NATIONAL QUALITY FORUM

Moderator: Andrew Lyzenga
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Operator: Welcome to the conference. Please note today's call is being recorded. Please go ahead.

(Jesse Pines): Great. Thank you very much. I'd like to welcome everyone today to our Patient Safety Complications Work Group B conference call. Just to introduce myself, I'm (Jesse Pines). I am relatively new to NQF. I've been here for a few months as a consultant. I'm an emergency physician, and also on the faculty at George Washington University, and why don't you guys go ahead and introduce yourselves from NQF?

Andrew Lyzenga: This is Andrew Lyzenga. I'm a project manager at NQF.

Jessica Weber: And this is Jessica Weber. I'm a project analyst at NQF.

(Jesse Pines): And so why don't we go ahead and go down the list here, and we'll first start with introductions of our work group for people who have joined the call so far, and then what we'll do is we'll do brief introductions for our measure developers after that, and essentially we have three hours slotted for this, our work group call. The expectation is that this probably won't go the whole time, and I do apologize if this does really straddle lunch, and - so if there's any chewing in the background, that's fine.

So why don't we go ahead and start with our work group. Is Dr. (Aholland) on the call? Okay. Is Bobbette Bond on the call? Can you introduce yourself?

Bobbette Bond: I am. This is Bobbette.

(Jesse Pines): Okay. John Clarke?

John Clarke: I'm here.

(Jesse Pines): Vallire Hooper?

Vallire Hooper: I'm here.

(Jesse Pines): Stephen Lawless?

Dr. Stephen Lawless: I'm here.

(Jesse Pines): Lisa McGriffert? Christina Michalek?

Christina Michalek: I'm here.

(Jesse Pines): Susan Moffatt-Bruce? (Lisa Morris)? Marc Moote?

Marc Moote: Here and present.

(Jesse Pines): Great. Gina Puglise?

Gina Puglise: Here.

(Jesse Pines): Ed Septimus? Is Ed on the call? Okay. And we also have some representatives from our measure developers. Are any folks from ARC on the call currently?

John Bott: Yes, John Bott, with ARC.

(Jesse Pines): Hey, John. From the Joint Commission?

Susan Yendro: Yes, hi. This is Susan Yendro.

(Jesse Pines): Hi, Susan. From the ANA? Okay, and from the CDC?

Paul Malpiedi: Hi, this is Paul Malpiedi at CDC.

(Jesse Pines): Hey, Paul. Okay, so we have seven measures to go through. Essentially what we're going to do is ask each of the folks who were asked to present the measures and just do a brief presentation of any of the major issues with the measure, and then we can open it up for discussion. So the first measure we're going to discuss is the death rate in low mortality DRGs, which is going to be presented by Dr. Lawless.

Dr. Stephen Lawless: Hi.

John Clarke: (Jesse), before we get started, could we clarify that all of these are existing measures for continuation and maintenance?

(Jesse Pines): They all are except for two, which are the two CDC measures, the MRSA and ((inaudible)) measures. Those are newly submitted.

John Clarke: Thank you.

Janet Nagamine: And I'm sorry. This is Janet. Just to clarify, Andrew, I'm on work group A, and so I wasn't sure if you wanted the whole group on this call or whether we - I noticed the others aren't on the call. I think I misunderstood what we're doing today.

(Jesse Pines): Yes, actually we don't need you on the call. You're on the other work group.

Janet Nagamine: Okay. Well then I have three extra hours. Thank you.

(Jesse Pines): You're welcome.

Janet Nagamine: All right. Well, catch you Thursday. Bye-bye.

(Jesse Pines): Thanks. Dr. Lawless?

Dr. Stephen Lawless: Yes, anyway, the measure is 0347, which is the death rate in low mortality diagnostic reviews related groups. This measure, which was first put into place back in 2008, so again we're talking about four years, or four plus years, has been put in place sponsored by ARC. They look at essentially all MSDRGs, diagnostic related groups, with an historic mortality rate assumed to be around .5%, and so various organizations would report on how they are compared with all of these that are unified, and then essentially what their death rates, their mortality rates.

The assumption is that if you have a higher than expected, that being .5% mortality rate, there must be a problem. I think it even mentioned in the documentation that there is likely - more likely that there was an error or some kind of an issue. The measure is mapped out very, very nicely of how it's done. It's done from administrative data and they've picked out deceased. That way they

list the DRGs that are there and it's kids - people over age 18. They also put in a lot - they've put in, and I compliment this, a lot of the data.

So they've sliced and diced essentially the different areas of the data, but in essence it's come down to where the variation exists, where the spattering of variation is about half the rate of expected, up to 1 ½ times the rate of expected. So not - relatively speaking not a huge variability, if the expected is .5 and it's .25 up to around a .7 or .8 mortality or not, not a huge rate that way. So that's one of my areas of concern with the measure itself.

In terms of the other two areas of concern, as I mentioned that this is based on MFDRGs, and I'm maybe the same, but I'm more familiar with APRDRGs and severity of illness, and so whether this is all-encompassing, but every one of the DRGs now has four categories of severity of illness to it, and on top of that, since 2008, the bigger push has been toward conditions which are present on admission, versus not present on admission, and the impact of that on this and their benchmarks and how people you know, uniformly coding has not really been brought into play here.

So as a measure, it was - it's fairly straightforward. The message that we're trying to get is very clear. I think since 2008 as the bigger emphasis on different grades of APRDRGs, plus present on admission and how that impacts it may show that this - that a lot of the patients that were - could be showing that a lot of the patients who were mortalities and as low mortality APR - MSDRG may actually have been more characterized as more of a severe illness, and therefore a higher mortality risk factor than was lumped into here.

So I think it's - I was so surprised they haven't updated for myself the characteristics and the criteria of the measure itself. But with that, let me stop there and see if there's any questions.

John Clarke: This is John Clarke. I have a question. And maybe it would be better for ARC to answer. I don't know, but there seems to be some inconsistency in the DRGs they're looking for. For instance, one of them is major male pelvic procedures with complications. And I can imagine that that probably consists of radical prostatectomy, but I can think of a lot of major male pelvic procedures with complications that would be highly morbid operations, four-quarter amputation or you know, something like that.

And number two is that they have on their - the list of things that they include total mastectomy for malignancy, and yet they say that the exclusion is any code for trauma cancer or an immune-compromised case, and so that seems like there's a conflict there. So I wonder if those two issues could be addressed.

(Jesse Pines): John, do you have any response to that?

John Bott: Well, I largely join these calls quite honestly to take notes and (Sharon) will pass them along to (Patrick) and (Jeff) who are the chief people that will be responding to most of these things. They have a lot more context and history in it than myself. If you just want me to do one or two small things, it was alluded to that the measure originated in 2008. I think it was probably endorsed in 2008. I don't have that in front of me, that...

Dr. Stephen Lawless: Yes, I hear you.

John Bott: There was some comment about the measure hasn't been updated since then. Our measures are updated every year, not just with the release of additional codes, but as a result of comments from hospitals, clinicians, other users, and the measure is updated every year. Risk factors can change every year. The coefficients can change every year.

Dr. Stephen Lawless: Well, let me just - Steve Lawless - let me just clarify what I said. If you look at case mix and exchanges, this - the APRDRG and severity of illness and present on admissions come into play, but there's been a jump up of case mix index in most - in a lot of hospitals, in most hospitals, because they're now coding them as higher level severities. And so if you're coding them as higher level severities, that's what I meant by the methodology. I don't see in here, and I've searched around for it, and it really formalizes severity of illness present on admission for the new APRDRGs.

(Crosstalk)

Dr. Stephen Lawless: ...updated at your ARC meeting, but I haven't seen it reflected in that.

John Bott: Yes, I appreciate that comment, and I think (Jeff) in particular will be able to respond to that in a more robust way in the call, but the risk model is updated annually, and (Jeff) can do a much better job of going into extraordinary detail about how that's done. This is a measure that does not use APRDRGs. We - I'm not sure if we created that confusion somehow. The IQI mortality measures use APRDRGs. These do not.

Dr. Stephen Lawless: And another question - a follow-up question I'd have is so, right now, it seems like from my mind it would be more work in order to separate out the specific diagnoses and upgrading them all the time to fit this measure, versus why not just have a composite of all the APRDRGs or MSDRGs you're having, and create an - from the standpoint of your organization, is there a specific expected mortality?

John Bott: Well, this is essentially a composite of all the MSDRGs that are where death is fairly rarely occurring. We're not reporting it MSDRG by MSDRG.

Dr. Stephen Lawless: Right. But you have a 5% mortality predicted, and there someone may say well, their mortality's only 2% or their mortality's 10% and we have this - could have the same impact. And this - I'm just curious, but from a workload standpoint, ((inaudible)) it may be more work to actually do this measure than it would be to actually do the more - same methodology for all the DRGs at one time. That's just more of a comment than a...

John Bott: Okay.

Dr. Stephen Lawless: That's it.

(Jesse Pines): Hey, John; maybe that's something you can take back to (Jeff) and for the in-person meeting you can help clarify some of these issues.

John Bott: Sure, yes. That's primarily why I'm here.

(Jesse Pines): Great.

John Clarke: This is John Clarke. I didn't hear an explanation why cancer is excluded but mastectomy for cancer is included.

John Bott: Yes, I don't know. That'll be a (Patrick) question. So, sorry I can't specifically address that.

(Jesse Pines): We'll make a note of these questions and we'll send the developers a list of questions that the work group had for the in-person meeting. They can respond a little bit more fully at that time. So just if you do have questions and the developer is either not on or doesn't have a response immediately, just make - again, make a note of it and we'll make a note of it. We'll come up with a list to send to them for their response at the steering committee meeting.

Great. Is there any additional question or discussion.

Dr. Stephen Lawless: This is Steve Lawless. One more additional just question for this. As I'm looking at a lot of these alpha measures here versus some of the process measures that were there, or some of the characteristics, I just - maybe - I don't know if it was on this call or the group call. It almost looks like for the justification for a lot of the process measures they talk about more - the impact on mortality.

Well, here is the mortality. Maybe a question for NQF is some time to think about almost creating a regression equation that would say are the process measures and here is where you stand on these versus the impact of mortality and to almost see whether they actually are linked or not, so just maybe more of a question for NQF on that.

(Jesse Pines): Yes, we'll - I'll you know, I'll look into it a little bit, ask some of the folks around here.

Dr. Stephen Lawless: Okay.

(Jesse Pines): We don't actually do measure development here. You know, we have other developers to submit them to us, but that's sort of an interesting question in terms of analysis of the measures, and we'll look into that.

Dr. Stephen Lawless: Thank you.

(Jesse Pines): Any further discussion on this measure? Okay, John, do you have what you need to take back to (Patrick) and (Jeff)?

John Bott: Well, I have some notes, but it sounds like I think it was Andrew who also found some other - some additional...

(Jesse Pines): Okay, great. Okay, why don't we go ahead and then move on? The next measure we're going to be discussing is 0206, which is the practice environment scale nursing work index, which is going to be presented by Gina Puglise. Gina?

Gina Puglise: Hi, thank you. This measure is a - it's an index. It's a composite measure, and there's five subscales, and it's based on a survey of nursing practice in - of the environment, and it's completed by registered nurses. And they develop a mean score on all these different subscales, and then a composite score. And some of the nurse participation in various activities, foundations for quality, you know, leadership, staffing, resource adequacy, collegial relationships and a couple of others.

And so the numerator is you know, the - what the survey completion's done, it's been over the number of denominators is over the number of nurses. It's not paired with another measure. In terms of the impact, there's been many studies linking this nursing environment to patient outcomes. A variety of studies were reviewed, I think over 26. In the performance gap, I didn't think that the performance gap was that great, and the various studies that they showed, one the joint commission, another one by Lake, you know, the - it was a - it's a four-point scale, a Lichert scale, and the lowest of all the studies was about 2.5, but you know, a lot of the means are in the threes, so not a huge performance gap.

In terms of the evidence, there's a lot of evidence that some of these scores are linked with many different outcomes, adverse drug events, death, failure to rescue, you know, rehospitalization, turnover. I don't know if I mentioned needle stick injuries, risk of infection, low birth weight incidence. So there's been lots of research done, and on an international basis, linking the scores to various outcomes. And it's used, you know, in many countries and the actual index is translated into a number of different languages.

I had a little difficulty with this measure because I'm not exactly sure how this measure is exactly used for you know, evaluating, you know, as a public measure evaluating care. I had a little challenge with that. There are a number of studies that talk about - 17 studies I think that have assessed validity and reliability of this, and there was quite a discussion on various sampling methodologies.

And then they said the minimum sample size required was 15 per hospital, which is kind of small. But then they recommend if you're going to do - going to be doing public reporting, that you should have a minimum of 30. So if sampling is done, you'd have to at least sample at least 50 to even get the 30, assuming that you have a 60% response rate, which they suggested, you know, was kind of an average response rate.

So the question is, if it's going to be used for public reporting, is there going to be a specific sampling requirement in the measure, and that was not clear to me whether or not there was going to be a specific requirement on how many you had to sample to turn it in. And they also recommended that if it was going to be used for public reporting, that you report all needed data at an organizational level, just because of - you know, the loss of opportunities for small sample size.

So I think this - if this is going to be used, I think it has to be very clear what the expectations are, versus how the measure could be used, you know, for research purposes looking at, you know, linking it to various health outcomes.

Dr. Eileen Lake: Pardon me. This is Dr. Lake and I'm the measure developer, and I had missed the very beginning of the call, but I didn't know if you wanted me to address any of your questions as you state them, or what is your preference?

Gina Puglise: I'm asking the person that runs the call. I don't know how the - I don't know what the protocol is.

(Jesse Pines): Sure. What we've been - why don't we go ahead and let Gina get through your - her set, and then we can have the measure developer response?

Dr. Eileen Lake: Great, thanks.

Gina Puglise: I didn't see, unless I missed it, any trending data over time to look at you know, any improvements, and wondered how this measure has done. I know it's been linked to various outcomes, but I didn't see any particularly trending, you know, to see how folks have been doing, you know, over a period of time.

You know, this is used in a variety of different public and health care related usages. For example, it's part of CMS's IQR measure, the requirement for participation in systematic clinical database registry for nursing intensive care. Also the VA nurse database uses it. It's used by the ANA national database of nursing, nurse quality indicators.

I think the feasibility of it - you know, the fact that you can do it electronic or paper, you know, potentially could be problematic in terms of you know, the consistency and the feasibility of actually doing this, but I understand that that's probably necessary in some of the smaller hospitals that would be collecting this data. It's you know, so those are my comments.

Dr. Eileen Lake: Okay, let me just go through them and add anything that might be helpful. This is Dr. Lake, and I developed the measure. So about the first question that you raised, which was about the performance gap not being that great, and the median level, the middle of the whole scale, is 2.5, and what we will see in a sample of hospitals, which studies have looked at many different sizes, that there is variation within a sample, but that overall the mean is about 2.5.

So I think that you can identify a performance gap across a set of hospitals in a sample, and that's evidence that we've presented over the past ten years showing that in fact the measure does identify differences in environments so that it is sensitive to differences in environments. And then in terms of how it's used as a public measure to evaluate care, we see that there are two instances where in Colorado and also in Massachusetts it's used for public reporting.

So we have those instances, but the much greater use is through the national database of the ANA, where hundreds of hospitals each year - I think it's now at least 600 hospitals or so - survey their nurses and have their values and can look at their values over time. So the trend data which I don't think we included but we could provide and you could have it for the final meeting in a month, we can show over the years that the hospitals that have used this survey, they look very carefully at these data to decide how to improve their nurses' work environment.

And they'll even look at in a whole health system which I visited last week, they have - they find the nurse managers that get the highest survey ratings. There's one subscale that's all about nurse managers, and then they have those nurse managers as the ones who cultivate all the other nurse managers in their successful management practices. So there's a lot of performance improvement that happens within institutions.

And in terms of what's the sample size for public reporting, the tool works within one nursing unit, in which case you don't need many respondents, and it also works - a lot of the research has been done at the whole hospital level. In that case again, the sample of 50 to get you 30 is what research shows us is a sufficient number to capture the nurses' ratings of their environment.

So I kind of was jumping through different points that you raised, and I'd be happy to address any other ones.

Gina Puglise: Cool, so let me ask you. So are you recommending then for public reporting you still use the organizational level for the public reporting, but that if somebody wants to do quality improvement within their organization, they can look at the - their individual unit, and that's a different sample size?

Dr. Eileen Lake: Yes.

Gina Puglise: Okay, so that wasn't clear in the measure to me, maybe to others, but it wasn't clear to me. So I mean, if this is going to be used for public reporting, then it would have to very clearly say that, you know, this is the sample size and this is the - this is what it can be used for at an organizational level.

Dr. Eileen Lake: Okay, because I think that see, say that it should be a random sample of staff nurses in an organization for public reporting.

Gina Puglise: So the measure specifications should be very clear on that, because I mean, certainly a lot of these things can be used for internal quality improvement, unit by unit, even with small samples, you know, just to compare in your own hospital unit, one unit to another, but not for public reporting.

Dr. Eileen Lake: Okay, so...

Gina Puglise: And just, you know - and maybe I misunderstood. Can I ask one more question? In terms of how you improve in each of these different subscales, are - is there a body of literature that teaches improvement in these subscales, you know, not being really familiar with how this works? Is there a body of literature so that if you wanted to improve your scores - I mean, other than if you're a magna hospital and you know - I mean, some of those, you know, just everything kind of works together. But is there anything that helps people specifically for that?

Dr. Eileen Lake: That's a body of literature that's now developing, that's - and most of that literature is on two of the subscales. One of them is the nurse manager one that I mentioned, and the other one is nurses and physicians, collegial relationships and communication. And so those two have begun to have a literature that shows how they can be used in pre and post studies with a performance improvement that's targeted to those two issues which are, you know, central to the patient care process.

Gina Puglise: So if you were a hospital wanting to improve your score, then how would you be able to do that for the other scores? What would be your source for information to - for your quality improvement initiative?

Dr. Eileen Lake: Well, what hospitals generally do is they look at their survey responses and they identify the subscales where they want to do the improvement, and then to date much of that improvement has been more ad hoc. And so it's only recently that research studies have begun to be reported, where they say this is the program we put in place to develop the skills and abilities of our nurse managers. And we looked at the nurses' ratings before and after we implemented that specific program. And then once that research comes out, that program can be disseminated. But previously it's been more ad hoc.

Gina Puglise: Well I think that, yes, and just to the group, I think that this measure is - you know, listening to the discussions here, that this is a wonderful measure for you know, quality improvement. I'm just a little bit concerned about it being a publicly reported measure. I think that you know, overall the research that's been done, and there's a huge body of research showing that you know, if you have all these different things in place, you know, you're going to improve, you know, outcomes.

But how each individual one affects the different outcomes - you know, there's been a little bit of study on that, but not a lot, so if you're going to be publicly reporting and comparing hospitals'

performance before you know more about what specific strategy they're going to improve different scores and subscores, I'm a little bit concerned about it being a publicly reported measure. That's just my - those are just my personal thoughts.

Vallire Hooper: And this is Vallire. Just as a point of clarification, when this is a publicly reported measure, is the institution required to report their score against the national benchmark? For some reason I just - in the course of the discussion it seems that when the institution is reporting this as a publicly reported measure, that they're just reporting their outcomes, but not required to provide any comparative information, which from a public perspective I don't know that that's helpful to the public. So could you please clarify that component?

Gina Puglise: Well, this is Gina. I think that, I mean, right now it's part of the CMS IQR, so you know, it's tied to you know, reporting it at least is tied to reimbursement in the market basket. But once it gets into the NQF endorsed measures, it's open for you know, including into value-based purchasing. That's - you know, anything we endorse for NQF is - and - is - has the opportunity to be used in the future for value-based purchasing.

Vallire Hooper: Okay. Thanks, Gina, that helps.

(Jesse Pines): And also just to clarify, this is measures going up for maintenance, so it already has been approved.

Gina Puglise: Right, but it isn't in value-based purchasing yet, I don't think. I haven't read the 800 page rule. We're still - we're getting - we're about halfway through it, but does the measure developer know if it's in the proposed IPPS, or the value-based purchasing requirements for the next two years?

Susan Yendro: Yes, hi, this is Susan. It is part of the structural measure for hospitals to report that they're part - that they're participating in a structural measure, nursing sensitive care measure database. I'm not aware if it - if this measure is specifically called out in the future, but - not that I'm aware of as an individual measure in value-based purchasing.

Gina Puglise: I don't - are there - Susan, are there any individual measures that are named or that...

Susan Yendro: Not that I'm aware of out of the nursing sensitive measure set.

Gina Puglise: So it's just the group of measures.

Susan Yendro: Right, as a structural measure of participation in the database.

Vallire Hooper: I mean, this is Vallire. I mean, this is - I'm very familiar with this instrument and have a good number of colleagues that use this from a research perspective. I think some of the information on the subscales is quite helpful, but this information in isolation of actually nurse-sensitive outcomes, I'm - from a public reporting perspective, I think this is important information.

I'm not sure that particularly scores as a standalone measure - you know, I'm not sure that they tell you a lot about their sensitive outcomes. They are confounding variables that may impact for some nurse-sensitive outcomes, but as a standalone measure, I'm - yes, I'm not - I think that it's important that we perhaps harmonize some other measures with this group so that you have a more robust picture of the practice environment.

Susan Yendro: Okay. I just looked up the IPPS rule and participation in the systematic clinical database register for nurse-sensitive - let's see. All the clinical database registry for stroke care, for nurse sensitive care, and for general surgery, they're all being proposed for IPPS payment, in fiscal year of '14, '15, and '16. But again, it's a generic participation in a measure.

It's not the actual score. So you know, indirectly if you participate in this database and collect this information you would be hopefully using it to improve care. So it's not going to be a comparative measure where you're going to be compared - your score is going to be compared with somebody else, just to concern that.

Dr. Eileen Lake: This is Dr. Lake, and I wanted to address your point, Vallire, which is in a public reporting or value-based purchasing sense, if this information is presented in isolation from nurse-sensitive outcomes, would it - you know, what is its utility for public reporting, and it - I think it would probably not be reported in the absence of other nurse-sensitive measures.

But regardless, this is a measure that reveals the staff nurses' ratings of their care environments, which given that nurses are the ones who are the largest workforce and are closest to the patient, that seems like I would argue a useful measure for the public to be able to access and to know from Hospital A to Hospital B what are the environments for nursing care in those settings.

But I also think it would also be reported with other nurse-sensitive measures so that they would get a package of information about the structural process measures of nursing care.

Susan Yendro: Well, and I agree that it is important information. I guess I am just trying to look at it from the patient safety perspective, in that from a patient safety and quality patient care, it would help me to have the full picture.

Dr. Eileen Lake: Yes, because...

Susan Yendro: I agree that it's important to understand this environment, but particularly from a clinical study perspective, it's important - you know, it's important to see the full picture. It's real easy to

explain when you've got poor nurse physician relationship, poor outcomes. But you - you know, I think you need the full picture.

Dr. Eileen Lake: Yes, because the other kind of work I do a lot is on the magnet hospitals, and we see that there's hardly any of them in the US, so it doesn't really help the public very much to know, you know, is my neighborhood hospital a magnet or not, whereas a tool like this in every single hospital, we can get a pretty nuanced understanding of the environment in which the nurses are practicing, and we can share that with the public.

And I was looking over the documentation we submitted on the topic of the performance gap, and under this section 2A, 2.3, we reported that in a study of 800 hospitals, the sample hospitals exhibited the full range of possible scores from one to four, so that again, hospitals do vary, and that's something that the public would learn more about if we could share that information with a consistent tool.

Susan Yendro: Hi, this is Susan Yendro. I also would draw your attention to the work of another project sponsored by (Robert Wood Johnson) Foundation by (Shoshana Sofar). She did a study of the nursing sensitive measures and how public - she used focus groups, and measured the response that the focus groups had to the different measures. And this measure particularly was one that consumers and patients found to be relevant to their care, and 80% of the participants found it very important, so I would draw your attention to that work as well.

Dr. Eileen Lake: To follow up Susan's point, this is Eileen Lake again, we see that patient assessments using the HCAPs, which is the hospital consumer assessment of provider experiences, that in research in which we measured nurse staffing and we measured nurses' environments in four states of hospitals, that it was the nurse's environment and nurses' assessments of environments that was highly related to patients' reported experiences through the patient survey.

All the items on the patient survey, like you know, understanding your meds and communication with nurses and you know, understanding plans for discharge, every single item was highly significantly related to the practice environment scores, and the individual items were not related to staffing, so that we'd see that there is a clear alignment in what nurses report about their practice settings and what patients experience.

(Jesse Pines): Any additional comments on this measure before we move on?

Ed Septimus: This is Ed. Can you hear me?

(Jesse Pines): We can, thanks, Ed.

Ed Septimus: I for some reason was muted. My question may have just been answered. There seems to be some overlapping measures here. How did HCAPS fit into this, because HCAPS are going to be part of value-based purchasing. There's certainly issues relating to a number of hours worked as well as turnover rates, and the patient's safety and teamwork environment. How do all these issues fit in with all these different measures, and can there be any harmonization of some of these measures?

Dr. Eileen Lake: I think that's the $64,000 question, is how to come up with something that we could integrate across multiple nurse-sensitive structural measures, and I think that a goal and a challenge, and I don't know that we have the plan for that right yet.

Ed Septimus: Unless I'm mistaken, and please correct me, I thought HCAPS were part of value based purchasing.

Dr. Eileen Lake: Oh, yes.

Ed Septimus: Okay, so they're already in there.

Dr. Eileen Lake: Yes.

Ed Septimus: And I think everybody I think accepts that the safety attitude questionnaire, whether you use the HRQs or others clearly does - has been shown to impact patient care and safety, and nurse turnover rates. Am I not correct about that?

Dr. Eileen Lake: That sounds accurate. This measure...

Ed Septimus: So I guess my question is, I mean, I think any measure that we want to approve, I would think number one would be don't want any unintended consequences, and number two we want to know that the measure actually impacts care. So I'm just - again, I'm relatively new. It's my first year, so if I'm asking stupid things just tell me to shut up and I'll listen to others, but it just seems to be an awful lot of overlap with some of these nursing measures, which by the way I think are critically important.

Susan Yendro: Hi, this is Susan again from the Joint Commission, just to point out that a number of these measures were originally part of the NQF nursing-sensitive measures set, originally endorsed I think it was 2004, and the joint commission received funding under two different projects from (Robert Wood Johnson) Foundation to bring the measures together under - the first project was to have one measure specification, manual, and then the second project was to test those 15 measures as a set.

So that work was completed, and as part of that work, we collaborated with all of the measure developers who were a part of - had measures in this time, including the ANA, CalMark, CDC, Dr. Lake, Dr. (Needleman). We worked very closely with all the measure developers to harmonize the data elements that were common to all the measures in that original set of 15 measures.

Dr. Stephen Lawless: Hi, this is (Steve Lawless) to reiterate what the gentleman had just said about the harmonization. You know, it's almost like we're looking at again, I mentioned the same thing, an economic model, like these are the variables, how they make up the outcome, because everybody's saying it's linked to mortality or length of stay or whatever else, and we're getting into lots of different tools or lots of different measures to measure the same, or a piece of the impact on this. It may be nice in the future to talk about a singular way of plugging all your numbers in to see the impact, or what's the most - one that has the most impact of all of these?

(Jesse Pines): And that may be what we may want to do in the in-person meeting, is to do some sort of harmonization, or choose among these measures, you know, which one is the most tightly linked to outcomes.

Dr. Stephen Lawless: And we can also identify this as, you know, an issue for future development and study in the report, so those are a couple of different options here.

(Jesse Pines): So this has been a really great discussion. Any final comments before we move on? Okay, thank you very much.

Male: So we're going to put this in the parking lot for the face-to-face meeting to really take a deep dive into this, or a deeper dive?

Dr. Stephen Lawless: That sounds great.

(Jesse Pines): Okay. Yes, we'll make a note of that. Okay, the next measure is 0207, which is voluntary turnover, and that's going to be presented by Bobbette Bond. Bobbette, go ahead.

Bobbette Bond: Thank you. Hi. All right, I think that the measure - this measure is going to end up having many of the same conversation elements that you just had about 206. So I think we are going to probably by the end of today have a whole set of things we want to see if there's any way to toggle them together better, live, I don't know. This measure is by the joint commission. It's been active since 2009, and it measures voluntary separations, they call it, three sets of clinicians, RNs, and APNs, and then LPNs and LVNs, and then unlicensed personnel that are assistants.

I believe, and I want joint commission to back up and clarify this one. I'm - after my brief introduction here. I believe it's based on the national database of nurse quality indicators, and so that's not a database I normally use, and so I may miss something here. We'll just make sure the joint commission can come back and clarify.

It's a structural measure, and it's - it's just - it's a numerator and a denominator, the numerator being the total number of voluntary separations, which they try to tie to job satisfaction, reasons for voluntary separation. Then the denominator is all employees, full and part time employees.

It's a monthly measure, so the ones that are doing it have to report the last day of the month the number of people that have voluntarily separated in those clinical categories compared to the entire population working at the hospital or the facility at the end of every month. So it's an attempt to get the turnover. The reasons are some of them that you've already heard today.

There's three studies that they specifically call out that talk about turnover, clinical turnover, being related to patient care. One study with higher mortality, one study with longer length of stay - so those same indicators, those higher mortality and longer length of stay, which you know, higher mortality's certainly an outcome measure that we're all trying to get to. There's the assumption that it links to those, so these three studies in 2011, 2010, and then one in - by the VA in 2002 are specifically discussed.

There's issues with this measure. I think that one that - one - I think it's an easy measure, so on the plus side it's really people are - these facilities are able to capture this measure. There is some validity problems in the assessment that they did, but it's mainly because just reporter error, you know. It's not difficult the way they've categorized this to come up with the ratio, but there's - they've removed things like from the numerator.

The only thing they're measuring is the people that left because of dissatisfaction with their compensation, with their work conditions, so you kind of lose the whole layer of reduction and force to exclude that, largess to exclude that. And because of that, it doesn't tie directly to patient ratios. So this is a measure of as some of the others said, an isolation from actual staff ratios and hospitals with patients who kind of - you can't there from here.

So again, we may want to figure out some ways to link better. There's also a wide range in variation in the data I saw, but again I want the joint commission to talk about that a little bit, the variation in the reports on that are being publicly reported. The example they gave was Colorado is using a Colorado hospital report card, and they've got ranges of variation for the clinical stuff between - shoot, I need to find it - I think zero to 35%, maybe, and then non-clinical zero to 56%, so it's a wide range.

The joint commission got for the clinical staff zero to 22% range, and for non-clinical 1% to 34% range, so I don't know if there's a more finite way to capture those - to stratify those in tiers that would be useful, if they're publicly reported, but that's certainly an issue. But my main thing, my summary would be that it's a useful measure because I think that there's clear recognition that nurse turnover, clinical turnover, is expensive and also leads to some quality issues in the facilities.

But I do think that this was one of those situations where the public reporting might be complex - need to be more complex to be useful, and I think it - in isolation there's problems with not

capturing the overall picture of nurse - you know, how many nurses there are managing those patients. So that's it for me. Questions?

Vallire Hooper: This is Vallire Hooper. I struggled a bit with this in that - and I know that this is one of those measures that is reported from an NDNQI perspective, but I struggle a bit with do we really drill down to the reason for the voluntary turnover, and I'm not quite sure that I'm seeing a list of transfers within organization that disability, you know, what type of separations were included as voluntary, but I'm not sure from a nitty gritty perspective that this really tells us anything.

Did they relocate? And what is relocation? Is it relocation to another facility in town? Is it relocation to another state? You know, if it's within a community, did they relocate to another facility because of better pay or because of a better work environment? Did they relocate within the institution because of a management issue on their particular unit?

I know we, at my institution, used this data, but we're not always sure that we get the full picture, because particularly when there are not a lot of other choices within the community, the nurse may not necessarily be completely forthcoming in their reason for either transferring from one unit to another, or for leaving a hospital and going to another hospital within the same community. So I struggle a bit with does this give us the true picture.

Bobbette Bond: Well, I'm sure - this is Bobbette again, and I'd really I think joint commission should weigh in here. I'm sure that you're right, that self-report, because it - you know, you're going to get these categories based on what the employee says about why they're leaving. The ones they specifically try to capture are compensation, work environment, team members, and management. Those are reasons for leaving that they want to capture.

The things they're excluding are you know, relocation, retirement, termination. But to your point, Vallire, particularly promotion, you know, within or without the facility, that could be a quality of

work issue that's not captured. I - but again, I don't use this data, so I would need to defer to people that are actually tracking this. All right, joint commission, can you weigh in here?

Susan Yendro: I'm sorry.

Bobbette Bond: Can the Joint Commission weigh in?

Susan Yendro: Yes, this is Susan Yendro from the Joint Commission.

Bobbette Bond: Great.

Susan Yendro: So you're correct in that the measure is focused on those reasons that somebody would leave an organization due to sort of dissatisfaction with their employment, and that the measure is limited in that you're - you have to go by what is reported by the employee as the reason that they're leaving. It is a measure - I think this is pointed out as well - that is easy to collect because through human resources typically there is a collection of reasons for an employee leaving an organization, so that information is available.

Getting down to the deeper level about some - why somebody actually does leave is a little bit more difficult to get to. You are correct in that. The measure was originally developed by the DHA and has been in collection since I think 2002 by different organizations. One of the biggest organization is the NDNQI database does collect this measure as well, so were there any other specific questions that I should be addressing?

John Clarke: This is John Clarke. I had a couple of questions as well. One of them, and I think the most important, is that your justification for this was the relationship between nursing ratios and quality of care, and yet we're not measuring nursing ratios.

The fact that you have high turnover is only indirectly related to whether or not you have adequate staffing levels, so you're not - so you're predicating this on the fact that you're trying to measure something which is related to quality, which is high staffing levels, but you're not measuring high staffing levels.

You're measuring turnover, which only has an indirect relationship to staffing levels. That's one question I had. The second question I had was the denominator is the number of people, but not the number of FKEs, so I would think that that might be affected by whether you have a lot of part time people or full time people, and so I was wondering why you made that choice.

And the third question is that you only involve people who have direct contact with patient care, but there is an important person in the area who is critical to patient care, and that's the word clerk, who although they don't have direct contact with patient care, are essential to make the system operational, and I was wondering why you left that person out.

Susan Yendro: Okay, the first question, the relationship, several of the studies that we looked at were studies that looked at nurse staffing in general, but they did specifically call out the turnover and turnover being an issue with quality with patient outcomes. Not all of the studies used this measure specifically when they were talking about turnover, but they did look at the turnover rate as it related to outcomes and found that there definitely was a correlation between turnovers and outcome, however, not specific to this measure and to the exclusions and inclusions of this specific measure.

The issue of ET - sorry, of full time employees, we include in both the numerator and denominator part time employees as well so we didn't look at it as a full time employee only. We looked at all employees ((inaudible)) as well.

John Clarke: The question was not full time employees versus part time employees, but full time equivalents

Susan Yendro: Equivalents, and that's just the way the measure was originally developed, was just...

John Clarke: The question is why did you develop the measure that way?

Susan Yendro: That I don't know. That I don't know. I could see if I could find that information out for the in-person meeting.

Dr. Stephen Lawless: This is Steve Lawless. I've seen the data from this, that same kind of collection, and they do capture both count and FTE, so I don't know why were just picking one versus the other, but they do capture it both.

Susan Yendro: Okay and...

Andrew Lyzenga: When you mention VHA, you mean Volunteer Hospitals of America?

Susan Yendro: Yes.

Andrew Lyzenga: Okay, part of the TICU project?

Susan Yendro: I believe it may have been. I don't know.

Andrew Lyzenga: That was pre-cusp. Is that the data you're talking about, the data center that was developed by (Brian Sexton) that eventually got rolled into HRQ's questionnaire on safety and teamwork?

Susan Yendro: That I don't know.

Andrew Lyzenga: But it just is, I was part of that project, and in fact again you can call it indirect or direct, but the climate, safety, teamwork survey correlated - in other words the lower your teamwork safety environment, the higher your nurse turnover rate was. I don't know if that answers that specific question, but it was sort of an indirect epi marker for the climate and - of safety and teamwork. And it did correlate with outcomes.

Vallire Hooper: And this is Vallire. The - I think your statement in and of itself points to the importance of you know, having more of a full picture because you know, you've got to understand the environment plus the turnover issue, which these - the previous measure that we discussed actually addresses the environment, but I think that this is going to be some work that we're going to have to do at the live meeting as to really pound out which of these measures are critical.

Andrew Lyzenga: And that's why I was talking about harmonization, because there's a lot of overlap here and maybe we can collapse some of these measures together.

Susan Yendro: Andrew, I think that the measures were developed as part of a 15-measure set originally in order to do that, to give a picture of different aspects of the care environment and what was happening from the hospitals, from you know, the structure process and outcome.

Bobbette Bond: Yes, this one - this is Bobbette - this one isn't identified as being paired with anything else now, so it was the result that each one of those 15 got pulled on their own.

Susan Yendro: I - yes, I believe you're correct. They all did get pulled out onto their own.

Bobbette Bond: Andrew, do we have the ability as a group to recommend relinking things? I know the last meeting, the last big meeting there was issues about medication and trying to link them with

outcomes with another pairing, with something it wasn't paired with, and I can't remember what we're allowed to do.

Andrew Lyzenga: Yes, we have recommended to - or had you know, steering committees have recommended to developers that they link you know, sets of measures together. Pair them is usually what we call them, even though there can be more than two. And the developers would have to agree to that, and we've got multiple different developers here at this point, so that's something we can bring up and discuss with them. If they don't agree, then you'd have to just sort of make decisions on the individual measures I think as they stand.

Bobbette Bond: Okay.

(Jesse Pines): Okay, and just to step back there, I think there was one more question Dr. (Clark) had that wasn't answered by the joint commission about including only people who have direct patient care and not word clerks.

Susan Yendro: Yes, again, I'm not sure why that wasn't included, but it was specifically developed to measure staff that has direct contact with the patient.

Bobbette Bond: You know, the flip side is that - this is Bobbette - I actually appreciated that, that there was only people in - you know, actually working with the patient in that database, because - or in that measure, because otherwise it gets even more murky and clouded with people that aren't directly reaching that patient, and you can have a complete disorientation as to what that data means. Even more so, I understand the concern that you're not getting all of the resources going to that patient if you don't have that clerk in there, but on the other hand it's about who's working with the patient directly that I think is the outcome issue, is my personal opinion.

(Jesse Pines): Okay, any additional comments on this measure? Okay, any comments from the joint commission?

Susan Yendro: No, thank you.

(Jesse Pines): Okay, thank you very much, Bobbette. Why don't we go ahead and move on to our next measure, which is 0204, skill mix, and that's going to be presented by Vallire Hooper, and it - do we have a representative from the ANA here on the call?

Nancy Dunton: Yes, this is Nancy Dunton, and there are several of us from NDAQI representing ANA.

(Jesse Pines): Excellent. Vallire, why don't you go ahead?

Vallire Hooper: Yes, this is Vallire Hooper. This is measure 204, skill mix, registered nurse, basically looking at RN, LPN, LVN, and UAPs as well as contract. This measure was originally endorsed in August of 2009, and was last updated in April of this year. Basically what they are looking at is the percentage of total nursing hours worked by LPNs, RNs, and separate categories, RNs and UAPs, with the denominator being the total number of productive hours worked by employee or contract nursing staff with direct nursing care responsibilities.

If you are in a hospital that is participating in the NDAQI data and benchmarks, this is a measure that is very familiar to you, and is very helpful in evaluating, you know, how your staffing levels and staffing mix are comparing to like sized facilities around the country. The data is well-supported. The measure is well-supported by evidence. There is a bit of a mix as it pertains to some outcomes as to the true impact of nursing a staff mix.

To outcome however, I think that the measure is - you have to have that information to truly evaluate confounding variables when looking at nurses to outcomes. The data is broken down by

types of unit, critical care piece, etcetera. Sorry, guys, my - we moved offices Friday, and so my - everything in my office is in a complete disarray, so I'm not quite as organized as I usually am.

Data is collected monthly and then totaled for a quarterly report, and I really did not have any questions with the measure, but that could be because I am familiar with this measure because we work with it on a regular basis, so I will actually defer to the rest of the group as to if they had any questions regarding the measure.

John Clarke: This is John Clarke. How did you measure productive nursing hours, and why do they use the word productive rather than just nursing hours.

Vallire Hooper: And I will defer to ANA on that.

Nancy Dunton: All right, thank you.

(Diane Boyle): This is (Diane Boyle) at NDNQI, and the - we were interested in again, the effect of the direct care providers, and the way we measure that is basically nurse-centered nursing activities by unit-based staff, typically in the presence of patients. So we give the example in our guidelines around medications, ministrations, nursing treatments, nursing rounds, admission, transfer and discharge activities, patient teaching, coordination of care, documentation time, screening, risk assessment, treatment planning, etcetera.

Nancy Dunton: This is Nancy Dunton. And so the things that are excluded are things nurses do in their jobs that are not patient related such as continuing education, organizational meetings...

(Diane Boyle): Vacation.

Nancy Dunton: ...vacation, sick leave and...

Vallire Hooper: Now, in this measure, are you - when you say non-patient related, are you considering shared governance activities to be patient related or non-patient related?

(Diane Boyle): I would say they're non-patient related.

Nancy Dunton: It certainly speaks to time in a unit, but it is not involved in the provision of care, and when you are looking at structure, process, and outcome models, you want to have this core measure of the sort of dose of nursing applied to patients.

(Diane Boyle): I think where that comes in, Vallire, is certain of the administrative activities that help the nurses provide that care.

Nancy Dunton: Yes.

(Jesse Pines): Any additional comments on this measure? Okay, well, we're being efficient here today. Why don't we go ahead and move on to a related measure, 0205, which is nursing care hours per patient day. That's going to be presented by Marc Moote. Go ahead, Marc.

Marc Moote: Oh, thank you. Good afternoon. So of the group to me this one seemed to be the most objective and have the most value, albeit still with a lot of the same issues mentioned in some of the other measures, but again this was originally endorsed in 2009. It is a structure measure related to nursing hours per patient day and pulls from administrative and management data.

In terms of impact, it obviously would impact large numbers of patients, and from the data included, it does appear that there is high variability across units within hospitals. What's unclear to me is whether there are yet benchmarks developed as to what optimal levels of staffing should

be, and my concern as it relates to the measure, much of what was said before is at it relates to public reporting.

I'm not sure that in aggregate or by mean with all units combined is actually very valuable, and I think a lot of that nuances will be unit specific, as a lot of their variability attests to. The other concerns I had from a definition standpoint, even just the one study that was included, by comparing the end to the end UI data, compared to our California database, there was not good alignment. They seemed to lack comparability between the two databases even on the same measure, which speaks potentially to the definition.

Also, let me pull up my comments on the cell. I felt that the evidence was weak as it relates to outcome, but compelling enough in the positive - the study that showed a positive association to still warrant endorsement, largely because again I don't think we have anything better to compare. I think this is more of a research measure, though, than anything else that will hopefully lead to better outcome data over time.

I have to say that at present with some of the contradictory studies, I'm not convinced that we have the answers today that this definitely impacts quality, although it may over time. I think that the risks to the institution other the time investment is minimal. Therefore I felt that the benefits outweighed any potential harm to the organizations and therefore is still suitable for endorsement.

Vallire Hooper: Hi, this is Vallire Hooper. I just have a bit of concern about this measure. What?

(Jesse Pines): Yes.

Vallire Hooper: Yes, sorry, I heard ((inaudible))...

(Jesse Pines): We're getting a little bit of feedback.

Vallire Hooper: But I had a bit of concern about does this capture, depending on the literature, does it capture value added versus non-value added activities? Does it capture the amount of time that the nurse may spend on a seek and find mission? I'm not sure that just nursing hours per patient day without some better differentiation of what those hours are spent doing - I'm just not sure how helpful this measure is in overall quality of care.

Marc Moote: So I felt this was the most helpful of the nursing measures, because it seemed to be the most objective. So they are saying the hours in direct patient care, and excludes certain staff categories. The bigger concern here is that despite even in the NDNQI study, a lot of hospitals incorrectly included their clerks or sitter hours or in other cases other excluded staff categories, so - which I believe ((inaudible)) brought up before, wanting to see data on that unintentionally was included in this measure, which was actually a problem, but I think that of all the nursing measures, this one seems to correlate or could correlate the most to actual outcomes data as opposed to these indirect measures. I just don't think we have the benchmarking yet to say, you know, what the optimal threshold should be, and it should be unit specific as opposed to an aggregate per hospital.

Vallire Hooper: And I can see your point. I just have concerns in that we are not necessarily capturing the full picture. When the nurse is spending a large amount of time basically babysitting the computer because of the electronic health record, that is technically counted in this measure as nursing care hours per patient day, but in fact the nurse is actually to a certain extent taken away from the bedside and actually taken away from the activity of direct nursing care.

And I don't know that there is a good fix for this, because we are all struggling with how to capture what actually goes on in a nursing - in the day, the type of care that the nurse provides, but much of this met administration - we're not capturing the wasted time, and I think that you could have a misleading high number of nursing hours per patient when in fact it is not depending on what

terminology you want to use, value added, and so therefore it is not necessarily contributing to patient - to positive patient outcome.

So perhaps the measure as a standalone measure may be problematic and should be paired with other measures.

Nancy Dunton: This is Nancy Dunton. (Diane Boyle) who is with me would like to speak to some of the measurement issues.

(Diane Boyle): Well, I'll just go down them in order. In terms of the optimal levels of staffing, our view is that it does need to be looked at by unit, and we provide each unit with their own staffing and then a benchmark for like units in like hospitals, so that they can see where they stand. Now I think your point about what optimal staffing is, is a little bit more difficult.

For us it has depended on the outcome, so for example with falls, what we have come up with for optimal staffing for fall is just a little bit different from some of the other outcome indicators. So it's a pretty ((inaudible)) complex picture, and I don't know if Nancy wants to say anything on that, because she's done a couple of those studies around that.

Nancy Dunton: I would like to just point out that while having a benchmark that is sort of the goal, the target that people should meet, that's been addressed in many states that have considered nursing ratios, and in nursing care hours for patient day, 24 divided by nursing hours for patient day equals a staffing ratio, and we believe strongly that we cannot - we cannot and should not be specific about benchmarks because they vary vacuity of patients and hospitals, by the kind of typical support available in hospitals, and in a number of other variables.

And so we feel that the best that can be done is that you do comparison to similar hospitals. And in terms of public reporting, I think that some states that you do public reporting on this measure do provide sort of state averages for comparison.

(Diane Boyle): Right.

Nancy Dunton: So that is ongoing.

(Diane Boyle): In terms of the comparison of the OSHPOD and the NDNQI data, yes, there was a bit of difficulty in matching up those two data sets, and some differences in the comparability, but the ICCs across the two databases were quite high. They were - for RN nursing hours, and inter-class correlation, it sort of tells the comparability across the two.

So the ICCs range from .71 to .95, so they - those are good ICCs, and indicate good reliability or good comparability across the two data sets. And in terms of Vallire's comment about value-added and non-value added, the definition of direct patient care activities for the nursing care hours is identical to the one for skill mix. So the hospitals should be reporting the same number of hours for each of them, and it's just the - basically a different way to slice the data in terms of this is total nursing care hours versus the other one is the proportion of the hours that are one group versus another.

So we define those hours the same way. I'd agree with Vallire that we don't have a way to know what fishing expeditions they've gone on, but that - and that's sort of a difficult thing to address, but the definitions are the same across the two, yes.

Nancy Dunton: We'd say this is the core measure, and certainly what Vallire was discussing would be sort of a next generation comparison measure which - companion measure, I mean, not comparison - which would be useful, but is certainly not underway here. And then about the ward

clerks and sitters and so forth getting counted in those hours, that was a pretty small proportion across the board, and what we are planning to do with that in our guidelines is to try to make it clearer about what those definitions are, and we're also actually considering collecting the data so that people can tell us, and then we can actually ferret it out from the other data. So we're looking at ways to solve that problem, and if we do that of course we would submit a measure maintenance update on it...

(Diane Boyle): Right.

Nancy Dunton: ...at the time of - as we collected it. And then - and we would like to say that these measures were originally endorsed in 2004, and then they had their reendorsement in 2009.

Marc Moote: Okay.

Vallire Hooper: And (Diane), given that these measures are basically dicing and slicing the same data, do you have any recommendations as to you know, do we need both measures? Could we live with one or the other? You know, what is the difference in the information that we're getting if we were to use one of these measures versus the combined measure, since they're using very similar definitions?

(Diane Boyle): So well one, the nursing care hours per patient day is part of our labor supply measure, and the other is sort of representing the quality of the care or the amount of - what we're particularly interested in, the percent that are RNs. And it's that percent of RNs that has shown up the law in terms of what's related to patient outcomes, but then so has the total nursing hours per patient day and the total RN hours per patient day.

And they've - I think they just represent different views of looking at the data in terms of how somebody might want to...

Nancy Dunton: And this is Nancy. I think that as a set, a measure set, when we're looking at supply of nursing care and the other looking at literally the skill of the nursing care since it's called skill mix, then it's a measure of expertise or it's not really a good measure of expertise, but a level of skill - is - are the two aspects that would be represented by these two measures.

Marc Moote: So I would have been inclined to say this, if we were to limit it to one, this would be the more important of the two, but there was the one paper from Dr. Lake that showed an increase in LPNs and nursing assistant hours actually increased the fall rates, whereas the RN hours was more better associated with lower falls.

But that was specific to an ICU and a magnet status, which I'm not convinced is applicable or useful, but there was some interesting data that dealt in the skill mix within the study they were providing. I guess I just struggle still with whether or not this is - how clearly linked this is to the outcome. I'm not convinced. You know, falls is used commonly here, but there were several studies that showed no correlation and no association, so I'm just not convinced yet, but again I think that's for the studies that showed a positive correlation was compelling enough to continue with the measure.

(Jesse Pines): Great. Any additional discussion on this measure? Okay, why don't we go ahead and move along? The - we've got two measures left, so we're in good shape time wise. The next measure is 1716, which is the national health care safety network facility wide in-patient hospital onset MRSA bacteremia outcome measures, so a whole lot of words, and CDC is the measure developer, and Dr. (Moores) is going to be presenting. Go ahead, Dr. (Moores).

(Lisa), are you still on? I may have lost (Lisa Morris). Did anybody else happen to take a look at this measure and could give us some thoughts on it, or somebody else?

John Clarke: This is John Clarke, and I reviewed the other measure, which was on ((inaudible)), and the techniques are similar. This particular measure looks at a methicillin resistant staph aureus MRSA, and of course we know that the literature on this is excellent in terms of what the problem is and what needs to be done in order to solve the problem.

The only question that I had on this was - and I might add that in both these measures, they're looking at observed to expected ratios. And they dichotomize - they stratify these in a kind of a risk assessment, not by patient, but rather by facility. So they look at it, slice and dice it, by whether the facility is teaching hospital, whether - how many beds it has and a variety of other measures.

The one thing that I didn't see on this was why - whether or not there is any indication, and this is true for both studies, whether or not there's any indication as to whether this stratification or valid, that is whether in fact there are differences between rates and they do have experience, whether there are differences between rates based on facility size, based on facility type, etcetera. So that was the only question I had about this, and actually was a question I had about the other one as well.

Dr. Stephen Lawless: Hey, this is Steve Lawless. When looking at the measure, what was looking at ((inaudible)) resistant staph, I didn't see much or a good indication that this was actually looking at the management of the practitioners in a hospital, which either sloughed this or recognized this or promoted methicillin resistant staph.

Like, it's too bad the measure doesn't look at overtreatment that led to this methicillin resistance, or incidences of methicillin resistant staph per hospital, antibiotic resistances or something, so - versus just isolates, because you could be coming into the hospital, and once you have methicillin resistant staph, you have it, so I'm not sure what we would - what someone does with - if the data, whether their incidence was 10% versus 30%.

Gina Puglise: And this is Gina Puglise. A question, the - it says the validity studies are ongoing, and just wondering if there was anything that we've learned from the studies, or - and what more we need in terms of whether or not the SIR is going to be something that's going to be helpful in comparing the hospitals.

And then the other question is, how robust are the hospitals that are currently using this? I mean, do we have enough information to - the data was from 58 units, so that's 58 - is that 58 hospitals, or could that be maybe 25 hospitals, 2 units per hospital? I was just curious as to how many hospitals have actually used this, and does CDC feel that's enough experience to - you know, to get this NQF endorsed at this point, was just my question.

(Jesse Pines): I believe we do have CDC represented on this call.

Dawn Sievert: CDC's on. This is Dawn Sievert. With - as far as the number of facilities go, we now have over 800 facilities from almost all ((inaudible)) reporting in ((inaudible)) and ((inaudible)) bacteremia for the ((inaudible)), which this metric is based on. But we do have sufficient data and we do have sufficient facilities using this metric and doing this reporting to know that, you know, the data that we're seeing is solid in that the way that they're using it, they're finding effective in identifying their ((inaudible)) infections and their ((inaudible)) bloodstream infections.

We are in the midst of doing our analysis for the SIRs and for all the risk adjustment and for - I guess on the - I - you know, if you want me to just cover MRSA, or we could do both at the same time. For CDIF, definitely we see that it is the facility level data that is playing a huge impact on the CDIF infections that are in the facility, and in those two that are most important are the present on admission, the community onset cases that are actually coming in the door of the facility.

And we're also seeing that important adjustment is the CDI test type that they're doing. So if they're doing PCR, then they're finding a lot more CDIF compared to the EIA tests or some of the other tests. So we've been asked numerous times if we're going to adjust on that to make sure that the numbers are fair between the facilities that are running this much more sensitive test, and we do see that is a very important risk adjustor to include.

We - let's see - we - you know, we don't - the test for MRSA isn't - it doesn't matter. There isn't a difference that way, so we don't have that, but we will in our looking at the community onset MRSA also that's coming into the facility.

Gina Puglise: And when do you expect to include that risk adjustment for the two different kinds of tests, the CDIF, did you say, you're working on it, or...?

Dawn Sievert: So we - right now we - the way we have it categorized is PCR versus EIA and other, so just two categories because really most of our facilities, when we ask them what they're testing, they're either doing PCR or EIA right now, and so it's falling into one of those two categories. So the adjustment is on basically whether or not they're doing PCR, because all the other tests sort of run - in fact, the high level facilities are doing - they run at a much more sensitive and specific level, where the PCR is sort of in a league of its own.

Gina Puglise: Great, thanks.

John Clarke: All right, could you get back to the issue of why you - whether you're hospital stratifications are in fact based on different expectations in those - different outcomes in those hospitals, or whether it's an arbitrary classification just dreamed up ad hoc?

Dawn Sievert: You mean the way we classify all of the variables that we'll be looking at?

John Clarke: Well, you say that you're going to report hospitals back according to whether they're medical school hospitals or graduate hospitals, major hospitals, etcetera. And the question - and the size of the hospital, and the question is this. Is there any evidence that the rates in fact are different for a 200 bed hospital versus an 800 bed hospital or for a medical school hospital versus a non-medical school hospital?

Dawn Sievert: Right, and actually in fact they are, and we have data now sitting in front of us that we are submitting to ID week to also be able to present there, and we are seeing that those individual stratifications that you talked about, the major versus what is it - major...?

John Clarke: Medical major...

Dawn Sievert: Yes, basically it's a high end level delineation of this major teaching versus all other, and that is showing very significant, and the bedside by all - by three levels - we're actually looking at multiple ways of looking at the bedside to the fact that you brought up, that we want it to be meaningful, that the bedsides' categorizations just aren't you know, sort of made up however we want.

But we really are seeing - as far as CDIF, we're seeing a significance between less than 200 beds, and then 200 to 500, and then much larger hospitals over 500. So we're seeing that important stratification by those three levels for MRSA. It's going to end up being more like a very - some more to the middle where it's 300, 350 beds versus higher, and there's a split somewhere in there.

And again, we're looking at you know, what does that mean? What is the meaning of those variations in the stratifications of the bedsides? But they are truly showing strong and significant differences based on their size with the rates of both MRSA and CDIF.

John Clarke: Do you have any sense of when you might have the full validity studies results and that type of information that you could provide to the committee?

Dan Pollock: So, the full validity studies - I mean, we're poised to have the two measures become part of IQR beginning in January of 2013, as Dawn - this is Dan Pollock at CDC - as Dawn Sievert just said. We have a substantial number of hospitals that are ready and reporting, so as part of the CMS IQR program, we expect there will be validation studies. As part of state use of NHSM, we expect that states will also be able to provide validation data, and we would anticipate the likelihood of that sort of data covering all the new reporting to begin as early as some point next calendar year.

Male: But just to clarify, I mean, there was a lot of new data mentioned that we don't have - I believe we don't have here in front of us. Would that be clarified for the - before the in-person meeting, or any additional data you could give us?

Dan Pollock: What in-person meeting?

(Jesse Pines): That's in June, the middle of June, June 14th and 15th I believe.

Dan Pollock: Yes, we have additional analysis using more recent data than were submitted with the measure proposal itself.

(Jesse Pines): And I think that would be very useful to - if you could give us that for the in-person meeting.

Dan Pollock: Sure.

(Jesse Pines): Then we can distribute it to the committee.

Dan Pollock: Yes.

Dawn Sievert: All right, I mean, I think the most clear way to do it would be to give you the abstract that we submitted, because we have the table with the results that show all those variables that I described with their rates and the significance of them.

(Jesse Pines): Okay, great.

Dan Pollock: Something else, with the significance of the methicillin and the CDIF are not the same - they're not matching each other in terms of what the locations, and what you're finding out is that the higher incidence, that itself is telling of itself. It sounds like it's still more of a randomness to it than that correlation that one hospital - you know, this is a hospital that has an infection problem or an infection management problem or not.

Dawn Sievert: And the test type and the prevalence are only one right now for CDIF, so we don't - we wouldn't run the test type for MRSA, and we have not run the community onset prevalence for MRSA, but teaching type matches and the bed size, again, we have to look a little further into the MRSA because that was the one that the high end to the low end was significant, but it was that - the middle factor of the bed size.

And again, I think that - you know, what's happening with the bed size is exactly - you know, the teaching type and the bed size are speaking to the type of facility that it is and the type of patients that it sees, and you know, I - that - it may be different and have a different impact for CDIF and for MRSA.

(Jesse Pines): Yes, thank you.

Ed Septimus: Yes, this is Ed Septimus. Hi, Dan. They've done a very nice job with ((inaudible)) and ((inaudible)) and SSIs, and I guess it would be useful, Dan, if some of that risk stratification could be shared before our face-to-face meeting to give everybody comfort that SIR for these two measures are as reasonable as they are for the other measures that are currently being publicly reported.

Dan Pollock: Yes, Dan, thank you. I'm sure that what we can provide will speak to that.

Gina Puglise: And Gina Puglise, just for clarification, as Dan Pollock said that they're getting ready to have this part of IQR January 13 calendar - is it fiscal - calendar year?

Dan Pollock: Correct.

Gina Puglise: And so that would mean that the hospitals would start collecting this data on MRSA and CDIF. And then it would be in the - then it would be used for payment starting fiscal year '15, which would be January of '14. So the plan is it would be a year of that data starting January of next year, and then the payment would start the following year, or October of that year.

Dawn Sievert: Right and it is our plan to report these data beginning in January 2014 as SIRs based on this risk adjustment, so that's what we've told CMS, and that is what we're working towards.

Gina Puglise: And just to confirm, you're going to be reporting all of these as SIRs, all of the things that NHSN, all of the rates?

Dawn Sievert: So, right. The rates that I'm talking about are the rates that go into our analysis to identify the significant risk adjustment for the SIR, and just to point out that these data are collected on a facility wide level, which is why you have not heard me bring up location.

Gina Puglise: Right.

Dawn Sievert: Since we don't have denominator data by location like we do for the ((inaudible)), this is facility wide data, which is why we're looking at the facility level ((inaudible)) descriptors, characteristics.

Bobbette Bond: This is Bobbette. I missed a second. Can I just clarify, is that true for 12 - for 1716 and also 1717?

Dawn Sievert: Yes, for both, yes.

Bobbette Bond: Okay, thank you. Great.

John Clarke: And what is your baseline year going to be for MRSA and CDIF?

Dawn Sievert: So definitely it will be 2010 and '11. What we're also considering doing is putting in 2012's data as well, so the analyses that we can do now and all of the risk adjustment that we'll be reporting on through the fall will be based on 2010 and '11 data. Our assumption is that 2012 data will not change any of the importance of the variables, but will just give us a stronger baseline with more facilities reporting because we've had additional state mandates come on.

And so the - and because we weren't going to report the SIR until 2013 our consideration was to use 2010 through 2012 as baseline.

John Clarke: Yes, my only other - you know, especially for CDIF, I think last recollection for those facilities reporting into the NDRO CDIF module, some 30 plus percent of facilities were now using PCR. Is that - am I correct about that?

Dawn Sievert: Yes, it's about 35 or 40%, yes.

John Clarke: And just as you said, I think you can confirm this. When I was last at the HPAC meeting, it was a clear understanding that because CDIF rates are higher with PCR, that they would try to separate those out based on what methodology you're using.

Dawn Sievert: Yes, we absolutely will, and we do have that information, and like I said, that is a definite significant variable that will be used for risk adjustment.

John Clarke: And that will be in place in 2013?

Dawn Sievert: Yes, and that's actually why we start at 2010 data, because that was the first year that we started asking that information on our annual survey from the facilities, and so that's why we're solid with those years, because we have that information from then going forward.

John Clarke: And that's actually partially why I asked the question, because you see more and more people...

Dawn Sievert: Yes.

John Clarke: And so that's why I was wondering with the baseline year was going to be, because this is going to be shifting, because I think you're going to see an increasing number of facilities going to PCR whose baseline data was EIA.

Dawn Sievert: Right, right. But again, we've got a significant amount in there already doing PCR for - especially if we add in the 2012 data, because we're already seeing it in 2010 and '11. So we think if we add this year in there too, that would - it wouldn't be like a drastic shift, and again, we're accounting for the variable in the analyses.

John Clarke: Right, and...

(Jesse Pines): Great, so I think we've had a pretty good discussion about the MRSA measure. We've kind of - we've also had kind of interspersed discussion about the CDIF measure. (John), did you want to talk to this any?

John Clarke: Yes, just one more thing about the CDIF measure, and that is unlike the MRSA measure, they made a point of saying that these were more rare events and that the numbers would be lower and therefore they were going to have to extend the data a little longer, and one of the problems that occurs when you have small numbers is that you have wide variations.

So for instance we have our long say surgery project here in Pennsylvania, and when we looked at the 207 onsite surgeries and 130 institutions over a two-year period and related to 12 million operations, we find that one case can make a big difference, and that in fact when you take an incidence of maybe one in 50,000, but you're talking about one institution, the error - the 95% confidence limits are so big that we had for instance no one who was - whose whiskers were totally under the bar, and we had very few places where the whiskers were totally above the bar.

So I was wondering if you have any numbers that confirm for you that you can in fact identify good performers and bad performers for this CDIF.

Dawn Sievert: Right and I think probably the clearest way to answer that is by saying that we're saying more CDIF and MRSA bacteremia than ((inaudible)) are being reported.

John Clarke: Okay.

Dan Pollock: I'd like to say this - and I'd like to say these are rare events, but...

John Clarke: That's what you said in - that's just what you said in the application, which is why I brought it up.

Dawn Sievert: Right, right.

Dan Pollock: I don't know that that's - I mean, Dan can comment on this, but they're not rare events. We have seen a bending of the curve for invasive MRSA, but unfortunately there's been some reduction in CDIF, depending upon which database you use, but neither of these are what I would consider rare, like wrong side surgery.

John Clarke: Yes, well, we've certainly reached that in Pennsylvania. We actually have two deaths per year from CDIF in outpatients getting outpatient surgery with antibiotic coverage, so it is a big problem.

Dawn Sievert: Yes, the rate that we reported in vital signs when we did CDIF and we used this data to do the CDIF analyses, and I believe it was 7.4 per 10,000, so again...

John Clarke: Yes, okay. Okay, that's all I had.

(Jesse Pines): Okay, any other comments about either measure? So we've kind of covered 16 - I'm sorry, 1716 and 1717.

Lisa McGiffert: Hi, this is Lisa McGiffert. I did join, but I'm driving, so I'm not - I'm on mute. So I don't have the papers in front of me, but can we not describe these as rare events? Is there a description that is using the term rare events that we could eliminate from the description?

John Clarke: It didn't say rare event, Lisa. What it said was that these - that the incidence was small enough - I'd have to look exactly what it said, but the incidence was small enough that they had to extent the data collection. Given the low numbers of expected infections, the time window will be longer than monthly. That's what they said.

Dawn Sievert: Right and that was us determining that it might be but now that we've looked at it we're seeing that it's not, so that - you know, and I think also too it's for us looking at what our baseline was and having enough data in the baseline and all of that. One of our you know, concerns at first was that we just didn't want to be looking at a small number of data, which we had - it looks lower to you as you've all acknowledged because we did this application a year ago or whatever to get the data, and we've come so much further now with the data that we have in the system.

So I think you know, with our worry and consideration of what our baseline would be and how we would look at the data, because we were getting data mainly driven by just a few state mandates, and it has opened up dramatically since then with more state mandates and more people using it outside of that, so the data to even to us has become more and more clear since we had to do this application.

Lisa McGiffert: That's great.

Bobbette Bond: Hey, this is Bobbette Bond. I have to go, Andrew. Thanks, this was really good. I'll turn in my next set of stuff.

Andrew: Great, thank you.

(Jesse Pines): Great. And so just to clarify, so the CDC will be providing additional data for the in-person meeting and we can talk offline about when we might be getting that, but would you want to make sure that the group has enough time to review that before the meeting.

Dawn Sievert: Okay, not a problem from us.

(Jesse Pines): Great. Any additional comments about either 1716 or 1717? Okay, we've been a very efficient group. We've gotten through all the measures that were on our agenda today.

John Clarke: That - can I ask a question, though?

(Jesse Pines): Yes.

John Clarke: I pose to everyone I know that BAP is being withdrawn.

(Jesse Pines): Oh, right. It's actually...

John Clarke: And I just - and I - by the way, I'm not a real fan of the current definition of BAP, so - but it is still in the HHS action plan to measure process measures.

(Jesse Pines): And in fact it's not actually being withdrawn completely. It's being withdrawn from this particular project, and we're moving it to a project that's going to be launching in probably about two months or so that's related to infectious diseases.

John Clarke: Okay, I know about that project. Okay, okay. It's fine. I just didn't want that to be - there are new definitions that are being piloted, and I don't think it's going to go away, but it's certainly one that still needs to be studied.

(Jesse Pines): Right, right. Okay, great. Any additional comments before we open it up to the public and NQF members? Okay, operator, could we open up the lines for public comment?

Operator: Thank you. If you would like to make a comment or ask a question, please signal by pressing the star key followed by the digit one on your telephone keypad. If you are using a speakerphone, please make sure your mute function is turned off to allow your signal to reach our equipment. Once again, it is star one to ask a question or make a comment at this time.

It appears there are no questions at this time.

(Jesse Pines): Okay, great, thank you. Well, at this point I'll just go through a couple of next steps. I mean, really, that's just - we'll compile some notes again and we'll get back to the developers with some questions so that they can follow up with us for the in-person meeting. If any of the work group members have any additional questions that occur to you between now and then let us know, and we can also contact the developers and try to get some info from them on those.

Just one note, steering committee members should have received information regarding your travel for the in-person meeting in June, so take a look for that in your email. If you have any questions or concerns about that you can contact us, and I think that's it.

Gina Puglise: This is Gina Puglise. I just have one quick question. Hearing that the measures and the background was submitted a year in advance from this review, I'm just wondering, do the measure developers have an opportunity to update anything? You know, like sometimes there are studies that - you know, in reviewing some of the measures the last time that we found that were published, you know, within the last year that weren't listed and that supported a measure or whatever. I'm just wondering, do they - do the measure developers have a chance to update their - or once they submit it, that's it?

(Jesse Pines): No, we can certainly open up the measure forms if the CDC - I guess we could ask them. Would you be able to give us some updated numbers? It sounded like you have some updated information on...

Dawn Sievert: Yes, I think that would be helpful, because if you know, the whole group of course is going to see this, not just us, and you know, some of the information like how many hospitals or - you know, have submitted data, you know, is very different than what was submitted on the measure, and I think that would be helpful for the full group.

Dan Pollock: And Gina, this is Dan. We certainly agree and we are going to provide an update in the form of a single-page abstract that will cover all of these issues.

Gina Puglise: Perfect.

Female: I'm just wondering as an in general to the NQF, is this something that's routinely allowed or encouraged that measure developers have an opportunity to update with any new information that's come out when a year has passed since you've submitted a measure?

(Jesse Pines): Right, I mean we do usually - we don't usually have quite this long of a time period between submission and when we review the measures, and when we do, we do encourage the developers to submit updated information and...

Female: Okay, thanks.

(Jesse Pines): So Dan, we can sort of touch base offline and coordinate that.

Dan Pollock: Sounds good, Andrew.

(Jesse Pines): Thank you.

John Clarke: I have a question about the upcoming meeting in June. How long will the meeting last on the second day?

(Jesse Pines): I believe we have it scheduled - I'm going to have to take another look at the agenda.

John Clarke: It said ((inaudible)) three.

Female: That's three o'clock.

(Jesse Pines): Yes, I think that is still our plan.

John Clarke: Okay.

(Jesse Pines): Great, any final questions, comments? All right. Thank you very much, everyone. We'll see you in person on June 14th and 15th.

Operator: That does conclude today's conference. Thank you for your participation.

END