February 24, 2017

To Whom it May Concern,

We would like to submit an appeal for your consideration regarding PSI-04 and recommend that NQF reconsider this measure for endorsement.
PSI 04 - Death rate among surgical inpatients with serious treatable complications (shock/cardiac arrest, sepsis, pneumonia, deep vein thrombosis/ pulmonary embolism or gastrointestinal hemorrhage/acute ulcer).
Our objection to the measure is based on several concerns:

1. The validity of the measure is based on outdated information that is poorly generalizable.
.Section 1c.3 of the #0351 NQF measure rationale says "the underlying premise was that better hospitals are distinguished not by having fewer adverse occurrences but by more successfully averting death among (i.e., rescuing) patients who experience such complications. The original definition used by Silber et al was based on key clinical findings abstracted from the medical records of 2,831 cholecystectomy patients and 3,141 transurethral prostatectomy patients admitted to 531 hospitals in 1985." The surgical cases reviewed by Silber in 1985 could be cared for at community hospitals as well as academic medical centers. Given the current payer restrictions and acuity of patients receiving advanced therapies available today, the patients that are presently cared for at academic medical centers would not have survived long enough to make it to surgery in 1985. Taking a premise that is over 30 years old and applying it to today's patient population exposes this measure to the need for reconsideration.

2. The assumption of the "preventable death" is dubious for patients transferred to tertiary referral centers. The implication of PSI 04 is that any hospital should be able to prevent death after surgery in patients with these serious complications. The reality is that there is a class of hospitals that recognize that these conditions in seriously compromised patients cannot be treated without extraordinary care and that sometimes, the care provided will not be enough to save the patient. These patients are then transferred to tertiary and quaternary medical centers, owing to the expertise and proficiency found in these institutions. They alone are able to provide evidence-based advanced medical and surgical in critically ill patients. Performing highly skilled procedures in a critically ill population as well as providing the clinical support needed for these complex patients should be proof that there is no "performance gap" as noted in section 1b of the #0351 NQF measure rationale. We would recommend consideration that these patients, inherently requiring very advanced therapies and interventions, be removed from the population of "treatable complications". We would strongly advocate for a definition that is more specific, with consideration of expanded risk adjustment variables, and specific exclusion criteria inclusive of those patients who seek advanced medical care as an option, given the severity of their underlying diagnoses and complications.

NQF Performance Gap statement on unintended consequences in section 4c brings into question whether this measure has been adequately vetted. "No evidence has been identified suggesting unintended consequences for this measure." Our experience, particularly in the 4th case example, shows evidence that we receive transfers outside of Silber's original population, and therefore exist outside of the "normal" expectation for "averting death". These high risk transfer cases should be excluded from the receiving institution's PSI 04 measure count. These extremely high risk cases are transferred to our institution owing to our expert capabilities in caring for the sickest of patients. Including these cases in the measure and then penalizing institutions for "harm" based on the otherwise inevitable patient outcome is incongruous with the ultimate goal of this very measure.

These 4 cases from our institution illustrate our concern about the face validity of the PSI-04 measure.

Case	Summary
Case 1	A 54 yr old collapsed at the airport, was cardioverted and intubated in the field. He was transferred to a tertiary care center where he had an urgent cardiac catheterization. He developed acute renal failure due to rhabdomyolysis. Dialysis was attempted but patient decompensated and died within 24 hrs of admission.

Case 2	A 57 yr old treated for sepsis, intubated, and transferred to tertiary center in cardiogenic shock for advanced therapies. Unstable hemodynamically and in respiratory failure despite intubation, he required a heart pump, an additional machine to oxygenate his blood, and continuous hemofiltration for renal failure because he could not tolerate dialysis. He continued to decline and expired within 3 days of admission.
Case 3	65 yr old found confused and disoriented by EMS. At a community hospital found to be unresponsive, intubated and transferred. At the tertiary center found to have a large cerebral hemorrhage. Despite surgery to relieve cerebral pressure, the neurologic evaluation showed no purposeful movement and no improvement. The patient expired 20 days after admission.
Case 4	40 yr old waiting for a heart transplant and receiving advanced therapy for chronic heart failure was inpatient at a tertiary care center and transferred to another tertiary care center for care and management. He sustained massive intracranial hemorrhage. His condition progressed to grave and recovery unlikely given the extent of brain damage. He expired within 6 days after admission

3. PSI-04 rates contradict disease-specific mortality findings.

While our organization consistently performs at the national benchmark or better in the CMS Mortality measures we have a PSI 04 rate worse than the national rate. Is this true for other hospitals as well?

We believe that PSI-04 is a flawed measure that does not justify NQF endorsement. We support the required research that would refine this measure with appropriate exclusion criteria so that tertiary centers are not penalized for providing the advanced care for which the community relies upon them.

Thank you for your consideration of our appeal,

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