# NATIONAL QUALITY FORUM

**TO:** Patient Safety Complications Steering Committee

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**SU:** Patient Safety Complications Steering Committee —Post-Comment Call to Discuss Public and Member Comments for Phase II Measures

**DA:** September 12, 2012

The Patient Safety Complications Steering Committee will meet via conference call on Monday, September 17. The purpose of this call is to:

- Review and discuss comments received during the public and member comment period.
- Provide input on responses to comments.
- Determine whether reconsideration of any measures or other courses of action is warranted.

Please let us know if you have any questions.

**Steering Committee Action:**

1. Review this briefing memo
2. Review the comments received and the proposed responses (see Excel and PDF files included with the call materials).
3. Be prepared to provide feedback and input on proposed comment responses.

NQF received a total of 36 comments on the draft report from public and NQF members. In order to facilitate discussion, some of the comments have been categorized into major themes, although comments outside of the major thematic categories also were received and may require discussion by the Committee. Where possible, NQF staff has proposed draft responses for the Committee to consider. Although all comments and proposed responses are subject to discussion, we will not necessarily address each comment and response on the post-comment call. Instead, we will spend the majority of the time considering the major themes and/or those measures with the most significant issues that arose from the comments.

We have included all of the comments that we received in the Excel spreadsheet that is included with the call materials. This comment table contains the commenter's name, as well as the comment, associated measure, theme (if applicable), and draft responses for the Committee's consideration. In some cases, specific questions are addressed to the Committee (these appear in red font in the draft response column).

**MAJOR THEMES**

Three major themes were identified in the comments, as follows:

1. Request for reconsideration of measures not recommended:
   *#0504: Pediatric weight documented in kilograms*
2. Need for measures that are meaningful to consumers
3. Additional areas for measure development
4. Suggested revisions of measure specifications

***Theme 1: Request for reconsideration of measures not recommended: #0504: Pediatric weight documented in kilograms***

*Description:* A comment by the Emergency Nurses Association (ENA) suggests that this measure should be reconsidered because of the importance of reducing medication errors in children due to incorrect weight. It cites additional evidence and notes that the use of EHRs may not eliminate errors, which further indicates the need for a quality measure.

> ***Proposed Committee Response:*** *TBD, based on discussion – does the Committee want to reconsider its initial vote on measure 0504?*

***Theme 2: Need for measures that are meaningful to consumers***

*Description*: We received five comments suggesting that certain measures would be more meaningful to consumers if their approaches to public reporting were altered. The comments are listed below, along with the developers' responses, if provided. Developer responses are also listed in the comment spreadsheet.

- ***0141: Patient Fall Rate***

The measure is reported as a rate based on patient day and not by patient admission. Consumers may find it easier to interpret the measure if it reflects how long they will stay in the hospital.

> **Developer Response (ANA):** Thank you for your comments. Instead of calculating rates per patient admission, NDNQI uses patient days as the denominator because a patient's fall risk is roughly proportional to the length of stay in the hospital—e.g., a patient staying 30 days would be much more likely to fall than a patient staying 1 day, all else being equal. Similarly, a unit with 30 admissions and 300 patient days in a month would be expected to have a higher fall rate than a unit with 30 admissions and 30 patient days. By dividing by patient days, we can meaningfully compare units with different patient volumes.

***Proposed Committee Response:*** *The Committee was satisfied with the developer's response, and reaffirms its recommendation for endorsement of measure 0141 as written.*

- ***0347: Death Rate in Low-Mortality Diagnosis Related Groups (PSI 2)***

The measure's hierarchical risk adjustment may remove important variation from the results and may complicate consumer's ability to distinguish between providers.

**Developer Response (AHRQ):** The table below (Table 1) provides information on the ability of measure #0347 to reliably discriminate based on provider performance:

**Table 1: Discrimination in Provider Performance, 2008**

| | | | | 95% Probability Interval | |
|---|---|---|---|---|---|
| Year | Number of Hospitals | Number of Patients | Reference Population Rate (per 1,000) | Better | Worse |
| 2008 | 4,239 | 7,130,445 | 0.30060 | 4.4% | 7.3% |

Source: HCUP State Inpatient Databases (SID). Healthcare Cost and Utilization Project (HCUP). 2008. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/sidoverview.jsp.

***Proposed Committee Response:*** *TBD, based on discussion – do Committee members believe this measure's risk-adjustment method allows for adequate variability in performance?*

- ***0538: Pressure Ulcer Prevention and Care***

It may be difficult for consumers to evaluate home health provider's prevention and care of pressure ulcers from this measure – the measure should incorporate outcomes and should score providers on an "all-or-none" basis.

**Developer Response (CMS):** CMS does not publicly report an outcome measure of how often patients develop new pressure ulcers because less than one half of one percent of home health patients experience this outcome. We will continue to refine these three process measures and evaluate the concordance between risk, inclusion on the plan of care and implementation for the next cycle.

***Proposed Committee Response:*** *The Committee was satisfied with the developer's response, and reaffirms its recommendation of measure 0538 as specified.*

- ***1716: National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure***
  ***1717: National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure***

Standardized infection rates are not as meaningful to consumers as the actual risk-adjusted rates of infection per admission.

**Developer Response (CDC):** We appreciate the commenter's feedback. The standardized infection ratio (SIR) offers clear advantages to healthcare consumers over infection rates as the summary metric for this measure. The SIR produces a single risk-adjusted metric that can be further aggregated to the state, regional, or national level, all while maintaining appropriate comparisons between healthcare facilities. Further, observed-to-predicted ratios, such as the SIR, are widely used in public reporting of healthcare quality data. CDC, the Centers for Medicare and Medicaid Services, health departments in many states, and Consumers Union all use the SIR to report HAI data.

***Proposed Committee Response****: All measures recommended by the Committee met the NQF criteria for usability and were recommended for endorsement based on the how they are currently specified. The Committee recognizes the importance of usefulness to consumers and suggests that the developers consider these approaches to reporting in the future.*

***Theme 3: Additional areas for measure development***
*Description*: We received 11 comments noting that measures recommended for endorsement should include additional settings and proposing four areas of future measure development.

***Measurement Gaps Identified:***

- Outcome measures that examine social factors in the prevention and treatment of falls, focusing on community level measurement.
- Measures that address falls across the care continuum. These metrics should include patient assessment, plan of care, intervention, and outcomes, and should address care across various settings, such as inpatient, outpatient, ambulatory surgical centers, and home health.
- Measures that derive information from voluntary patient surveys, which capture critical quality improvement information.
- Measures that focus on complications linked to surgical site infections (including cesarean sections) and outcomes.

***Proposed Committee Response:*** *The Committee reaffirms the importance of the measures recommended for endorsement, while also supporting the suggestions for future measure development. The report will be updated to include these gaps.*

***Theme 4: Suggested revisions of measure specifications***
*Description*: The following comments addressing specifications have been forwarded to the developers for response. The developers' responses are listed in the comment spreadsheet.

- ***0035: Fall Risk Management***

The measure should involve an all-or-none principle instead of incorporating individual numerators and denominators.

**Developer Response (NCQA):** Thank you very much for your comment. We would like to clarify that the measure is not a composite measure as defined by NQF and the two rates do not use the same denominator. The first rate addresses whether health care providers discussed falls or problems with gait or balance with consumers. Many of these consumers will have no history of falls and/or balence/gait problems and therefore follow-up care is not necessary. The second rate addresses whether health care providers provided follow-up care for those individuals who had a fall or problem with gait or balance. Having the two rates separated (as opposed to an all or nothing measure) provides health plans with the adequate information to identify where a quality problem is occurring (i.e. are consumers not being asked about falls/balance and gait problems OR are consumers with identified falls/balance and gait problems not being provided appropriate follow-up care).

***Proposed Committee Response:*** *The Committee was satisfied with the developer's response, and reaffirms its recommendation of measure 0035 as specified.*

- ***0101: Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls***

The measure may not result in an improvement in patient outcomes and may become a "checkbox" measure. Patient-reported data would be a better source of performance information.

**Developer Response (NCQA):** Thank you for your comment. NCQA believes the two measures (0035 and 0101) are complementary and provide valuable information from different perspectives. Measure 0101 assesses provider report of clinical processes for all patients at risk of a future falls and is not subject to many of the limitations of the similar patient-reported measures (0035) such as recall bias, non-response bias and proxy bias. The use of these two measures together provides an important insight into where quality gaps exist.

***Proposed Committee Response:*** *The Committee agrees that patient-reported data is an important element of falls-related measurement efforts. However, provider data is also an important element, and helps to ensure a fuller picture of falls prevention activities. The Committee reaffirms its recommendation of measure 0101 for endorsement.*

- ***0202: Falls with injury***

The measure does not take into account that studies have demonstrated patients in rehabilitation settings may have higher fall rates due to cognitive impairment and lower staffing ratios. Additionally, collecting information on sub-specialty analysis for patient populations (such as stroke, brain injury, etc) may be useful.

**Developer Response (ANA):** Thank you for your comments. Using NDNQI data, we have found the inpatient rehabilitation unit (N = 514 units) injury fall rates to be: mean (SD) = 1.91 (1.36); 25th percentile = 0.00; median = 0.93; and 75th percentile = 1.69. NDNQI provides member hospitals with quarterly national comparison data by unit type and several hospital characteristics. Because we stratify our staffing data to account for various levels of patient acuity, our main stratification is by unit type (e.g., adult or pediatric critical care, step down, medical, surgical, combined medical-surgical, and adult rehabilitation in-patient). NDNQI also classifies rehabilitation units by sub-specialties, such as brain injury/SCI, Orthopedic/amputee, neuro/stroke, cardiopulmonary, and none. However, some of the subspecialties do not have enough units enrolled to provide stable national comparison data. In addition to unit type, the stratifications can be done by facility bed size, teaching status, Magnet(R) Designation, Metropolitan status, census division, state, case mix index, and hospital specialty type (e.g. pediatric, psychiatric). Further, rehabilitation units that also report nursing care hours to NDNQI would receive nursing hours per patient day and skill mix, along with comparison data. We encourage site coordinators and staff members at NDNQI hospitals to consider more than just fall rate when thinking about improvement. These factors include staffing; nursing characteristics such as education, certification, experience; rate of fall risk assessment; recency of risk assessment; whether prevention protocols are in place; and so forth.

***Proposed Committee Response:*** *TBD, based on discussion – the measure currently allows for stratification by unit type, including inpatient rehabilitation facility. Does the Committee think there is a compelling reason to measure falls in IRFs separately?*

- ***0204: Skill mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], unlicensed assistive personnel [UAP], and contract)***
- ***0205: Nursing Hours per Patient Day***

The number of specialty certified nurses can affect patient outcomes and should be addressed in the ratios. Variations in staffing mix may depend on the geographic region of the country

and in some instances specific nurse staffing mandates are stipulated. Finally, staffing ratios may differ from freestanding inpatient rehabilitation facilities and hospital-based rehabilitation units.

**Developer Response (ANA):** Thank you very much for your comment and we agree. In our recent studies, we also found that there were variations in the relationships between nurse staffing and patient outcomes by unit type, nurse specialty certification, and geographical location (Boyle et al., 2011; Choi et al., 2012). Nurse staffing levels represent the conditions in which care occurs. At this time we do not have a statistical risk model for the nurse staffing measures. However, NDNQI provides member hospitals with quarterly national comparison data by unit type and several hospital characteristics. Because we stratify our staffing data to account for various levels of patient acuity, our main stratification is by unit type (e.g., adult or pediatric critical care, step down, medical, surgical, combined medical-surgical, and adult rehabilitation in-patient). NDNQI also classifies units by sub-specialties, such as brain injury/SCI, Orthopedic/amputee, neuro/stroke, cardiopulmonary, and none. However, some of the subspecialties do not have enough units enrolled to provide stable national comparison data. In addition to unit type, the stratifications can be done by facility bed size, teaching status, Magnet(R) Designation, Metropolitan status, census division, state, case mix index, and hospital specialty type (e.g. pediatric, psychiatric). In research on the relationship between and nurse staffing and patient outcomes, all of these were typical control variables that were included in the data analysis for control variables.

***Proposed Committee Response:*** *TBD, based on Committee discussion – does the Committee think that the variables mentioned by the commenter need to be taken into account in these measures?*

- ***0266: Patient Fall***

The measure could be expanded beyond ambulatory care, to include inpatient and outpatient settings.

**Developer Response (ASC Quality Collaboration):** We thank the commenter for their support of capturing patient falls. The mission of the ASC Quality Collaboration is to develop quality measures appropriate to the outpatient surgical setting. The NQF portfolio includes measures that examine falls in other care settings.

***Proposed Committee Response:*** *The Committee was satisfied with the developer's response, and reaffirms its recommendation of measure 0266 as specified.*

- ***0537: Multifactor Fall Risk Assessment Conducted in Patients 65 and Older***

The measure could be expanded beyond the 65 and older population, to include patients 18 and over.

> **Developer Response (CMS):** Thank you for your comment. In our initial submission, we included all adult patients to whom OASIS applied, but the previous panel did not endorse the measure for the <65 population because of concerns about the body of evidence for community dwelling adults less than 65. We and the current NQF Committee agree that this measure would be valuable for patients of all ages in home health care. We will pursue expanding the measure when it is next re-evaluated for NQF endorsement in 2015.
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> ***Proposed Committee Response:*** *The Steering Committee agrees that a measure applicable to all ages would be preferable; the Committee supports the developer's proposed effort to expand the measure before its next endorsement review.*