



CONFERENCE CALL FOR THE STEERING COMMITTEE OF THE NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR PATIENT SAFETY MEASURES

August 15, 2011

Committee Members Present: William A. Conway, MD (co-chair); Lisa J. Thiemann, CRNA, MNA (co-chair); Jan Allison, RN; Donald Kennerly, MD, PhD; Clifton Knight, MD; Stephen Lawless, MD, MBA; David Nau, PhD, RPh, CPHQ; Paul Sierzenski, MD; Iona Thraen, MSW; David E. Turner, MD, PhD, MPH

NQF Staff Present: Helen Burstin, MD, MPH; Heidi Bossley, MSN, MBA; Karen Pace, PhD, RN; Melinda Murphy, RN, MS, NE-BC; Andrew Lyzenga, MPP; Elisa Munthali, MPH; Jessica Weber, MPH

Others Present: John Bingham; Sophia Chan; Jennifer Chemi; Leslie Conwell; Sarah Croake; Maureen Dailey; Roxanne Dupert-Frank; Tom Granatir; Bruce Hall; Daniel Pollock

WELCOME AND INTRODUCTIONS

Ms. Thiemann and Dr. Conway welcomed the Steering Committee and thanked them for their continued participation. The purpose of this conference call was to review three-revised 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*
- *PSM-001-10: National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure*
- *PSM-003-10: National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure*

PROJECT UPDATE

Mr. Lyzenga reviewed the revised project timeline. He noted that the phase I draft report would have a supplemental comment period from August 24, 2011 through September 7, 2011 to allow NQF members and the public an opportunity to provide feedback on the three-revised measures. A Steering Committee conference call will be held in mid-September to review any comments received. Member voting on the report is scheduled to take place from October 7, 2011 through October 21, 2011. This will be followed by the Consensus Standards Approval Committee (CSAC) review in November 2011 and the NQF Board review in December 2011.

The phase II draft report underwent CSAC review. Measure *PSM-044-10: Radiation Dose of Computed Tomography* was ratified by the NQF Board and has been posted to the NQF website for a 30-day appeals period. Measure *PSM-043-10: Participation in a Systemic National Dose*



Index Registry has been held for further discussion at an upcoming NQF Board meeting in September.

INTRODUCTION TO PSM-002-10: AMERICAN COLLEGE OF SURGEONS – CENTERS FOR DISEASE CONTROL AND PREVENTION (ACS-CDC) HARMONIZED PROCEDURE SPECIFIC SURGICAL SITE INFECTION (SSI) OUTCOME MEASURE

The measure developers from the CDC and ACS provided an update on the main elements of the harmonized SSI measure. They explained that the measure focuses on two procedures: colon surgeries and abdominal hysterectomies. It is specified using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) procedure codes for CDC's National Healthcare Safety Network (NHSN) operative procedure categories, with additional current procedural terminology (CPT) mappings to those categories. The measure will use separate standardized infection ratios (SIRs) for the two operative procedure categories. For hospitals performing more than 42 colon surgeries per year, SIRs will be calculated using a sample based on the first colon surgery per eight-day cycle. For hospitals performing over 200 abdominal hysterectomies per year, SIRs will be calculated using a sample of the first five abdominal hysterectomies per eight-day cycle. Data collected and reported to the ACS National Surgical Quality Improvement Program (NSQIP) would be available for data transfer to NHSN. ACS-NSQIP uses a sampling procedure for hospitals that exceed a certain volume of procedures. While the NHSN has not historically used a sampling model, it is committed to moving towards one in the future. Follow-up will occur within 30 days using admission, readmission, and post-discharge surveillance. The measure will include inpatients over 18 with deep incisional and organ/space SSIs. Risk adjustment will be based on age and the American Society of Anesthesiology (ASA) Physical Status Classification system. The developers described this measure as the first in a larger set of measures focused on surgical procedure categories with additional risk factors incorporated.

REVIEW OF MEASURE PSM-002-10

One Steering Committee member questioned whether it would be difficult for hospitals not previously involved in NSQIP to adapt to an eight-day sampling cycle. The developer clarified that the measure will initially calculate the SIR based on a sample of retrospective data. The Steering Committee then discussed how the 30-day follow-up will be conducted. The developer clarified that, after discharge, patients may be contacted by phone or letter, or follow-up could be conducted by the physician responsible for the patient's care.

The Steering Committee requested additional information on the plan for public reporting. The developer explained that the Centers for Medicare & Medicaid Services (CMS) inpatient prospective reporting system (IPPS) requirements released on August 1, 2011 call for abdominal hysterectomies and colon surgeries to be reported by the CDC to CMS. Therefore, the NHSN will serve as the single reporting system for CMS-required reporting. However, facilities may choose which calculations of performance on the measure can be accomplished using either the NHSN or NSQIP data system. The measure developer acknowledged that for hospitals participating in both systems, there could be duplication.



The Steering Committee questioned why both organ space and deep incisional infections were included in the measure. The measure developer described the approach as a long standing precedent and stated that superficial infections are considered trivial events and therefore not included. However, organ space infections that drain through the incisions are classified as deep incisional infections. The combination of organ space and deep incisional infections are considered a clinically coherent grouping.

Finally, a Steering Committee member requested clarification on the NSQIP policy on the use of performance data. The developer noted that hospitals that participate in NSQIP have an agreement that they cannot use this information to the detriment of any other participating hospital. They are allowed to use it for public relations, contract negotiations, and other quality improvement activities. This remains at the discretion of the institution.

INTRODUCTION TO PSM-001-10: NATIONAL HEALTHCARE SAFETY NETWORK (NHSN) CENTRAL LINE- ASSOCIATED BLOOD STREAM ASSOCIATED INFECTION (CLABSI) OUTCOME MEASURE AND PSM-003-10 NATIONAL HEALTHCARE SAFETY NETWORK (NHSN) CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI) OUTCOME MEASURE

The measure developer introduced the changes to these measures, which extended the scope of coverage for both measures beyond intensive care units (ICUs) and acute care hospitals. Each measure now includes non-ICU locations, acute care general hospitals, free standing long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals where patients reside overnight. CMS has requested measures in these domains for IPPS reporting requirements. The measure developer also noted that the measures are currently in use in non-ICU locations, acute care hospitals and inpatient and long term care facilities.

REVIEW OF MEASURE PSM-001-10

The Steering Committee questioned whether the measure took into account the duration of catheter use. The measure developer stated that while measuring the patient length of stay would be useful individual patient level data, currently there is not compelling evidence that the collection of these data would be worth the additional burden. Along these lines, the Steering Committee also noted that while catheter usage may decrease, if the number of infections does not reduce proportionally, the result may be a higher rate. The developer responded that in the future a companion measure could be developed to measure the rates of device utilization.

The Steering Committee suggested that it may be valuable to collect information based on the categorization of long-term and short-term catheter use to capture these differences. The developer explained that they currently stratify the data by areas where permanent catheters are found, such as bone marrow transplants and dialysis locations. They defined a permanent catheter as a “tunneled central line” and a short-term catheter as “non-tunneled.” They noted that it would be difficult to further stratify catheter use without counting the days.

Finally, one Steering Committee member questioned the degree to which electronic health records (EHRs) will be used to collect the data for the measure. The developer highlighted the



importance of EHRs and explained that they are encouraging their use wherever possible. They noted that the CDC is working with a variety of partner organizations such as IT vendors, standards development organizations, and leading developers in the area of decision support to provide implementation guidance to capture data. Currently, facilities must validate any electronic methods used to capture summary data by concurrently validating that electronic and manual data do not have a difference of greater than five percent.

REVIEW OF MEASURE PSM-003-10

One Steering Committee member questioned whether specialty care areas included swing beds, since rural hospitals may not have an ICU but may have in CAUTIs. As a result, this measure could have implications for skilled nursing facilities. The developer responded that swing beds are referred to as mixed acuity areas in NHSN. They are classified as outside both the critical care and specialty care designation. The developer noted they have been building a long term care component in NHSN, beginning with reporting on urinary tract infections (UTIs) and CAUTIs. The approximate timeframe for release is within one year.

The Steering Committee questioned whether the developer had considered including delirium as an early warning sign of UTIs in the elderly population. The developer noted that it had been considered but was not included due to lack of specificity and evidence to support inclusion.

A Steering Committee member asked if the CDC and Medicare both defined CAUTIs as “never events.” The developer clarified that the CDC and Medicare monitor CAUTIs using different types of data.

The Steering Committee requested clarification on how infections are attributed in transfer patients. The developer explained that infections that occur in transfer patients within the first 48 hours after their transfer are attributed to the previous facility.

Finally, the CDC revisited the issue of catheter days resulting in potentially higher infection rates. The CDC stated they are in the process of writing a memo to CMS regarding this issue that will provide interim ways to present data on CAUTIs and device utilization; they are also proposing studies to further examine the issue.

MEMBER AND PUBLIC COMMENT

There were no comments.

NEXT STEPS

Mr. Lyzenga invited Steering Committee members with any additional questions or comments to contact NQF staff. He noted that the Steering Committee’s endorsement recommendations on the three revised measures would take place formally through an online survey. The survey will be forwarded to Committee members within the next few days.