

## **NATIONAL QUALITY FORUM**

**Moderator: Jessica Weber**  
**February 23, 2012**  
**9:00 am CT**

Operator: Welcome to the conference. Please note, today's call is being recorded. Please stand by.

Reva Winkler: Good morning. This is Reva Winkler at the National Quality Forum. Thank you all very much for joining us today for this call of the Critical Care Workgroup for our Pulmonary and Critical Care Endorsement Maintenance Project. This call is a public call so we do have audience members listening, and we will provide an opportunity for public comment when, before closing the call.

Also, the recording and transcript of this call will be posted on NQF's Web site. The purpose of our call today is to give this workgroup an opportunity to review the preliminary reviews of eight of the measures in the Pulmonary and Critical Care project. There will be 35 measures in all discussed in our in-person meeting in March. That's a large amount of work.

And so the preliminary workgroup calls are intended for the workgroup members to share their thoughts and concerns and raise issues around the measures in a first-pass effort, so that we could identify the areas of concern, provide an opportunity for questions and have the developers respond to those questions, and try to be sure that we have all the information needed.

The workgroup members and the ratings and comments in these discussions will be summarized to be presented at the in-person meeting, so that we can be very focused in our conversations around the issues and concerns around the measures, rather than starting from scratch for each measure with all of the criteria.

So that is our goal today, is to look to see what the initial review of the measures have identified, what the concerns are. We will be working off of a document, primarily the spreadsheet that was sent to you all, to the committee members last night. It is a spreadsheet that shows the ratings and comments of the committee on these eight measures.

We are showing that spreadsheet on the Webinar for any audience reviewing members. So for committee members, if you want to just look at your own version rather than through the Webinar, that's certainly up to you. We'll try and stick to the order of the discussion of the measures in the agenda. And so does anybody on the workgroup have any questions about what we're going to try and do today? Okay.

Let's start off with the first measure. And we're going to start off with Measure 0356, which is Blood Cultures Performed within 24 Hours Prior to or 24 Hours After Hospital Arrival for Patients Who Were Transferred or Admitted to the ICU Within 24 Hours of Hospital Arrival. And these are patients with diagnosis of pneumonia.

Has Dr. Levy joined us? All right, perhaps he's caught up. I think if we look at the spreadsheet, there are - three of you have submitted your ratings. And in general it looks like you've rated the measure favorably on most of the criteria if we look across - important, high impact, moderate to high opportunity for improvement.

This is a measure that has been reported by CMS on Hospital Compare, and it is currently - I'd have to go back, the most recent CMS rate is at 96.9%, so I think there was - is this the measure,

there was some data showing that it's a low end, the bottom fifth, really, we're still struggling for appropriate performance.

You all have rated the quantity, quality and the consistency of the evidence at least high with just a single moderate, and in general feel that it does meet the importance criteria. Does anybody from the workgroup have any comments about the importance criteria for this measure? Okay, I'm going to assume I've kind of summarized it well. But again, I think this is one where there really is fairly good consistency, not a lot of issues raised or concerns.

I will point out that we did receive one implementation comment on this measure from APIC, who felt that, "Samples of blood and sputum for culture and antigen testing are clear cut for those with severe community acquired pneumonia who need critical care. We're not as sure at the use of the timing of such measure for a performance measurement."

Kind of a little bit unclear what the intent of their comment was for this particular measure. The developer responded that, "The measure simply asked whether a blood culture was obtained within 24 hours of hospital arrival for those patients who are admitted to the ICU within 24 hours of hospital arrival, consistent with IDSA ATS 2007 guidelines," and that they had representatives from those societies on their technical panels for that measure.

Any comments from the workgroup in terms of the concerns raised by APIC? All right, so in terms of the scientific acceptability of this measure, again, you all rated it high on reliability and validity and felt that it meets the scientific acceptability criteria, again, high for usability, high and a couple of mediums for feasibility, but again high to moderate ratings for both usability and feasibility.

And all three that submitted ratings indicated you feel that it meets the criteria. So, you know, I hate having a monologue, here, but Dr. Almenoff or Dr. Stockwell, Michael, any comments?

Dr. David Stockwell: David Stockwell, I mean, I think you've summarized it well.

Reva Winkler: Okay, so is this really as straightforward a measure as you, as it appears to be.

Male: I think it is.

Dr. David Stockwell: It was in my opinion.

Reva Winkler: Okay. All right, well that's fine.

Male: Yes, I mean, I think it's straightforward, also. I mean, it's been around for quite a while.

Reva Winkler: Okay. Effective...

Male: It's reasonably and scientifically sound, so...

Reva Winkler: Okay.

Male: ...I'm not sure we have to spend a lot of time on it.

Reva Winkler: Okay, all right, that's fine. Because there are...

(Crosstalk)

Reva Winkler: ...others where we will. Okay, if you're, if you all feel comfortable that there really aren't any major issues and concerns with that measure, then let's go ahead move on to...

Dr. Mitchell Levy: And that would be a, that was a blood culture admit - measure?

Reva Winkler: Yes, correct. Question about it?

Dr. Mitchell Levy: No, I agree, Mitchell.

Reva Winkler: Okay, yes. So we'll move on to Measure 1861, which is the National Healthcare Safety Network Ventilator-Associated Event Outcome Measure. And I will just say that this is a new measure. Previously NQF has had endorsed the measure from CDC on Ventilator-Associated Pneumonia.

CDC has indicated they are retiring that measure, and this measure is intended to replace it. But this is a new measure submitted to NQF. So Peter, I believe you were the discussant for this measure. Would you like to kind of summarize and go through the criterion?

Dr. Peter Almenoff: You mean, 1861, I'm not the discussant for this one.

Reva Winkler: Oh, do I have the wrong one?

Dr. Peter Almenoff: Yes, I'm the discussant of the...

Reva Winkler: Okay.

Dr. Peter Almenoff: ...of the Pediatric ICU one.

Reva Winkler: Okay. My list has you on two, but that's okay. In this case...

Dr. Peter Almenoff: I'd be glad to give you my...

Reva Winkler: Okay, that would be super.

(Crosstalk)

Reva Winkler: Because I think this is one where we're going to have to have some discussions.

Dr. Peter Almenoff: I guess I had some concerns about the new criteria, because in the, when you kind of read through their description or their analysis, they sort of say the data's insufficient to really say whether there's any validity or acceptability of the definitions. And I think they cited a couple of abstracts, but I didn't see any real defined papers.

And, you know, VAP has a history of being problematic to start with, and now this, I think is, is sort of an alternative to VAP, but maybe it's better than the VAP, but still when I looked at the definitions, they were pretty complicated. And so I did have, I mean, I think, you know, I had some concerns about, sort of, how, where we should go with this.

Because the - I guess when you go to the validity piece, they actually talk about the fact that there is not a lot of, there is really not much information here to say that the way they measure it for the new, the VAC, IVAC measure, a concept is valid or not.

Reva Winkler: Okay.

Dr. Peter Almenoff: So, I mean, in their own description they weren't really describing this as being yet a valid definition and system of measurement. And so I sort of have out some concerns about pushing this forward since it does have a history of VAP, you know, which has been a problem in the past, just definition-wise, and I think NQF had approved the VAP concept before.

It's run into a lot of problems with reliability of the definitions and, et cetera, and the radiograph identification of an infection. So this is a, I think, an improvement over the original definition, but yet they still don't say that it's a valid definition and process yet. And there have been some, you know, they did cite some abstract and they did talk a lot about VAP, which has been a problem.

And they talk about it being a problem, so if the concept is, this is a brand new thing and VAP didn't exist and VAP hadn't have been such a problem, that'd be much harder say this should move forward. If this is to replace VAP, which has historically been a problem, and hopefully this will be better, then maybe this is a better process, and maybe we, you know, we probably should at least consider moving forward on it.

So if it's going to replace the current VAP, which has caused chaos in the system, this might be an alternative improvement, but it's still not - at least according to their description, it's still not ready for, it doesn't seem like it's ready for prime time yet.

Reva Winkler: Okay, Shelley, you're on the the line...

Dr. Peter Almenoff: Now, I wasn't ((inaudible)) for the reviewer of this, but I just thought I would, you know, kind of give you my...

Reva Winkler: Yes, no, okay. You know anybody else in the workgroup comments? We do have Shelley from CDC, this in respond to some of her...

Dr. Mitchell Levy: Yes this, so this Mitchell. And I guess...

Reva Winkler: Oh great, welcome.

Dr. Mitchell Levy: So I do a, I need to do a full disclosure, because I was part of the workgroup, and Shelley's going to talk about it in a second, that developed this, these measures. So this was, and then I'll let Shelley speak as well, but there is clearly an enormous amount of problem, or really, honestly a lack of definition of VAP up until now.

And NHSN has been using a kind of very rudimentary and weak definition, and everybody in the field's in agreement about that. And therefore we've never been able to surveil the true incidence of VAP because the definition's never been agreed upon. And over the last two years...

Dr. Peter Almenoff: I can't hear very well. Can this person speak up a little?

Dr. Mitchell Levy: Over the last two years - are you still having trouble hearing?

Dr. Peter Almenoff: That's better.

Dr. Mitchell Levy: So over the last two years there's been a drive by Don Wright and, from HHS, and others to convene a consensus group to build new definitions. And that's what you see here, is the results of that document, with the understanding that none of this has really been tested, formally yet.

But in just some attempt to produce some measures that we felt would give us a chance to do a better surveillance of ventilator-associated conditions. Shelley?

Dr. David Stockwell: Can I ask a question? Do you mind if I - I'm sorry to interrupt. It's David Stockwell.

So I have a question for the folks at the NQF that, I have the exact same concerns that were stated previously. I certainly applaud the effort to get to a more workable VAP definition, and look forward to throwing the old one entirely out the window, that's terrific.



But for the NQF purposes, as I look through the evaluation criteria and guidance summary tables, this, the major gap here seems to be that it's never been field tested. And so, is the NQF interested in encouraging the use of a non-tested measure? And if so, that seems to be appropriate, but that's not how I read the evaluation criteria for looking at all of these items.

Reva Winkler: Right, and David, you're absolutely right. No, we're not. There are some very rare circumstances at this point, that NQF would consider them. But that doesn't seem to apply under this circumstance. I guess one of the questions I had, and I know I've talked with Shelley about this before is, you know, she, the kind of reference or allusion to unpublished or preliminary data, you know, it sort of indicates that CDC is moving ahead with this measure.

Because they are at least getting some good feedback, or getting feedback from preliminary study that this is going to work out, certainly better than the old VAP measure. And if some of that even, data were available, would that be more, would that make the committee feel more comfortable about it?

Dr. David Stockwell: Well, it would for me. I mean, if we are here to base the appropriateness of a measure to be endorsed by the NQF by the current evaluation criteria, then we must have that...

Reva Winkler: Right.

Dr. David Stockwell: ...as I read this. And look, I would love to see this go and work. And I think the only thing from my perspective that needs to be added are some exclusions that weren't in the document that I saw. Maybe I missed them. But I would love to see this move ahead. But as I see it laid out in the evaluation criteria, we just don't have the ability to approve it as it stands right now.

Dr. Peter Almenoff: Yes, this is Peter again. I'm glad at least somebody agrees with me. You know, if you look at the definitions on page 10 and 11, they're also pretty interesting to try to follow that, it's sort of an algorithm of how to determine or not to determine. And, you know, based on, we have problems with people just doing very simple measures, this becomes an even more challenging concept to try to even see whether we can even do this in the field as a measure.

I think we can do it as a research project, but I don't know whether it can be done as an applied measure throughout the country. The other problem is, for us is, we already report VAP throughout the country in all of our hospitals, and we put it on a public Web site. And so I know what's going to happen is that if we do approve it, we'll switch the criteria and we'll be publicly reporting this data, and it's not been field tested.

So that's just some of my concerns. I think it would be good if we had sort of like the in between, like the preliminary measure versus the actual final measure that people might actually go and do. So, you know, I agree with the person who just spoke in that, you know, I think it's a great attempt to get it forward. We really need to do something about VAP.

But it's not even been field tested and, you know, maybe the NQF has to have another criteria of acceptance like, you know, sort of a preliminary acceptance, something that, you know, we don't want the field to think it's not good. We want them to think that maybe this is the way to go, so we don't want to give the field the wrong message.

But we also don't want to give the field something that has not been tested well.

Reva Winkler: Okay. Shelley, did you want to comment?

Shelley Magill: Sure. And, you know, thank you for all of your comments and thoughts and careful review of this. I mean, we certainly appreciate it and, you know, we have been thinking about this and

working on this for quite a while now. And, you know, definitely your concerns are shared and have been shared by us at CDC and by our working group members, as Mitchell mentioned.

So this was a consensus process with the working group members. You know, we had struggled with how to modify this definition for a while, to make it more reliable, as you're all very familiar with, the current pneumonia definitions are very, very complex, and have many subjective elements that just make them unworkable in today's environment.

And so we, you know, we convened this working group to develop this algorithm, you know, really with the intent of getting a lot of input from all of the stakeholder communities, including Critical Care. And the algorithm that you see is, you know, what the group felt was the best direction to go, and kind of acknowledging that, you know, there just simply isn't a gold standard definition for pneumonia, for VAP in particular today.

And so, you know, the NHSN definitions that exist right now are not good, but they're, you know, arguably not worse than anything else that we might choose to use that's out there for VAP right now. So, you know, we did want to focus on reliability. We thought, from a prevention standpoint it was also important to kind of emphasize conditions or complications that occur in the ventilated patient as a whole as opposed to perhaps focusing on a specific entity that's not easily diagnosed.

And I think that, you know, there is some experience, not necessarily with the identical algorithm that you see, but if you're familiar with some of the - there is, actually a PLoS ONE paper that's cited in there by Dr. Mike Klompas at Brigham and Women's and the CDC Epicenters.

And the abstract, you see, there is some experience with variations on the theme of this definition, so there is work that's been done and published looking at kind of the foundational

elements of the definition which is that change in oxygenation or worsening oxygenation after a period of stability or improvement.

And in addition to that PLoS ONE paper, there is a paper that was just published after this submission in Clinical Infectious Diseases. And, you know, although there are elements of the algorithm that are different from what appears in those papers, I think there is every reason to expect that they would perform similarly.

Because again, the key piece of it really is that, that kind of respiratory deterioration piece. There is a little information about inter-rater reliability in that recently published CID article, and in work that appears in that PLoS ONE paper as well as in the abstract, the - a streamlined VAP definition that, again, includes the foundational elements that are in this VAC and IVAC algorithm.

Patients meeting those criteria did have worse outcomes than patients who didn't meet the criteria, in terms of length of stay, duration of mechanical ventilation and even mortality. So I think there is good reason to expect that this will perform well in kind of a real world setting. The Epicenters are doing work right now to look at some of these issues more closely, related to preventability and the reliability issue.

You know, but you're right, we are in need of additional experience with it. That's just the reality that we're dealing with. So I don't know if that's helpful at all, but again, I certainly appreciate your comments and concerns about this.

Reva Winkler: Shelley, this is Reva. What do you think your timeline is for having, you know, some data on this, to be able to respond to some of these concerns?

Shelley Magill: I would anticipate that probably within the next year, you know, as I mentioned, we are moving forward with implementing this in NHSN for 2013. There are a number of things that need

to happen to make that, to get this deployed, so we are, you know, moving in that direction, currently.

But as I mentioned, there is, the Epicenters' work that's ongoing, and I do think that we will have some data, hopefully within the next 12 months or so.

Reva Winkler: Okay. Because I'm just trying to think, perhaps, trying to look at this now might be premature. Because I certainly get a sense from the workgroup that you would be very interested in an improved measure to replace the old one. But you really can't evaluate it now without data, and perhaps we can work out something to look at this, maybe in 12 months, when we do have data that is, can respond to the various questions and criteria.

And it just might be premature at this time. Thoughts from the workgroup?

(Crosstalk)

Male: Go ahead.

Reva Winkler: Yes, who was talking?

Dr. Mitchell Levy: It's Mitchell. So it's a Catch 22. I totally agree that it's too soon to accept measures that really haven't been subjected to reliability and validity testing. I also feel that part of the reason why we needed these measures is the current measure is truly unreliable and not valid, which is why, fortunately, CMS has never used it as a pay for performance, because the agreement is, is the definition is just inadequate.

So it does sound like it's - it sounds like it's appropriate to wait. Part of the impetus for this happening and it being submitted is the sense that CMS might move ahead with the inadequate definition of VAP that's already being reported, and make it a pay for performance.

And so there is some feeling that this current set is better than the one that has been previously used. But I can understand the reticence of the group not to want to push something forward that doesn't meet the criteria that we're being asked to apply to all the other measures.

Reva Winkler: Right. This is Reva. Shelley, I just want to verify, but CDC has basically pulled out the old VAP measure saying that this is the planned replacement. So NQF's course with that, is that measure is going to lose its endorsement from us during the course of this project regardless of whether this one actually goes forward at this time.

Male: That's the best thing I've heard all day.

Reva Winkler: Okay. I mean, Shelley, you're, I mean, CDC has said...

Shelley Magill: I meant find it.

Reva Winkler: Yes, that they're retiring it. So it's on our retired list. You're going to find when we give you the documents for the meeting, that there are - I can't remember how many, eight or ten measures that aren't, that had been previously endorsed that, for a whole variety of reasons the developers are not pursuing them for continued endorsement, and the old VAP measure is on that list.

So it will lose its endorsement during the course of this project. So it does - so the two are not strictly tied together. So we can lose the old VAP measure and maybe wait a while before replacing it with the new one when we get more data.

Dr. Peter Almenoff: And this is, you know, Peter. You know, I think that's good if we can, if it can be retired. Maybe we just need to have a honeymoon period. You know, the concern is, if we do agree to move this measure forward and then next year we find there are more problems with it...

Reva Winkler: Right.

Dr. Peter Almenoff: ...and then we have to make more modifications, this is going to be a measure that will never live to see the light of day again.

Male: Yes.

Reva Winkler: Right.

Dr. Peter Almenoff: Because we can't just keep saying, you know, we didn't get it right, we're going to do it again.

Reva Winkler: Sure.

Dr. Peter Almenoff: So, you know, I'm...

Dr. David Stockwell: And in that...

Dr. Peter Almenoff: ...not sure how, you know, the sponsor feels, but if they think within a year it's going to be ready, it might be good just to get everyone to stop thinking about VAP and their distaste for it, and then, you know, when the data comes in that this is really what we're going to do, then we go ahead and review it and hopefully approve it. And then it goes into the system.

If we approve it now and it's got problems again, you know, everyone's going to see it's had problems for, it's got problems again, this is never going to be right. And that's just some of my concerns. But I, you know, the other concern was, that somebody brought up, it's a Catch 22, and I think you resolved that by saying, we'll retire the other one anyway. And so maybe there'll just be a small period of time where we won't have one...

Reva Winkler: Okay.

Dr. Peter Almenoff: ...until this one is ready to go, and then we'll put this in, you know, then this would go into the system for use.

Male: Okay.

Reva Winkler: Because one of the things we can do in the report out is to indicate that there is support for an improved measure, and it's just not ready yet, and when it is, we're looking forward to evaluating it after we've got some testing data and some experience with the measure.

Dr. Mitchell Levy: And I think if you add to that, acknowledgement that the old measure is being retired, it then becomes a very powerful statement.

Reva Winkler: Okay.

Dr. David Stockwell: Can I offer - one thing that I didn't note in the definition, and maybe I missed it, but I, there are several reasons for potentially having an increased oxygen requirement, and it may be that you have a catheter-associated bloodstream infection that's caused you to have ARDS. You may have a stroke and get ARDS as a result of that.



I would think about adding in some exclusions so that you're, one, hospitals aren't double counting a BSI and a ventilator-associated complication. And just make it very, very clear for the users what's going to end up in what column so that it can be as workable as possible.

Male: But if you look at the definitions, it looked like fluid overload would trigger this every time.

Shelley Magill: And this is Shelley, and Mitchell can certainly comment as well but, you know, with this new algorithm, we are recognizing that, you know, even with the current definitions, or perhaps particularly with the current definitions, we are not accurately identifying VAP. We are identifying lots of other things too, including CHF, including ARDS, including lots of other things.

So this algorithm is not, you know, intended to be specifically identifying patients with VAP. We know we're going to get patients with other conditions and complications. And again, the thought is that, you know, if they have that period of stability or improvement and then they get worse, you know, there has been potentially a complication of care and that we would be interested in capturing that from a prevention standpoint.

So, you know, you're absolutely right, there are, you know, a patient can be septic and have a decline in oxygenation as a result of that, not necessarily related to primary infection of the respiratory tract. And we will have this...

Dr. David Stockwell: And I didn't see that algorithm - you know, I didn't see the flow chart of how the sepsis related increase in oxygen requirement would be removed from this category, and it...

Shelley Magill: It won't be removed.

Dr. David Stockwell: Okay. Now, what if it...

Shelley Magill: There are care rules within NHSN around secondary bloodstream infections, and whether a bloodstream infection is secondary or primary. And there will be operational guidance about when a user can check that secondary bloodstream infection box for this algorithm. But you're right, there will be circumstances like that, that, you know, will result, will trigger the VAC or IVAC definition or determination, and could potentially...

Dr. David Stockwell: But I guess...

Shelley Magill: Go ahead.

Dr. David Stockwell: Well my hesitancy with that is that, if you have an increased oxygen requirement as a result of sepsis for one reason or another, is that ventilator-associated? I mean, we have to, the clinicians have to sort of buy into the concept. And so if - I, how is sepsis ventilator-associated?

Shelley Magill: It's a process that has occurred in a patient who is being mechanically ventilated after a period of stability on the ventilator. So it's not necessarily, you know, we're not, I guess, making statements about the ultimate, kind of, causality of that. But it is a complication that occurred in a patient who is mechanically ventilated.

And to the extent that we can learn about what those things are and how to prevent them, you know, this, I think is a useful approach. Again, because, you know, with the VAP definitions now we're also capturing some of those patients. I mean, we're not - the universe of patients who have a pneumonia or VAP event right now includes lots of patients who don't actually have VAP. And we're missing a lot of patients who actually do have VAP.

Dr. Mitchell Levy: And I think the other important thing that I think is in, is, there's no question this has gotten more vague. At the same time, the specificity of the previous includes anybody who gets an infiltrate within the first 24 hours of admission. So we've done away with that. We've stopped

the validity measure that actually gives - a hospital gets dinged for a ventilator-associated pneumonia in a patient who comes in with (sound) down on the outside.

So that's a huge step forward. So there is definitely a kind of balance between getting a little more vague and a lot of concerns about that, and at the same time getting more rigorous, so that there's clearly a period of stability of a patient on a ventilator before a condition develops, before you can call it a ventilator-associated condition.

Dr. David Stockwell: I guess I would just consider maybe changing the language. Because some of these things we're talking about aren't associated with a ventilator. And look, I'm a Pediatric Intensivist, and we don't even sniff that VAP definition, because it's inapplicable to our patients. And so, that's great, and I'm glad that this is moving forward.

But I guess if we're going to call something ventilator-associated condition, I think that the clinicians out there, for them to buy into it, harking back to what Peter was saying earlier, it should be ventilator-associated, or the name should change.

Reva Winkler: All right. I think we're going to have to move on to discussion of the other measures. And I thank the, Mitchell and Shelley for being part of that conversation. So I think the next measure we'd like to talk about is 0334, which is PICU Severity-adjusted Length of Stay. And Dr. Stockwell, I think this was one you were leading.

And in general, if we look across the ratings from the three folks who submitted their ratings, generally it seems to be rated quite well and high, and - but, any comments, please?

Dr. David Stockwell: It's David. I guess I'll start it off. I think that I was fairly comfortable with this. This is sort of a known approach to measuring pediatric ICU length of stay with a very well validated

measure using PRISM III. So I think that the experience of using it is out there, and as I recall I don't think I had a lot of problems with this.

Reva Winkler: Okay. Yes, it - the one thing I would just mention, in looking at the submission information is, there really wasn't much entered under reliability testing yet. Further down on page 9 they talk about this, these data elements, "Our numerators, denominators and all definitions are standardized with an interrater reliability of greater than 96%."

And so it just isn't necessarily inserted right in the best place for it. I had one question, just for clarification, in terms of specification, it's actually a subtraction of dates, or are we looking at hours, when you're talking about, you know...

Dr. David Stockwell: I've always thought this was dates, but I don't know. Is there really somebody from VPS on the call?

Reva Winkler: Yes...

Dr. David Stockwell: Maybe they can...

Female: Christine Gall: Gall should be on the call. If she's on the public line, Operator, can you open her...

Operator: Sure. Ms. Gall, your line is open.

Christine Gall: Oh, can you hear me?

Reva Winkler: Yes, now we can. Thanks.

Christine Gall: Hello - oh, hi. Hi everybody. Actually the way VPS calculates the length of stay is, we go down to the minute and then roll it back up to the hour, because we collect both date and time of ICU admission and discharge. So that is how we use that tool, and that's consistent with how it was developed.

Male: Okay.

Reva Winkler: Are there any other comments, because I think generally everyone felt it met the importance criteria, met the scientific acceptability criteria...

Dr. Peter Almenoff: Well I think - this is Peter. I just, one thing, you know, we do a risk-adjusted length of stay also, and we've found, at least in the ICU what was happening was people were physically - on paper, moved to another location, yet they were physically still in a location. So it's very easy to game the measure.

And that's why we sort of went to a hospital length of stay. We do an ICU one, but we also do a whole hospital length of stay, which includes the ICU stay, because of the gaming. And we do it all electronically, but they can still game it, because electronically they'll basically still physically be in the unit, but they are - on paper, they're still somewhere else because they haven't been moved yet.

So just, as an FYI, I mean, the measure's okay, I'm telling you that it's easily to game, you can game this pretty easily.

Reva Winkler: All right. One other question I just wanted to clarify, Christine, is in, when you, on the specifications when you talked about the risk models, you talked about selection criteria for risk adjustment tools, and then you talk about the PRISM III meeting those criteria, but is the specification for this measure to use the PRISM III model for, absolutely no others?

Christine Gall: Yes. This tool spec requires PRISM III.

Reva Winkler: Great, okay. I don't know, at least my reading of it, I wasn't totally clear, and it's good to verify that. Are there updates or updates to PRISM III that are done regularly?

Christine Gall: We, the team, our analytic team is in the process of doing updates. We have intended to do it very frequently, however we transitioned our application from one desktop module to a Web based module, and that took, absorbed a little more resource than we have intended.

So we're now back on track and we have our analytic team ready to focus on this. We now have data in the Web-based model approaching 200,000 records, so we feel confident that we can revalidate the tool and the very - and then we plan to do that at least, I think the plan is annually.

Reva Winkler: All right. And...

Dr. Peter Almenoff: Were you planning on doing an acute care risk-adjusted length of stay?

Christine Gall: Acute care?

Dr. Peter Almenoff: Yes.

Christine Gall: Not in our immediate future. However, we're approaching, we're thinking about approaching first the intermediate level of patients. I appreciated the comments earlier about gaming or gamesmanship, whether intentional or not. You know, we have challenges to length of stay that relates basically to the structure of the institution.

For example, intermediate care, if there's a separate intermediate care unit within an organization, just that structural element alone can impact the comparative length of stay. So we want to approach, we want to go to that level, in possibly acute care. We're looking at other surgical and trauma type populations as well.

So my - based upon the previous conversations I've had with my team, I think that that is definitely possible in the future.

Dr. Peter Almenoff: And then we, and, you know, in the acute care, I mean, it does include the ICU and the wards, so it goes together. So it would be too hard to build one just for the ward, because the death rates tend to be too low.

Christine Gall: Right, right.

Male: Just to catch people up about what VPS does, VPS is only a group of intensive care units. As I understand it, you guys haven't expanded out beyond that.

(Crosstalk)

Christine Gall: Critically, we are critical - yes, pediatric intensive care, yes. We have currently 118 ICUs participating.

Reva Winkler: Do you know if this measure is used by hospitals that are not VPS participants?

Christine Gall: The risk-adjusted length of stay?

Reva Winkler: Yes, or any of these measures, but yes, particularly the risk-adjusted ones.

Dr. David Stockwell: I think to participate with, presume it's a proprietary risk-adjustment model, you have to participate with VPS, isn't that correct?

Christine Gall: Currently, yes.

Reva Winkler: Okay, so PRISM is not available to anyone else unless you participate in VPS, okay. I mean, I think that's a usability issue. Okay, any other comments, thoughts, concerns by the, from the workgroup members on this measure? But you generally, it looks like you generally feel comfortable with it, and have rated it as meeting the criteria.

All right, then let's move on to Measure 0335, which is the PICU Unplanned Readmission Rate. Who was the discussant here? My list says Dr. Levy. Have you had a chance to look at this, Dr. Levy?

Dr. Mitchell Levy: No, I haven't, unfortunately. So I'm not prepared to do that. I have been traveling extensively for two weeks, sorry about that.

Reva Winkler: All right. Thanks for being here today, then. Then if you look at the spreadsheet, I think that there are a couple of questions raised by David and maybe a little bit from Peter in terms of their criteria for importance. High impact seems to be there. Opportunity for improvement, David you weren't so sure about that.

Readmissions are typically felt to be more of an outcome than a process measure, so the evidence doesn't have to be quite the same level for process measures, but I think you had some concerns about this one. Do you want to talk a little bit more about that, David?

Dr. David Stockwell: I guess, yes, and it's based in two things. One, if I recall correctly, I don't remember a lot of evidence to support the, that this measure is something that does have real impact, and



that combined with our own experience, we've been tracking 24 hour readmissions for about three years.

And for most of the time in the PICU it's either the seizure patients or often bronchiolitic patients that just change ever so slightly, and there doesn't seem to be any area for opportunity for improvement that we've noted. So I guess I'm biased a little bit by our local experience.

But I certainly support the idea of reviewing these readmissions as something that any ICU should do as an outcome of their care. It's just, we've been doing it and I'm not sure it's changed a whole lot of what we've been doing.

Reva Winkler: Does VPS have any trend data for this, to see if your participating hospitals are changing their performance?

Christine Gall: Actually, yes. We do track, comparatively, every participating center. And, you know, we've had experiences that run the gamut from not much change to some pretty obvious changes. The comment earlier, I don't know who made it, is accurate that there's definitely a low occurrence of unplanned, unscheduled readmissions within 24 hours to the PICU.

So it makes determination or - it makes usefulness of the measure in itself sometimes challenging. However, what we've seen over time is, we have seen some cyclic patterns that tend to be influenced when the entire hospital is full. And then decisions to transfer or discharge a patient earlier than would have been preferred, has occurred.

We also, related to the other measure of the evaluation of the unplanned readmission, with the ability to categorize contributing factors in the areas of, you know, was it a systemic factor, was it an issue that the hospital was full or there wasn't an ICU bed? Was there an issue related to the

receiving unit that they may not have had the competencies that this particular patient, or the staffing ratio to support the care and the observation that that patient needed?

Was there, perhaps a decision that was determined in the course of the review to be, maybe incomplete in deciding to transfer a patient out? So I think as we get more experience with these two measures together, we definitely have opportunities, I think, to learn.

Because, you know, while one center may have low numbers, aggregately, we have the ability to really look at factors that seem to be influential, you know, overall, and then factors that seem to be influential, you know, given a set of circumstances, like the ratio of acute care beds to critical care beds seems to be a factor that has influenced this. So definitely, we're looking at trends.

Dr. David Stockwell: I think that's in, very interesting points that you bring up. Has any of that been published? Because I don't see it in the applications.

Christine Gall: Not yet, not yet.

Reva Winkler: Well, I mean, if there's some way we could get a summary of some of that to include, I think that's very informative to really explain, sort of, the big picture on the use of this measure. So perhaps we can work with you to try and get some of that information included in the measure information.

Christine Gall: Okay. Okay, sure, (Katy), should I work with you offline on that?

(Katy): Yes, we'll do that.

Christine Gall: Okay.

Reva Winkler: So we'll try to get - yes, David?

Dr. David Stockwell: Can I ask a question? I struggled a little bit with the difference between 0335 and 0336, and wonder, is this is an opportunity to harmonize, I believe is the term that you guys like to use. And if we could - could we talk about what the difference between these two things are, and what the intent of the difference are?

Reva Winkler: Sure. Three three six, Peter was this the measure you were reviewing?

Dr. Peter Almenoff: I was wondering, maybe, if Christine wouldn't mind tackling it.

Reva Winkler: Sure.

Christine Gall: Oh, okay. I'm sorry, I didn't want to speak out of turn. So, I think that as a benchmark or as a starting place, having an understanding of the rates, the raw rates, the unplanned readmission rates is really an important start. From that evaluation you can see things, like seasonal trends.

You can look at whether or not there seem to be patterns related to staffing changes. For example, did you get, you know, if in July when the new group of residents or fellows comes in, do you see any decision making? For - another example is, how do you staff your unit? Do you have 24/7 in-house attending coverage, or alternatively do you rely on fellows to run off-shifts with attending support via phone, and in person as necessary?

So I think that based upon looking at the rates themselves, you can come up with questions that are important to ask. And then, I think, I agree, the 0336 is complementary to that. Once the questions are asked, how do you systematically evaluate factors that might have contributed to a potential pattern you might be seeing?

And that's where the documentation and the categorization of pretty infrequent events over time, hopefully, you know, helps to inform those questions. So I see that there could be an opportunity to harmonize, although I do think that each of these measures kind of looks at the question from a different level. Does that help?

Dr. David Stockwell: So...

Reva Winkler: Do we want to just look at the details to 0336 so we know what we're talking about?

Christine Gall: Was that to me?

Reva Winkler: Well, I guess, I had the question because when I read the numerator denominator description of the measure, I have to admit I was a little bit confused as to exactly how this 0336 works, which is review of unplanned PICU readmissions, and described as periodic clinical review of unplanned readmissions to the PICU that occurred within 24 hours of discharge or transfer.

Is that a yes or no answer? Is it a percentage of something?

Christine Gall: The - yes or no, did it occur, but then there's a categorization of the contributing factors to that review. So was, were the contributing factors related to the receiving unit? Was it determined that the transfer back was truly not clinically indicated, but for example, the resources on the receiving unit were either insufficient or not of the appropriate competency to manage that patient's non-critical issues?

That's one example. So there is various categories that allow you to basically code the contributing factors that can over time be aggregated.

Reva Winkler: Members of the workgroup, what are your thoughts on Measure 0336, the review of the unplanned readmissions? David, your ratings are on the low side. You seem to...

Dr. David Stockwell: I didn't understand it, because I had a little bit of the same concern that you expressed about what does this actually mean? I feel like if I took this to our staff and said, okay we want to implement this measure now, I couldn't explain it to them. And that may be my problem, I'm certainly willing to admit that.

But the, I guess one of the assumptions is that 0335 is just a straight rate, and - but I guess where I'm stumbling is with the language of unplanned. Unplanned seems to me to be some kind of clinical determination, meaning therefore someone has reviewed it. And so if you are just taking all readmissions within 24 hours and calling that a rate, and that's 0335, then that makes sense.

And then 0336 is actually to do a clinical review of those readmissions within 24 hours, then that makes sense. But that's not what I read between the two, and maybe, and if somebody could just clarify that for me, that'd be great.

Christine Gall: I can clarify the definition of unplanned. And I'll do that by contrasting a planned readmission to the unit. Let's say somebody has cyclical surgical interventions or procedures, that following that procedure they need a period of recovery or monitoring in the ICU, and that occurs with some frequency.

Those, so we differentiate between that type of planned upgrade in care from something that was not previously planned. And that's the difference between unplanned and planned readmissions. We really want to focus on those that were not, the upgrade in care was not anticipated or intended.

Dr. David Stockwell: But doesn't that require a clinical review? And if so, then how is that different than 0336?

Christine Gall: Well, so the coding of planned versus unplanned has definitions in itself. And that is that the team was aware that the patient was going to arrive to the unit within 24 hours. So for example, you know that this patient who you just transferred out to the acute care intermediate floor, tomorrow is on the surgical schedule for whatever.

And you know that post-operatively that patient is going to come back to you, that would be considered planned. So it's in the collection of the data, so to speak.

Dr. David Stockwell: Well, maybe the other part of my problem is that we're a VPS client and, is this something that all of your clients are participating in? Because when I spoke with our reviewers, we are not asked to determine whether or not readmissions within 24 hours are planned or unplanned, as I understand - as I was told by our guys.

Christine Gall: Actually, that's not exactly accurate. Every admission that your data collection team enters, there is a field that requires them to say scheduled or unscheduled according to the definition. The calculation of unplanned readmission, though, is made on our end. It's behind the scenes. There's no additional data collection that needs to happen.

We just know that within the - we will track patients from the time that they left the unit till the time they came back, and if they fall within that 24-hour threshold, we then look at the additional field of scheduled or unscheduled in order to calculate this rate, you know, that being the numerator.

So it is something that is based upon the data collection that the data collectors do that we then calculate.

Dr. David Stockwell: Okay, so that's helpful. So now let's go to 0336. Three three six means that of those that are unplanned, your, this measure is looking somehow for additional factors. And you don't have to go into them again. I completely understand what could lead to those factors, but that the individual ICU should go back and review those, and I didn't understand, does that mean that this is a sample, or it's a complete comprehensive review, or...

Christine Gall: It is a, the module is available in VPS, and it's totally voluntary. So for the teams that choose to collect, they can choose to collect these data. So typically the teams will review this at a monthly M&M or whatever. There is then a module that they can go in, where all of the unplanned readmissions have been populated, and they can then click off the, you know, the results of their review.

So was the reason for readmission a deterioration in patient condition related to the initial diagnosis, or a new diagnosis? So there's a series of reasons that can be documented over time. So it's not a required or mandatory field in VPS. It's something that's totally available if centers want to use it. And then there's an on-demand report that they can print off as needed. So that's how it works.

Dr. Peter Almenoff: That was kind of my confusion also is, I mean, if you're going to do 0335, why would you not do 0336? And why is there not one measure? I'm kind of wondering why you would review a hospital, look at the unplanned readmissions within 24 hours, calculate it, get a number, and not pay any attention to it. That just seems...

Christine Gall: Well I guess, so if...

Dr. Peter Almenoff: It seems kind of odd that, just, you know, we had to do 24 hour reviews. That's sort of...

Christine Gall: Right.

Dr. Peter Almenoff: ...used to be Joint Commission to...

Christine Gall: Right, we, there's some teams that don't have any issues. They have no unplanned readmissions, so I guess the rate is the baseline to see if there's an issue. And then the review of any unplanned readmissions occurs when an issue is identified.

Dr. Peter Almenoff: Okay.

Reva Winkler: This is Reva. I'm still struggling to really understand how this functions as a performance measure, because on page 6 on 0336, under the calculation algorithm, it says, "There is no better score." I mean, what does a score on this measure look like? And can it be used to compare one hospital to another?

Christine Gall: I think that the, this measure, the unplanned rates, 0335, is definitely something that you could look to do a comparison between organizations. But the factors that influence that rate, I think, is it appropriate to compare them? I think we need a little bit more information. We need more documentation to determine, you know, are there - if a ratio of acute care to critical care beds, for example, falls below X.

Or if the average tenure of the nursing staff on the intermediate unit is below X years, that, those seem to be triggers that might increase this rate. I mean there are things that this could contribute to the body of knowledge, and I think how hospitals decide to structure and manage their...

Dr. Peter Almenoff: Reva, at least the way I kind of read this was that, in 0335, let's say you have a 10% readmission rate within 24 hours to the unit. Then Measure 0336 would say, of the 10% that got



readmitted, 50% or 75% of them were reviewed. I mean, that's what it looks like, you know, had a clinical review of the implications. You should get a percentage for both.

Christine Gall: Yes, there's a review rate and then there is an assessment of the appropriateness of the initial transfer out of the unit, the appropriateness of the receiving unit, and then the appropriateness of the transfer back to the unit, as well as contributing factors for the readmission. You know what might help is, I could send a screenshot of how we document this, if you'd like. And that might help understand.

Dr. David Stockwell: I just think it needs to be, the definition needs to be - the numerator statement, the denominator statement, to me, I can't tell the difference between those two things. And so, you know, I think you're hearing some confusion from so many other people. I think that the worksheet needs to perhaps go back and think about how to better define exactly what the measure is.

Christine Gall: Okay.

Reva Winkler: Also, can you give us some examples, since it's in use, of what the results are? I mean, you know, you've given us the unplanned readmission rate range of, what is it, 0% to 3.14%, I get that. That makes sense.

Christine Gall: Okay.

Reva Winkler: I'm looking for the similar data for this - for 0336.

Christine Gall: Okay. So we've really treated 0336 in a non-comparative format, I guess, is the best way to say that. We feel very comfortable re-evaluating and comparing 0335, because the definition is

very standardized. However the factors that may influence the unplanned readmission rates might be obvious and may not be.

So we have treated 0336 more as something for internal inquiry to be able to explore what might have contributed to that rate. And starting with the percentage of those unscheduled readmissions that are reviewed, that's the benchmark. Obviously we could compare that rate, but then deeply diving into the factors that are influencing.

So I think what I hear you saying, and something that we could definitely provide is the percentage of unplanned readmissions that were, that had a review completed. That would be something we could, that could be comparable easily. But then the factors that contributed to the unplanned readmission, as determined through the review process, I think would not be something that we would want to compare at this point until we get more experience with it.

Reva Winkler: Then the question I would ask workgroup members is, is this review, and I understand the importance of it, certainly from an internal quality improvement perspective, but is this the kind of performance measure you would want to use for comparative purposes, accountability, public reporting and some other very external uses?

Dr. David Stockwell: My - this is David. My thoughts would be that it would be somewhat similar to, do you use steroids in asthma? Yes, right, yes, and we review these measures. You know, we review our readmissions, and so I don't know if there's a lot of utility in saying, how many of you hospitals out there, or how do you guys compare to each other about reviewing?

Because I would assume that, as somebody had said earlier, you're reviewing them. I mean, this is just sort of an obligation.

Dr. Peter Almenoff: But David, does everyone do 100% review of every readmission?

Dr. David Stockwell: We do.

Dr. Peter Almenoff: Do we know, of the country, if everyone does 100% review? I mean, we don't.

Christine Gall: Well I can tell you that the answer to that is no, based upon what people have told us.

Again, the documentation of this module is not required in VPS, so I can't say that 100%, but as we review data with every center, there are some centers that do not routinely incorporate this into their M&M or other QI activities.

Dr. Peter Almenoff: Well that would give me some idea as to how aggressive their safety program is, if people get readmitted within 24 hours and Hospital A does 100% review, and they really take it seriously, and Hospital B does only a 30% review...

Dr. David Stockwell: Well, I'll give you that, it would certainly be a lot more workable than as it reads right now.

Dr. Peter Almenoff: Yes, I guess maybe I read it as - in my simple mind I read it as that percent. I didn't realize they were breaking it out into all those subcategories, which is very confusing.

Reva Winkler: So am I hearing that as presented to us right now, we have lots of concerns? And we've had, given feedback to the developers, and that perhaps if they want to, you know, reformulate some of the responses in here to respond to these questions and concerns, perhaps that will clarify things for folks and, you know, we might think differently about it.

Male: I agree with that ((inaudible)).

Reva Winkler: Thoughts?

Female: Yes.

Reva Winkler: Okay. So Christine, you know, you've heard the conversation.

Christine Gall: Yes.

Reva Winkler: We'd be happy to work with you, (Katie), (Jessica) and I'd be happy to work with you if you would like to kind of re-do this, because I think it's not really telling a story that's readily understood by audiences in terms of what the measure is, whether it's intended for accountability, public reporting, what the current - what a performance result looks like, and that sort of thing.

Christine Gall: Okay, sure.

Reva Winkler: So we'd be happy to work with you just to see if we can clarify things.

Christine Gall: Okay, what is the time frame to do this?

Reva Winkler: We would need it back before the meeting in March.

Christine Gall: And what date is the meeting in March?

Reva Winkler: Twenty-first, twenty-second.

Christine Gall: Okay. That's absolutely doable.

Reva Winkler: All right. Okay.

Christine Gall: Thank you.

Reva Winkler: That would be helpful.

Christine Gall: And thanks for the comments. I - that, when, being in the weeds with this all of the time, I can understand your perspective and I appreciate the feedback. So I think we can clarify this sufficiently, based on what you've said. Thanks.

Reva Winkler: All right. That's one of the benefits of having these preliminary reviews. Okay, we're moving through these measures, so the next one, 0341 is PICU Pain Assessment on Admission. And then a very similar measure is 0342, which is PICU Periodic Pain Assessment. These, Dr. Larson has been the lead on, and she's unable to be with us today.

So I will just kind of do what I've been doing. For the pain assessment on admission, 0341, this is the percentage of patients receiving a pain assessment. For the four folks who rated it, generally it looks like the ratings are high across the board. And all four folks thought it met the importance criteria. Any comments from the workgroup members?

Dr. Peter Almenoff: You know, the only comment I have, and this doesn't necessarily pertain to this one is, when you go to validity, and everything under validity is N/A, N/A, N/A...

Reva Winkler: Right.

Dr. Peter Almenoff: ...but we don't have an N/A box...

Reva Winkler: Right.

Dr. Peter Almenoff: How do you, you know, maybe we need an N/A box, or maybe they can't put N/A.

Reva Winkler: Right. Well, that I think was supposed to be...

Dr. Peter Almenoff: I've noticed on a couple, so I kind of put my hands up and said, I don't know what to do there.

Reva Winkler: Okay. I think that points out...

(Crosstalk)

Reva Winkler: Okay, I think that applies more to the scientific acceptability, but in terms of importance and opportunity for improvement, they're noticing, or they, the results show the completion rates for the VPS participants of 83% to 100%. So I don't know how that breaks out into deciles, how many are in the 100% and how many are substantially below that for the opportunity for improvement.

But are there any other concerns on the importance criteria from the workgroup members? Okay.

Dr. Peter Almenoff: No.

Reva Winkler: All right. In terms of scientific validity, or scientific acceptability, Peter's concerns are noted that we really just don't have information on the validity. And I think that probably the technical group or the people you work with, Christine, you know, sort of based it on the face validity, which is very common for performance measures, and sort of using that to respond to that question might be useful.

Are there any other comments on the scientific acceptability from the workgroup members? I guess one thing I'd like to ask about is on page 5, under the specifications, you have, under

numerator time window, "Pain assessment on admission equals will be defined by each PIC or policy statement in compliance with the Joint Commission expectations."

I don't quite understand that, because that doesn't seem very specific or very standardized.

Christine Gall: That's actually true. What we started out with is, after surveying the VPS participants we realized that everybody's internal policy related to the collection of a baseline pain assessment was variable. There was no standardization. However, at a minimum they needed to meet whatever the Joint Commission had required.

So, we didn't, we weren't prescriptive there, and that was intentional. We wanted, number one, for centers to document that according to their own internal policies.

Reva Winkler: How do you collect the data, then?

Christine Gall: It's simply a yes/no. Was the periodic pain assessment done for this patient, yes or no? Or sorry, the baseline pain assessment at admission, according, in accordance with your policy, yes or no.

Reva Winkler: Oh, because you write, you say that the numerator details that you collect the ID, time, date and time of admission, documented pain assessment value and the pain scale, and the date and time of the initial assessment. So those are the data fields that you collect.

Christine Gall: That's accurate as well. Sorry, I just meant for the reporting of the measure, the numerator is all of the yes's, the denominator is all patients. But yes, in order - all of that is documented.

Reva Winkler: Is, and I'll ask maybe David or some of the other clinicians who do this, variations in pain scales that people might use...

Dr. David Stockwell: Yes, I had a question about that. I don't know the pain - I can't quote them to you chapter and verse, but is that fairly standardized, so that each individual center knows exactly which ones that they should be using?

Christine Gall: We, again, that's another area we don't prescribe, although every center, in their internal policies, and I believe this is dictated by the Joint Commission, must identify the validated scores and scales that they use. So do they use faces? Do they use a Likert scale, you know, the ten point scale, what are they using?

And then, obviously their assessments have to follow whatever their internal policy is, so that's the approach we've used.

Reva Winkler: I guess the other question I had was, on admission, what's the time frame for that?

Christine Gall: Again, the admission assessment, so that is dictated by internal policy. In some organizations it might be within the first 15 minutes or the first hour. Whatever is determined baseline or on admission is what is followed then to determine yes or no to that response.

Dr. Peter Almenoff: I mean, the overall intent of the measure is to make sure they're doing the pain scale, but you don't to be prescriptive in which pain scale to use because that would never go anywhere, and...

Female: Correct.

Dr. Peter Almenoff: ...you'd really basically have to comply with Joint Commission standards, which is written in your policy.



Female: Right.

Dr. Peter Almenoff: So you're basically just going to report Hospital A is doing their pain assessment within 80%, you know, within their expected time.

Female: Correct.

Dr. Peter Almenoff: Right.

Reta Winkler: So it's really an assessment of performance against the internal policy. And those policies are....

Dr. Peter Almenoff: But it's a requirement that everyone have a pain assessment.

Female: Right.

(Crosstalk)

Dr. Peter Almenoff: They just don't want to be prescriptive of which one because that would create a nightmare for everybody, because everyone uses - there's not, probably one better than another, but every hospital has their personal feeling about which one they like.

Female: Absolutely.

Male: And some hospitals have more than one.

Dr. Peter Almenoff: Right.

Female: Yes.

Dr. Peter Almenoff: And then the timeframe, some scales might be supposed to be used in 15 minutes, some might be used in a couple of hours, so you can't really put a number there, because it's based on internal policy. So as long as they're following it..

Reva Winkler: Okay, so essentially this measure is an assessment of whether the hospital is, follows their internal policies, rather than an assessment of - but there's no evaluation of those policies.

Female: Correct.

Reva Winkler: The thing I would ask the workgroup then is, do you feel that the measures are sufficiently specified for comparative accountability purposes?

Dr. Peter Almenoff: I think it's - I'd love to see the variation across the country. If the number is 100% across the country, it's probably not a big, it's not a valuable measure but, you know, there are a lot of places that don't follow their own internal policies, and that's what you'll see in the reports, which I think is very valuable.

Reva Winkler: Christine, is that data that perhaps we could get from you, the variability?

(Crosstalk)

Reva Winkler: Yes, you know, ranges on performance for hospitals, break it down just a little bit more?

Christine Gall: I can see what I can do there.

Reva Winkler: Okay. All right, any other comments on - 0341 is the initial pain assessment. The three of you that reviewed it said that it, yes, it met your scientific acceptability. You rated it high to moderate on usability, high to moderate on feasibility, and all of you felt it was, met the criteria for endorsement.

Any other thoughts or comments, issues or concerns about this measure? Okay. We'll see if perhaps we can get a little bit more of the details on the data for the hospitals that do report to VPS. When we go to Measure 0342, this is a periodic pain assessment, I think the only thing that's different compared to the initial, or on admission pain assessment, is that it's done periodically.

But essentially, Christine, is it really minimally different from the other measure except for the time frame?

Christine Gall: The ongoing nature and the assurance that pain is monitored throughout the ICU visit is the main distinction. And whether that is - Joint Commission requires at minimum of every six hours, there are hospitals that I'm aware of that actually tighten that up to an every four hour window.

So again, this is following their own internal policy with the awareness that their policy better at minimum meet the requirements of the Joint Commission.

Dr. Peter Almenoff: So is six hours Joint Commission standards?

Christine Gall: Yes.

Dr. Peter Almenoff: Okay. And if they do it every four hours, that's okay?

Christine Gall: Sure, absolutely. So it, my point there was, there are a couple of hospitals that have actually tightened the requirement to four hours. I don't know if that was intentional or if they weren't aware of, that they were exceeding the Joint Commission requirements. But, so in those instances we instruct sites that they need to be in accordance with their own internal policy.

Because if the Joint Commission came in, for example, and they would look first at the standard, but then they would look at policy, and if sites weren't following their own policy, they would take issue with that as well. So that's what we have, that's the approach we've taken.

Dr. David Stockwell: What do you guys see as the benefit of splitting these two things out?

Christine Gall: I think initial - from a nursing perspective, absolutely - and a care perspective, I think it's really important that not only was there a baseline assessment and a plan of care developed around the baseline assessment, but then ongoing, the evaluation of the effectiveness of that intervention needs to be monitored over time.

Dr. David Stockwell: But if they, it, wouldn't it hold it to a higher standard if you were combining them as one and saying that you wouldn't get full credit for either initial assessment or ongoing assessment, you just get credit for pain assessment, and pain assessment is defined as admission as well as ongoing assessment, wouldn't that be a stronger measure?

Christine Gall: I see that point. I think that the, if you focus on just the initial baseline admission assessment, that that then allows you to determine whether or not the development of a plan of care really started with consideration of pain as one of the factors.

And then the ongoing, I've already mentioned what I think the intent of that is. But certainly if, it would be of benefit to merge these measures, I'm not sure if merging them though would get at both of those distinctions easily. But that's just my thought.

Reva Winkler: Any other thoughts from the committee members? In general it looks like you've rated this measure to meet the criteria. Is this another one where perhaps a little bit more detailed current performance data may be helpful to the committee, how it's performing nationally? And we can see...

Male: Yes.

Female: Yes.

Reva Winkler: We can see how we can work with Christine on that. Any other comments on either of the pain assessment measures? Okay. All right, then we move to our last measure, which is the 0343, which is the PICU Standardized Mortality Ratio. And Dr. Stockwell, I think was, David, was this yours to look at?

Dr. David Stockwell: Yes, I think so.

Reva Winkler: Okay, great. Do you want to take a stab at it?

Dr. David Stockwell: I, yes, I think that I didn't have major concerns with this. It's, again, using a method and a well-established risk of mortality assessment, and something that I know is used fairly - it's probably the main reason that you engage a company like VPS, is to get this kind of a metric from them. And so this is, I think, you know, I think that it's fairly useful. And I didn't have major concerns, as I recall.

Reva Winkler: Okay. Are there folks on the committee, because again, this is an outcome measure, clearly an important outcome measure. I did note that they mentioned some focus group testing

of families prior to publication of - this data was felt to be important to families, so that's, you know, speaks to usability.

It is published. And I checked those Web sites and did see the current data from Wisconsin and Cincinnati. So it certainly is in use for public reporting by some hospitals. Feasibility sounds like it's totally dependent on use through VPS at this point. So no one else would have access to the PRISM risk model?

Dr. Peter Almenoff: That's accurate.

Christine Gall: Right now, yes, that's the current state.

Reva Winkler: Okay.

Dr. David Stockwell: How has VPS, I'm sorry, how has NQF treated that kind of a situation, just out of curiosity?

Reva Winkler: Well, I mean, what we generally require is that the information be publicly available, and it isn't exclusively available through a proprietary system, so that the information about the model is available. Now, what clearly happens in other circumstances is it's far easier, it's probably the very best way is to use the registry or the company that does it.

But it is the information about how the model's put together, the risk factors, the coefficients, the intercepts, the - and all of that is supposed to be publicly available. And one of the things I want to talk to Christine about was, when this measure was initially endorsed, that agreement was established. And so, kind of hearing that it isn't available is news to me, and I want to pursue that further. But we can do that offline.

Christine Gall: Okay.

Dr. David Stockwell: Yes, I know the developer of the PRISM, and it's never been publicly available, even before VPS got the rights to it.

Reva Winkler: Okay. I mean, I think that's, that raises an issue, because measures endorsed by NQF - there may be an entity that is the easiest best way of doing it, but we aren't trying to promote measures that funnel folks in one direction, per se, so that typically there is a requirement that the information to calculate the measures be transparent and available. And so we need to pursue this one further on that basis.

Dr. Peter Almenoff: Hi, can I ask a couple of questions?

Reva Winkler: Yes, sure.

Dr. Peter Almenoff: In the first place, I don't know the PRISM model that well. If somebody dies in the ICU, it's considered a death. If they go to the floor is it still part of the model?

Reva Winkler: No.

Male: No.

Dr. Peter Almenoff: So if they go from the ward to the - if they go from the ICU to the floor, it's still in the hospital, it's not considered part of the model?

Christine Gall: Correct.

Dr. Peter Almenoff: Really?

Christine Gall: It's...

Dr. Peter Almenoff: That's, you know, that's completely different than all the adult models. In all the adult, acute care models, if you die in the unit it counts, if you die on the floor it counts.

Christine Gall: That is not how...

(Crosstalk)

Dr. Peter Almenoff: ...take you from the ICU and you go to the floor it counts. So, you know, that's a little concerning. The second question is, have you considered doing an SMR 30 as opposed to just an SMR?

Female: I'm sorry, can you repeat that?

Dr. Peter Almenoff: I asked if you considered doing an SMR 30, which is 30 days from admission, as opposed to doing in an in-house death rate.

Christine Gall: Currently we haven't calculated that way, no. I'd have to look into that. I'm not real familiar with that.

Dr. Peter Almenoff: Well, I mean, that's the way CMS publishes their model data, the way we do our data. I'm just, I'm curious. It's more expensive, because you have to look 30 days from admission, but it's a little more valuable to know what happens, because that same issue of gaming, if you move patients around in the hospital, you won't see where the death is, and it'll look like it's a good hospital with a low death rate when in fact they're just moving them to another location where you're not tracking it.



The next question I had was, I guess it's not an issue yet for public reporting, but if you do publicly report, I mean, we find, we do an SMR also, and we find the public has no clue what it is. And CMS does an RSMR, and that's something we're thinking of doing also, because it's, it might be something to consider.

It takes your SMR and converts it into a percentage instead of a decimal. And so you would get a risk-adjusted mortality of 8% or 2% or 5%, as opposed to 1.32, which nobody understands. So I also found it interesting that you have SMRs of 0. Maybe that's - I'm not a pediatrician, I'm more of an adult ICU person, but is that common?

Dr. David Stockwell: That's a good point. I missed that, that's a good point.

Dr. Peter Almenoff: Is it common that nobody - I mean, maybe you guys are better than we are, but...

Dr. David Stockwell: No, I don't think so.

Dr. Peter Almenoff: I find it pretty unlikely to have a zero death rate. That just seems, that would be very suspicious to me.

Dr. David Stockwell: Yes.

Christine Gall: That speaks to the variability in the size of some of the pediatric intensive care units. In some of them, if a patient gets to a certain level, they transfer them out to a, you know, to a tertiary quaternary center. That has to...

Dr. Peter Almenoff: I mean, I actually do support it. I'm not trying to be critical. I'm just trying to give you some suggestions with what at least the adult arena has done, to make it more robust. But I

would, I would really question the fact that you have SMRs of zero, because I've not had a hospital that says, nobody died. And I...

Christine Gall: For a reporting time frame, obviously, not ever.

Dr. Peter Almenoff: The last question is, is that an electronic, are you pulling this out of the electronic health record, or is this a manual system?

Male: It's manual.

Dr. Peter Almenoff: Manual?

Christine Gall: It's manual data collection.

Dr. Peter Almenoff: So you have to review, every hospital has to put the data, log the data into a system?

Christine Gall: Yes, right now that's the process.

(Crosstalk)

Male: We've got a very arduous system.

Christine Gall: Yes.

Dr. Peter Almenoff: Now I mean, we have a completely automated one, that's why I was curious. Okay. That's, those were my questions. So I just, really...

(Crosstalk)

Dr. Peter Almenoff: ...I think it's a good measure, I think it's very important to be done. There just might be in, maybe in the future some considerations to figure out where the deaths are occurring as part of the model, because all of the adult models really look at death in the unit and on the floor as part of the model.

And all the newer ones are looking at death 30 days from admission, so it doesn't matter if you're home it tracks the death in 30 days, which becomes a lot more robust.

Christine Gall: And how is that captured if the patient has left the hospital?

Dr. Peter Almenoff: We go to the Social Security files, there are a bunch of files that we look at. Now, you know, it might be slightly different for pediatric. I don't think it is, though. But, you know, Medicare does the same thing. We have to go to the death files and look them up. I mean, it's much more complicated to do, but it's a much better measure at the end.

Dr. David Stockwell: Yes, I think there, all of those are great points. I mean, I think that PRISM, in and of itself is the risk adjustment side of it, right. So there's an assessment at 12 hours and 24 hours, and then it's done. And what the, all of the items that you're now discussing are really, how do we figure out the mortality piece of it?

And I'd love to see that continue to evolve in all those ways that you've just mentioned, that'd be great.

Dr. Peter Almenoff: And we can talk off line about it if you'd like, you know, show you some of the stuff that's being done, if you're interested.

Christine Gall: I would definitely be - yes, thank you.

Reva Winkler: Any other thoughts about these measures or this measure, rather? Well this group has done a very efficient job of getting through eight measures. I think we've had the opportunity to pull out some concerns, give that feedback to the developers. There are some areas where we're going to try and grab some more information to be either clarifying or more helpful to the committee as we go to the meeting.

What we're going to do is summarize all of this, and we will be putting these on slide sets so that they're available at the meeting. We'll be able to give it to you ahead of time prior to the meeting so that you can see what the comments and the concerns were. We will want any changes or clarifications reentered into our system by the developers, so we will provide revised versions of these submission forms for you and let you know which ones have been revised.

So are there any other questions or concerns from the workgroup, in terms of what we're doing and what we're going to be doing next? Okay, any other questions or comments on these measures? All right, then, (Kelly), do we have anybody on the, in the audience who'd like to ask a question or make a comment, in our public comment before we close?

Operator: And at this time, for the public, if you would like to make a comment or have a question it's star  
1. And we don't have any questions or comments at this time.

Reva Winkler: Thanks very much, (Kelly). Okay, well if there's nothing else from the workgroup, we've completed our agenda items, and with a little time to spare. And I thank you all very much for doing this work. For those of you who haven't completed all of the ratings, we would be happy to have you enter them into the system and we will incorporate them in with the rest of the data that we have for the entire workgroup.

The more we have for the workgroup ratings going into the meeting the better it is for the entire committee and the more helpful. But if anybody has, doesn't have any more questions or anything more to say, then I think we're finished with our business today, and I thank you all very much for joining us.

Male: Thank you.

Christine Gall: Thanks.

END