10. For PSM-003-10 I would recommend changing the population to the same population required by CMS; Adult and pediatric ICU.	General Draft
Public	Lauren Agoratus, Family Voices NJ; Submitted by Ms. Lauren Agoratus	In general we strongly support quality improvement in preventable medical errors both in terms of financial cost as well as the human toll. Hospital acquired infections are a huge concern as are medication errors, but we agree there are other adverse events as well. We understand that other concerns include pressure sores, falls, VTE (venous thromboembolism), blood, and burns, shock, or other injury. We also understand that besides the maintenance of the 44 NQF endorsed measures, these are new "complications-related patient safety measures". We would also like to see the addition of hospital readmissions reduction.	General Draft

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Public	Lauren Agoratus, Family Voices-NJ; Submitted by Ms. Lauren Agoratus	Thank you for the opportunity to comment on the proposed National Quality Forum (NQF) Patient Safety Measures: Complications Endorsement Maintenance Standards. Family Voices is a national network that advocates to "keep families at the center of children's health care," with a special focus on behalf of children with special healthcare needs and their families. Our NJ State Affiliate Organization is housed at the Statewide Parent Advocacy Network (SPAN), NJ's federally funded Parent Training and Information Center which is also NJ's Family-to-Family Health Information Center and a chapter of the Federation of Families for Children's Mental Health. The Family Voices Coordinator also serves as the NJ Caregiver Community Action Network representative for National Family Caregivers Association in a volunteer capacity.	General Draft
Public	Submitted by Mr. Mike Whitehair	Data collection could be burdensome and increases the need for resources for hospitals. Not only does this increase the cost of care, but increases the demands on a hospital's Infection Control Department. Increasing infection data collection causes the Infection Preventionist to spend more time collecting data and less time on needed infection control surveillance and interventions. . For that reason, I recommend limiting data collection to measures that are already mandated by most states or required by CMS.	General Draft

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Council	Submitted by Dr. Michael P. Phelan, MD, FACEP	On behalf of Cleveland Clinic PSM-003-10 NHSN CAUTI measure CDC: The CAUTI measure is also targeted to include hospital rates.This will require more time-intensive surveillance nationally and will impact larger facilities which have targeted CAUTI surveillance in the ICUs. (Our community hospitals collect CAUTI surveillance hospital-wide due to lower patient volumes.) Automated surveillance systems can assist with screening results before the ICP assigns the infection. In addition, nursing documentation is needed to facilitate collection of device information.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure

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Council	Submitted by Dr. Michael P. Phelan, MD, FACEP	On behalf of Cleveland Clinic The harmonization effort is a lofty goal that remains difficult and was not accomplished by the NQF team. The recommendation to consider either NSHN or NSQIP creates a quandary for hospitals that include both metrics, but the opportunity to consider either for NHSN entry should be discussed more fully because it may allow an either/or option to assess trends. The proposed colorectal procedures are high volume at most large teaching facilities. Many organizations collect SSI data on other high volume, high risk and problem-prone procedures including Cardiac, Orthopedics, Neurosurgery and Spine. The reports suggest that SSI surveillance will expand to include other procedures which leans towards total SSI surveillance which is burdensome and resource heavy. It is difficult to staff ICPs appropriately to conduct total SSI surveillance, and the time spent on total surveillance can preclude sufficient ICP time to feed back data on infection trends and educate HCWs to promote infection prevention. As surveillance increases to include other high risk incidents, more novel approaches to surveillance must be explored. An example includes targeted periods of specific surveillance rather than 12 month surveillance for each category. In addition, automated surveillance as well as increased ICP staffing must be considered to manage increasing burdensome surveillance.	PSM-002-10: American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

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Council	Submitted by Dr. Michael P. Phelan, MD, FACEP	On behalf of Cleveland Clinic PSM-001-10 NHSN CLABSI outcome measurement CDC: The changes include expanding CLABSI surveillance to include non-ICUs as well as ICUs. On one hand, this proposed change seems appropriate considering the risk of CLABSI is high in the non-ICU in larger facilities such as the Cleveland Clinic, and our surveillance program has been expanded to include total house CLABSI. On the other hand, in its current iteration NHSN has no built-in adjustment for varying patient populations who have an inherent risk for bloodstream infection. In these circumstances surveillance definitions attributing an infection to a catheter is a poor approximation of clinical reality. This is another example of using surveillance methodology which errs on the side of being overly sensitive to act as a proxy for quality of care delivered and outcomes. A truer metric would be total hospital acquired bloodstream infection.	PSM-001-10: National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure

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Council	Denise Graham, Association for Professionals in Infection Control and Epidemiology; Submitted by Ms. Denise Graham	PSM-007-10: Risk Adjusted Urinary Tract Infection Outcome Measure (ACS) Risk Adjusted Urinary Tract Infection Outcome Measure After Surgery APIC does not support endorsement of this measure.APIC comments submitted in 2010 also reflected non-support of this measure. APIC believes that catheter associated UTIs should be aligned with the NHSN definition and be identified if they occur less than 48 hours after removal. Counting all UTIs up to 30 days post-surgery will not generate as meaningful data because of the many variables that are involved with development of a UTI. For example, providers are using SCIP measure # 9 and removing catheters within 24-48 hrs after surgery. Do UTIs that develop weeks 2-4 after the procedure represent a feasible opportunity for prevention given the catheter has been removed many days prior?	Not Recommended

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Council	Denise Graham, Association for Professionals in Infection Control and Epidemiology; Submitted by Ms. Denise Graham	APIC supports endorsement of this measure.APIC supported this measure in 2010 for populations cared for in ICUs. Therefore for SCAs and other inpatient locations the NHSN SIR should be the methodology used. APIC believes that this measure is appropriate but as highlighted previously, its expansion to SCAs and other inpatient locations would entail resources and a scope that is not currently included in many facility-specific Infection Prevention & Control Plans. We therefore encourage a scalable, flexible approach for providers who choose to use this measure. There is also evidence that a focus on processes involving use of indwelling urinary catheters such attention to prudent catheter stewardship, automated stop orders or reminders, etc., may significantly improve patient safety more than dedicating resources to identifying CAUTIs in all locations in a particular facility (see: Meddings J, et al Clin Infect Dis. 2010 Sep 1;51(5):550-60).	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure

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Council	Denise Graham, Association for Professionals in Infection Control and Epidemiology; Submitted by Ms. Denise Graham	APIC supports NQF endorsement of this measure.APIC previously supported one procedure-specific SSI measure. Our members have been aligned with the use of the NHSN SSI SIR measure. We appreciate the collaboration between CDC and American College of Surgeons (ACS) to harmonize this measure. It specifies a 30 day post-operative period of surveillance for SSIs, and CMS has already adopted this measure for colon and abdominal hysterectomy procedure groups for inclusion in the Hospital Inpatient Quality Reporting Program for Medicare and Medicaid reimbursement. The measure excludes secondary or harvest site infections; which are already excluded in the SIR. The harmonized measure between CDC & ACS also excludes extension of surveillance for SSI for up to one year after the date of the initial procedure when non-human implants are used. It also excludes superficial incisional SSI; with the rationale being there is much greater morbidity, and possibly mortality with deep or organ/space SSIs. APIC anticipates this measure will expand the scope of surveillance for procedures involving implants and that additional NHSN procedure group categories will likely be added. As indicated above, however, such expansion will involve the need for additional infrastructure, training and resources at the provider level. We encourage awareness and sensitivity to this by NQF and those third parties that use NQF endorsed measures.	PSM-002-10: American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

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Council	Denise Graham, Association for Professionals in Infection Contro and Epidemiology; Submitted by Ms. Denise Graham	APIC endorsed the CLABSI SIR measure in 2010. Consistent with the expanding scope of locations captured by this NHSN measure, we believe there is growing evidence of the need to address prevention of CLABSIs beyond ICU locations. We ask that NQF verify the following statement in the source document (of 8/26/11; page 10, lines 182-3) which reads: "…The measure uses a standardized infection ratio (SIR) to compare a given healthcare facility's observed CLABSI rate to that facility's expected CLABSI rate…" We understand the SIR as a ratio of the observed number of CLABSIs collected via surveillance performed by the infection preventionist for a facility or location over the number predicted from a national standard – rather than a ratio of CLABSI rates. The predicted number is derived from analysis built into NHSN that multiplies the number of central line days for a facility or location by the appropriate standard rate in NHSN system for that facility/location. It is important that NQF be aware that while many facilities are beginning to report CLABSIs for SCAs and other inpatient locations to NHSN - many are not, such as freestanding behavioral health or rehab or have not enrolled in NHSN. Enrollment in, and use of, NHSN needs to allow sufficient time for planning, data entry and collation to permit this system to assess performance and allow feedback to clinicians and others.	PSM-001-10: National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure

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Council	Submitted by Dr. Beth Kosiak, PhD	The American Urological Assocation supports the exclusion of patients who undergo urinary tract surgery because indwelling catheterization is frequently a requirement of postoperative management.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure
Public	Christy Bonstelle, Children's Hospital Boston; Submitted by Ms. Christy Bonstelle	Children's Hospital Boston has specific concerns with revisions applying "PSM-003-010: National Healthcare Safety Network (NHSN) Cather-associated urinary tract Infection (CAUTI) outcome measure (CDC)" to pediatric populations. While the CAUTI measure is excluded from neonatal intensive care units, revisions as described in the draft consensus report would apply the measure to all other inpatient pediatric areas. This change of the measure is proposed despite the fact that there are no published studies addressing evidence-based measures to prevent CAUTI in children. Additionally, many of the components of the bundles of care available to prevent CAUTI in adults, such as the use of condom catheters, are not applicable to children. For children who require ongoing urinary catheterization, it is not known if any specific interventions can decrease the rate of CAUTI in children. In fact, the Joint Commission explicitly excluded children from their 2012 National Patient Safety Goal focused on CAUTI because "Research resulting in evidence-based practices was conducted with adults, and there is not consensus that these practices apply to children."	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure

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Council	Submitted by David Birnbaum, PhD, MPH	We agree that it is important and valuable to monitor the types of healthcare-associated infections described, but disagree with proposed use of SIR as the appropriate metric. The Standardized Infection Ratio (SIR) that is proposed for CLABSI and CAUTI is based on an entirely different mathematical approach from the SIR proposed for SSI risk adjustment. Our publication in a peer-review journal examines the weighted average SIR approach that has been widely promoted for CLABSI and CAUTI: Birnbaum D, Zarate R, Marfin T. SIR, you've led me astray! INFECT CONTROL HOSP EPIDEMIOL 2011;32(3):276-282. As our title implies, when compared to other standard epidemiologic metrics, the unpredictable shifting-base bias inherent in the SIR calculation led to serious misclassifications and erroneous conclusions about hospital performance. Risk stratification of rates is more informative and more accurate than risk adjustment using SIR. We respectfully disagree with claims in the report that SIR "creates significant added value" and meets "scientific acceptability". The logistic regression SIR approach being promoted for SSI may or may not also suffer the same inherent distorting mathematical flaw when used for multiple comparisons. A study similar to the one we conducted with CLABSI data should be required before SIR for SSI is given approval as a national standard.	General Draft

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Public	Submitted by Alan Levitt	On page 7-8 on the CDC CAUTI Module, an arrow is missing between the "positive urinalysis" box and the SUTI-Criterion 2a group on the right.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure
Council	Jan A Orton Intermountain Healthcare	1. While we understand that NQF has deadlines imposed by CMS, NAHQ believes that NQF should have a policy that ALWAYS allows for a 30 day commenting period by the members. Large, multi-stake organizations need that time to coordinate the efforts and thoughtfully review the large documents produced by NQF to provide appropriate feedback.	General Draft
Council	Jan A Orton Intermountain Healthcare	2. NAHQ would encourage CDC NHSN and ACS to evaluate and review the different types of surveillance methods to determine if this affects the SIRs outcome (risk method). An example might be: one hospital may query every surgeon at 6 weeks about infection noted in the physician office where another only identifies infections if patients are readmitted or a physician notifies.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure

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Council	Melanie Young Society for Healthcare Epidemiology of America	SHEA recommends endorsement of PSM-001-10 and supports replacing NQF-endorsed measure #0139: Central line-associated blood stream infections rate for ICU and high-risk nursery (HRN) patients with PSM-001-10. A given facility's observed number of CLABSIs is compared to the number expected for that facility from CDC/NHSN's comparable national incidence density. The SIR accounts for length of stay, duration of use of central lines, location, and others. We agree with description from NQF, and provide comment: 1) Interfacility comparison: SHEA supports the reporting of CLABSI SIRs since they are more accurate and readily available using analysis that the developer, CDC, has built into its modules for facility-specific comparison to a national, standardized frequency measure.2) NQF endorsement: SHEA has always requested CMS to select only NQF-endorsed measures. SHEA supports NQF endorsement of the SIR measure since it adds much value to CLABSI comparisons.3) Risk stratification: SHEA supports the risk stratification currently used by CDC. Although the measure is based on unit experience there are methods to stratify patients by risk.4) No additional labor or impact on current processes - SHEA supports the SIR measure since it does not add facility time or labor. CDC calculates the SIR before sending to CMS and does not add additional labor or resources for NHSN users nor impact NHSN vendors supporting NHSN.	PSM-001-10: National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure

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Council	Melanie Young Society for Healthcare Epidemiology of America	SHEA recommends endorsement of PSM-003-10 and supports replacing NQF-endorsed measure #0138 Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients with PSM-003-10. This measure utilizes a SIR to calculate a given healthcare facility's observed number of CAUTIs to the number of CAUTIS expected as derived from a national standard contained in NHSN and accounts for length of stay, length of urinary catheterization, location, and other factors. 1) Interfacility comparisons. SHEA supports the reporting of CAUTI SIRs since they are far more accurate for interfacility comparisons. CMS IPPS eligible facility using NHSN will be adding this CMS required CAUTI as of January 2012. 2) NQF endorsement: SHEA has always requested CMS to select only NQF-endorsed measures. Although the current CAUTI definition is NQF endorsed, SHEA supports NQF endorsement of the new SIR measure since it adds much value to CAUTI comparisons. 3) Risk stratification: SHEA supports the risk stratification currently used by CDC. Although the measure is based on unit experience there are methods to stratify patients by risk. 4) No additional labor or impact on current processes: SHEA supports the SIR since it does not add facility time or labor. SIR calculations do not add additional labor for NHSN users nor impact NHSN vendors supporting NHSN since CDC generates the SIR from the CAUTI data before transmitting to CMS.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure

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Council	Melanie Young Society for Healthcare Epidemiology of America	SHEA recommends endorsement of PSM-002-10. SHEA had earlier supported having only one procedure-specific SSI measure and supported the CDC/NHSN SSI SIR measure and support this harmonized measure. We agree with NQF introductory remarks and offer additional comment: 1) Specifications: SHEA fully supports applying the measure only to organ/space and deep incisional infections. These categories have serious consequences for patient morbidity and mortality, which is not the usual case for superficial skin infections. We expect expansion of the prototype using the 30 day post-discharge time frame will be modified for post-discharge of implant type procedures requiring a year follow-up. 2) NQF endorsement: SHEA has always requested CMS use NQF endorsed measures CMS has selected and requires reporting of these same two procedures to CMS via NHSN starting January 2012. Therefore SHEA supports endorsement of SSI PSM 002-10 outcome measure which focuses on two procedures at this time, and is reported as an SIR. 3) SIR not a burden: SHEA also supports the use of the prototype SIR since it will not impose a burden on NHSN users nor impact the vendors supporting NHSN. CDC calculates SIRs before sending to CMS.	PSM-002-10: ACS-CDC Harmonized Procedure Specific SSI Outcome measure

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Council	Melanie Young Society for Healthcare Epidemiology of America	SHEA does not support PSM-007 This is a risk-adjusted, case-mix adjusted urinary tract infection outcome measure of adults 18+ years after surgical procedures. This measure is currently used in the ACS NSQIP surveillance system. The developer (ACS) reiterated that the measure assesses UTIs within 30 days of surgical procedure but is not necessarily catheter-associated. Non-Device-related Although no changes are offered, SHEA does not support endorsing this measure. It is interesting that the justification for this measure reference catheter-associated UTIs. We believe this measure is unnecessary given the CDC/NHSN CAUTI measure as the current NQF-endorsed SCIP measure, requiring removal of the urinary catheter in surgical patients one or two days post-op and removes a primary risk factor for CAUTI – the indwelling urinary catheter. We're not sure of the proportion of UTIs identified under this outcome measure that are attributable to the catheter. There is also uncertainty as to the preventability of these UTIs in absence of an indwelling device. We note the barriers to this measures raised by NQF TAP and Committee as well. We have concerns for its adoption by other 3rd party payors who may not appreciate its inability to develop strategies for prevention. Finally since it is not associated with catheter devices it simply adds a collection burden without much practical value.	General Draft

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Public	Bruce Gans American Medical Rehabilitation Providers Association (AMRPA)	In the discussion of this measure NQF acknowledges the decision of the measure developer to extend the measure's scope of coverage beyond intensive care units (ICUs) and acute care hospitals to other healthcare settings, including IRH/Us. We appreciate the decision of the measure developer and NQF of the important role of IRH/Us in improving patient care. In addition, in consideration of this measure, NQF recommended	PSM-001-10: National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure

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Public	Bruce Gans American Medical Rehabiliotation Providers Association (AMRPA)	In the discussion of this measure it is unclear how the data for this measure would be collected and the method by which attribution for the SSI would be applied. For example, will the entity that performed the surgical procedure be responsible for reporting the SSI or will any entity, including subsequent providers such as IRH/Us, be required to report its presence? When a SSI is reported, who will bear the responsibility (e.g. accept any negative financial implications or reduced quality score) for the SSI; the entity that reported it or the entity that performed the surgical procedure? This is of critical importance because it is rare that a surgical procedure is performed in an IRH/U. However, it is likely that a post-operative patient admitted to an IRH/U from another setting could develop an SSI that should be reported and attributed to the setting where the surgery was performed. To require the IRH/U to accept responsibility for the occurrence of a surgical site infection not performed within the IRH/U would be inappropriate. We request that NQF clarify these issues in a way that protects IRH/Us from bearing unwarranted responsibility for others' actions before recommending this measure as a voluntary consensus standard.	PSM-002-10: American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

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Public	Bruce Gans American Medical Rehabiliotation Providers Association (AMRPA)	As with the CLASBI measure addressed above, it appears that the measure developer has elected to expand the use of this measure to post-acute care settings such as IRH/Us. We appreciate the recognition of IRH/Us as a partner in the prevention of CAUTI. Additionally, we note that this measure has already been adopted by CMS for use in IRH/Us for quality reporting purposes. However, AMRPA has several concerns about this measure. First, we support the interpretation that the measure would not include patients with CAUTIs that were present on admission. If these patients were to be included in the count for IRH/Us, the measure would be unfair because it would mislead observers trying to assess an IRH/U's quality by saddling the site with a demerit it did not deserve. CAUTI present on admission reflects the quality of care of the prior setting, usually an acute care hospital.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure

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Council	Aparna Higgins America's Health Insurance Plans	We support the expansion of the CLABSI measure beyond the ICU into non-ICU care locations. Such an expansion provides the opportunity to track a significant volume of HAIs that may occur outside the ICU. The measure should consider exclusions of patients with compromised immune systems, such as active chemotherapy patients and patients with severe third degree burns. The CDC measures calculate a standardized infection rations (SIR) to assess facilities observed infection rate compared to an expected rate. NQF should explore ways to ensure that these measures are understandable to consumers.	PSM-001-10: National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure
Council	Aparna Higgins America's Health Insurance Plans	We support the harmonization of the CDC and American College of Surgeons (ACS) SSI measures. This measure could also be improved by broadening the denominator to include additional surgical procedures, such as those that are high volume and for patients who are at high risk of developing an SSI (e.g., caesarean section) as well as procedures performed in the out-patient setting.	PSM-002-10: American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure
Council	Aparna Higgins America's Health Insurance Plans	We support the expansion of this measure beyond ICU into non-ICU care locations. We also encourage NQF to braoden the measure's applicability to out-patient populations as well.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure

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Public	Carrie Kakehashi California Pacific Medical Center	Wholehouse FCUTI is too burdensome with no practical value.	PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure
Council	Rabia Khan Centers for Medicare & Medicaid Services	CMS strongly supports the CDC's achievement in expanding the scope of measures PSM 001 and 003 beyond ICUs and acute care hospitals to non-ICU locations, acute care general hospitals, free standing long-term care hospitals, and rehabilitation hospitals and behavioral health hospitals where patients reside overnight.	General Draft
Council	Rabia Khan Centers for Medicare & Medicaid Services	CMS supports the harmonization of the ACS and CDC SSI Outcome measures, however the language in the Draft Report is not clear regarding measure use. Line 300 refers to "time-limited use" of the harmonized measure, but it should be clarified to state that the currently intended use of the measure will be expanded upon, following implementation.	PSM-002-10: American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure