Attachment 6.B.1

PMCoE PICU Expert Work Group & Leadership Team Roster

Name	*Organization/Affiliation*
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Curley, Martha	University of Pennsylvania School of Nursing
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Dull, Maude	Huntsville Hospital for Women and Children
Feldman, Jonathan D	Kaiser Santa Clara Medical Center
Forbes, Michael	Akron Children's Hospital
Franke, Hillary	University of Arizona, Tucson Medical Center
Goyal, Arvind K.	Illinois Department of Healthcare and Family Services
Jeffries, Howard	Seattle Children's Hospital
Montgomery, Vicki	University of Louisville, Kosair Children's Hospital, Norton Healthcare
Moss, Michele	Arkansas Children's Hospital
Niedner, Matthew	University of Michigan Medical Center, Mott Children's Hospital
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Silver, Peter	Steven and Alexandra Cohen Children's Medical Center of New York, North Shore, Long Island Jewish Health System
Smith, Sophia	Shady Grove Hospital & Children's National Medical Center
Stockwell, David C	Children's National Medical Center
Thompson, Ann E	Children's Hospital of Pittsburgh, University of Pittsburgh School of Medicine
Ullem, Beth Daley	Parent Representative

Vernon, Donald D	University of Utah
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PMCoE PICU Leadership Team & Staff

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Attachment 6.B.2.

PMCoE PICU Expert Work Group, Leadership Team, and PMCoE Members Conference Call

September 18, 2014 (2pm – 4pm CST)

- Dr. Rice welcomed everyone and reminded the group that the final report on these measures is due the end of February, 2015.

- Purpose of this conference call is to bring the group up to speed regarding the activities since the last conference call and to discuss the comments that were received back for the Wave 1 measures which were out for public comment on the five measures:
    1. Rates of Catheter-associated urinary tract infection (CAUTI) acquired in the PICU (eMeasure)
    2. Incidence of Hospital Acquired Serious Pressure Ulcers in PICU Patients (administrative claims)
    3. Initial Risk Assessment for Immobility-related Pressure Ulcer within 24 Hours of PICU Admission (eMeasure)
    4. Appropriateness of Red Cell Transfusions (eMeasure)
    5. Initial Baseline Screen of Nutritional Status for Every Patient Within 24 Hours of PICU Admission (eMeasure)

- At the direction of AHRQ, teams have also been working on the two Composite Measures (Preventable Harm and Patient Comfort) which the team felt were valid per the results of their survey. Because of funding, timelines, and the complexity of concerns regarding these measures, the AMA has been assisting the teams. It is the hope that these component measures can also be put out for public comment and then to identify specification and testing for this group of measures as well.

- A question was raised in one of the conference calls regarding whether we were including an age range in a particular composite measure. Because we were asked to create pediatric measures, none of our measures specified an age range but rather they were specified geographically; therefore, no age population was identified that would be used for measure testing. Discussion commenced whether or not team should specify an age range:
    - ADHD does specify age ranges (4-18) because the current guidelines for diagnosis was at age 4.
    - In Developmental Follow-Up Screening, certain age ranges were identified when the follow-up had to be completed.
    - It was noted that there are sometimes 25 year olds in the PICU so do we want to include them? However, there is a concern from a measure design standpoint if the age range did not cut off at age 18 then there might be a bias regarding the unit size. A an example of this would be a 25 year old that would be in adult care in a smaller community based hospital or they might be in the PICU in a larger hospital. Therefore, there might be variability across different programs and age case mix will vary within the different units.
    - It was recommended to look at the metric individually and see if it makes sense within each measure rather than have a blanket statement. (This would not make sense in the DSF measures which only pertain to children but care in the PICU for Pressure Ulcers would apply to adults as well.)
    - Consensus was that anyone within the PICU should be considered as a pediatric patient. Measures are proxy for care delivered in an ICU and should be whatever care is delivered within that PICU. However, each measure will be examined individually and an age range will be included if the measure needs it. (Patient Comfort did include a specific age range limit which is 0-18 years of age.)

- Discussion on the public comments commenced as the team began to discuss and reconcile comments for the Wave 1 measures. These summarized comments are only meant to inform and to be considered by the expert workgroup. The workgroup is not bound to make changes.

Measure #1: Rates of Catheter-associated urinary tract infection (CAUTI) acquired in the PICU *(eMeasure)*

- Not risk adjusted, creating potential for PICUs providing end-of-life comfort care will be unfairly compared to PICUs that do not care for the same level of severity (Care Setting)

  These patients should be diluted out. Risk adjustment will not address this issue. No change.

- Should only be measured monthly, not weekly (Feasibility)

  It was recommended that this be defined and group agreed to monthly.

- Since CAUTI measure is rate per 1,000 catheter days, decreasing catheter usage will significantly increase CAUTI rate even if number of infections remains steady. Should the measure be a reduction in foley days per patient days? (Measure Description)

  Will continue to measure the rate and not the raw number of infections. No change.

- Given the penetration of EMR into ICUs, it can now be determined the time a catheter is placed or patient is transferred – rather than rely on calendar days (Timeframe Concern, EMR Feasibility)

  Team is currently following the CDC framework which indicates two calendar days. No change.

- Difficult to distinguish between asymptomatic bacteria in children with long term indwelling catheters or CIC and true symptomatic UTIs (Definitions)

  This statement is very true and important. Team will not change the definition but will add the exclusion of the children who have chronic and long term indwelling catheters. However, the measure champions will further discuss a more specific definition.

- Mandate that catheter placement be documented (Measure Description)

  This does not affect this measure. No change.

Measure #2: Incidence of Hospital Acquired Serious Pressure Ulcers in PICU Patients *(administrative claims)*

- Essential to engage a core group of providers dedicated to skin care and HAPU prevention, e.g., an institution-wide skin-care council led by wound care experts and unit-based skin care champions, strong collaboration among medical/surgical stakeholders including CCM, ENT, General Surgery, Plastic Surgery, Dermatology, Transplant Surgery, Trauma Service (Implementation)

  Will include this feedback on final report to AHRQ. No change.

- Specifications should align with the Solutions for Patient Safety HEN and NDNQI to the extent possible; need to align the numerator statement with other programs, e.g., NDNQI does not count PU present on admission but that worsen, as hospital acquired pressure ulcers (Harmonization with Existing Measures)

  Dr. Mikhailov will reconcile this comment with Chris Schindler to clarify that team is trying to align with SPS.

- PUs acquired outside of the PICU should not count in the PICU rate (Clarification – Measure Description)

  Team will look at their wording to make sure that they are being clear.

- Clarification needed about reporting – monthly? (Clarification – Reporting)

  Team will use "monthly" but Dr. Mikhailov will clarify with Chris Schindler. Team is trying to align with SPS.

- Measure title includes "serious," but Stage II is not considered serious PU in the SPS program or in the federally mandated ACA which directs states not to pay for certain HAC never events; recommend to NOT include Stage II PUs (Validity)

  Dr. Mikhailov will reconcile this comment with Chris Schindler to clarify.

- Staging of Pressure ulcers would need to be done by a wound care expert vs. the PICU staff nurse (Validity)

  This is not feasible in all PICUs.

- Evaluation of potential pressure injury is labor intensive and subjective; data cannot be obtained via EMR data dumps (Feasibility

  The ideal would have been an EMR approach but it was recommended to do this as an administrative claims measure in order to use the most generalizable data source available. This measure would evolve over time as the emeasure could become more feasible.

- While the ultimate goal should be zero patients with these ulcers, is there some % of patients goal that should be stated in terms of reducing incidence of pressure ulcers (Clarification – Desired outcome)

  Recommendation would be to use benchmarking. Team avoided putting a threshold since they did not have a good answer for this.

Measure #3: Initial Risk Assessment for Immobility-related Pressure Ulcer within 24 Hours of PICU Admission *(eMeasure)*

- Denominator states "admission ending during the reporting period;" confusion whether that means the PICU admission is ending or the hospital admission ended; could be very long and/or involve multiple stays (Feasibility)

  Recommend change language to: "Patient admitted to the PICU and there at least 24 hours" (Clarification – Measure Description)

  Good recommendation. Team meant - Discharge from the PICU. Team will work off-line to review for clarity.

- Recommend two scales (Braden Q, plus one other) to adequately address the population; Braden Q not relevant for infants (Validity)

  The Braden Q was the only one that was validated in the pediatric population. However, Dr. Mikhailov will take this back to Chris Schindler to discuss.

- Recommend risk assessment be performed again if patient becomes sicker (e.g., intubated, sedated) greater than 24 hours after PICU admission (Clinical Relevance)

  Team will not be able to move to testing, but it will be submitted to AHRQ.

Measure #4: Appropriateness of Red Cell Transfusions *(eMeasure)*

- Evidence is not complete and refers to adult medicine (Validity)

  Will substitute the pediatric reference for the adult reference. Not all of the bibliography was included in the piece for the public comments – only an adult reference was selected under the evidence.

- Should it be "% of transfusions for Hb >7" (higher % = worse)? (Clarification – Numerator Statement)

  Indicates the same thing. No change.

- Difficult to capture the exclusions in the EMR (EMR Feasibility)

  True statement for some of them and the diagnostic ones might be picked up in the administrative database. There were concerns about how this was captured in the EMR.

- No intersection with institution's current EMR regarding the appropriateness of blood transfusion, but there is value in enabling this – e.g., as blood supply diminishes – appropriate utilization will bring cost savings and reduction of potential immunomodulation (EMR Feasibility, Importance)

  Team agrees with statement.

- Need more information on application, e.g., presence/absence of congenital heart disease (Clarification – Exclusions)

  Team feels this seems clear. No change.

- Given that HgSS patients are excluded, consider extending to active cancer patients (Additional Exclusion)

  This really does not impact the results. Do not exclude cancer patients.

- Consider excluding ventilated patients with cyanosis (>5 g/dL deoxy-Hgb), or potentially a P/F ratio <150; although most would likely be on some form of 'cardioactive drug' (Additional Exclusion)

  Not adding this as exclusion.

- Consider excluding other acute hemolytic anemias as well as sickle cell (Additional Exclusion)

  Will add another exclusion - All patients with acute hemolysis.

- Tracking the measure at an institution will be difficult, and given the number of patients that will be excluded – it may come down to individual review of all situations where a transfusion was given yet the hgb was >7.5 (Feasibility)

  Team is already aware of this.

Measure #5: Initial Baseline Screen of Nutritional Status for Every Patient Within 24 Hours of PICU Admission *(eMeasure)*

- Implementation new tools for any screening/assessment (e.g., STAMP, PYMS) creates education and compliance challenges at first (Feasibility)

  Team was not suggesting that any method needed to be used.

- More nursing work would be required in the first 48 hours of admission (Feasibility)
- Limited or no dietician availability on weekends (Feasibility)

  Screens that team has looked at will take only about 5 minutes to complete so this was not an excessive burden for the nurses. They also do not generally require a dietician. It is a requirement by the Joint Commission that a screen be done.

- Would need to incorporate screening tool into current EMR to replace or be integrated with home-grown nutrition screening tool (EMR Feasibility)

  Team will possibly make this clearer.

- Aligned with the trend seen where pediatric EDs are screening and referring children/families who reveal difficulty having enough food to eat (Clinical Relevance)

  No action required for this – only a comment.

- New data states that early feeding has a negative effect on outcomes (Clinical Relevance)

  This one is not about feeding.

- Scores provided are not standards of practice; need more data/validation before recommending any standard scoring (Validity)

  Team will look at the clarity of the language.

- Screening nutritional status may not translate into providing adequate appropriate nutrition for PICU patients, e.g., doesn't assure that nutrition is instituted early in the course of the PICU stay (Importance)

  This refers to some of the other measures in nutrition.

- Given the severity of illness/injury in PICU patients, 48 or 72 hours seems more reasonable to conduct baseline screen; not necessary to conduct within 24 hours – just early in the PICU stay (Timeframe Concerns) Consider revising to "day of PICU stay that enteral or parenteral nutrition were initiated"

  Suggested that the timeframe be revised and team to do an alignment with the Joint Commission. Waiting for the decision to begin would be too late so it needs to be done sooner.

- Assessing nutritional status may not be relevant at admission for all patients, but rather for longer-stay patients or patients with malnutrition (Timeframe Concerns)

  Team wanted to add something to address why patients have longer stays but there was not good evidence regarding when and how to assess.

- No need to measure on discharge from the PICU if the baseline screen is conducted within 24 hours of admission (Timeframe Concerns)

  Team will make the language /denominator more clear so the intent is understood.

Review Next Steps

- Testing/IRB Considerations
  (Next Steps will be discussed at the next conference call as time ran out.)