



September 30, 2010

Donald Berwick MD, Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

**RE: Implementation of specific quality measures published by CMS in its Final Rule for Medicare Program;  
Hospital Inpatient Prospective Payment Systems July 30, 2010**

Dear Dr. Berwick:

We would first like to congratulate you on your appointment to this important role at a most critical time. As organizations that strive to improve patient safety and reduce healthcare-associated infections (HAI), we are pleased with your new role in keeping patient safety at the forefront of CMS efforts.

We also wish to acknowledge and thank CMS for responding to our collective suggestions to not only focus on HAI prevention but support our request to measure HAI reduction using rate-based, risk-adjusted measures developed from evidence-based guidelines. We are particularly pleased that CMS will utilize the standardized Centers for Disease Control and Prevention's (CDC) definitions and process of data submission from CDC's National Healthcare Safety Network (NHSN), a decision welcomed by all partners in infection prevention. Further, we appreciate CMS listening to our requests for a more deliberate time-sequenced approach to HAI data collection to meet CMS goals as well improve patient safety and prevent HAIs using robust quality data.

We are writing today specifically to address the issue of surgical site infections (SSI) and appreciate that CMS has revised the data collection to begin in calendar year (CY) 2012 for fiscal year (FY) 2014. Although that date seems distant, we all understand that planning, education, training and ensuring robust and validated data quality takes time. We as a group are committed to make this a success as soon as possible for the sake of our patients. We believe it would be of value to all if CMS made clarifications as soon as possible.

CMS did clarify in its final rule that it is limiting procedures to NQF-endorsed procedure categories used in SCIP, that is: "coronary artery bypass graft and other cardiac surgery, hip or knee arthroplasty, colon surgery, hysterectomy (abdominal and vaginal), and vascular surgery, and the populations that apply are both the adult and pediatric populations."

We concur with this approach as a starting point, and understand CMS appreciates that within each of these procedure categories issues still need clarification on both a broad and specific scale. For example, it is critical for hospitals to measure surgical procedures based on their type of surgical program, as well as risk and/or volume for each. CDC's NHSN provides the spectrum of NQF endorsed procedures that fit large academic, as well as community and specialty hospitals with widely varying populations and surgical procedures. There are also finer points such as defining the minimum threshold per procedure when the numbers of cases would be too small to be meaningful. Since all SCIP measures but one (normothermia) exclude patients under 18, there is a need to address SCIP's applicability to a pediatric population. Finally, we believe CMS realizes the HHS HAI Action plan never intended even large hospitals to collect data on *all* NQF endorsed or SCIP surgical procedures.

Given the extensive elements that need to be collected to determine SSIs, hospitals must balance the time necessary for prospective surveillance coupled with chart review for all other quality and HAI measures proposed by CMS. This balance is essential in light of sustaining intervention activities demonstrated for example by Keystone, and other

breakthrough initiatives along with other infection prevention and control requirements. CMS continues to work with CDC, and hopefully will develop more specific criteria such as risk/volume and details of procedure(s) selection from SCIP measures that best fit each hospital's population, while optimizing the overall most frequent procedures for standardized public reporting. Ideally hospitals would be permitted to begin with one procedure the first year and add as appropriate in a systematic manner given the importance of validating both numerator and denominator data.

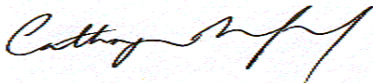
In anticipation of the many issues raised, we are seeking a meeting with you or your designees to share ideas gained from experiences in states already collecting SSI data from selected SCIP procedures. We have found our partnering and sharing with CDC invaluable and seek a similar opportunity to share and learn with CMS. We believe such a meeting will be productive for everyone and identify information that will benefit all participants

Further, we also understand the continuing need for education on all levels. Past outreach efforts by CMS have been valuable. Following any discussions or meetings with you, we would be pleased to host and support educational conference(s) with CMS presenters to ensure appropriate, accurate messages, furthering understanding for all stakeholders. We believe such an effort will highlight mutual efforts to seek full transparency as we report our progress to CMS and the public.

For questions regarding follow-up, please contact Linda Rouse O'Neill, Director Federal Affairs, Premier healthcare alliance, ([Linda.Rouse@Premierinc.com](mailto:Linda.Rouse@Premierinc.com) or 202-879-8005)

We appreciate your leadership and commitment to quality and thank you for your consideration of our request as we strive to improve patient safety together. We look forward to hearing from you regarding a meeting in the near future.

Sincerely,



Association for Professionals in Infection Control and Epidemiology Inc (APIC),  
Cathryn Murphy, RN, PhD, CIC, President



Council of State and Territorial Epidemiologists (CSTE)  
Stephen Ostroff MD, President



Premier healthcare alliance, Washington, DC Office  
Blair Childs, Senior Vice President, Public Affairs



Society for Healthcare Epidemiology of America (SHEA)  
Neil Fishman MD, President

CC: Barry Straube MD, Chief Medical Officer