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Agency for Healthcare Research and Quality
5600 Fishers Lane #7
Rockville, MD 20857

RE: Comments on AHRQ's Patient Safety Indicators gap analysis and update opportunities

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to provide comments on the Agency for Healthcare Research and Quality's (AHRQ's) Patient Safety Indicators (PSI) gap analysis and update opportunities. IDSA is a global community of 13,000-plus clinicians, scientists and public health experts working together to solve humanity's smallest and greatest challenges, from tiny microbes to global outbreaks. As the leading professional organization representing infectious diseases physicians and researchers, IDSA has significant expertise in healthcare-associated infections, sepsis, and antimicrobial stewardship that is directly relevant to several existing PSIs and identified measurement gaps.

Overall perspective on PSI limitations

IDSA acknowledges that PSIs serve an important role in patient safety measurement; however, we must note concerns about their fundamental methodology. PSIs rely exclusively on administrative billing codes, which substantially undercount actual patient safety events compared to more comprehensive surveillance methods. This reliance on billing codes alone can result in inaccurate data suggesting significantly fewer patient safety events than actually occur. Any updates to the PSI program should focus on addressing these methodological limitations to ensure accurate measurement and meaningful improvement.

Existing PSI-13: Post-Operative sepsis rate

IDSA has strongly advocated for meaningful sepsis outcome measures that accurately reflect patient outcomes and care quality. We are pleased that CMS has referred the development of a sepsis mortality measure to CDC, with significant input from IDSA members including Dr. Chanu Rhee, MD, MPH, FIDSA, who has been actively involved in this development.

Given the ongoing development of a more clinically robust sepsis mortality measure, **we recommend that PSI-13 (post-operative sepsis rate) be considered for retirement.** This recommendation is based on several factors:

- The significant challenges in accurate sepsis diagnosis, especially using billing codes alone
- The availability of more clinically meaningful sepsis measures under development

Duplication with existing CDC NHSN measures

IDSA is particularly concerned about the significant overlap between existing PSIs and established CDC National Healthcare Safety Network (NHSN) measures. This duplication creates unnecessary burden and potentially conflicting and confusing definitions within the same federal department (HHS).

Existing PSIs with NHSN counterparts:

- **PSI-07 (Central Venous Catheter-Related Blood Stream Infection**) duplicates NHSN Central Line-Associated Bloodstream Infection (CLABSI) measures
- Ventilator-associated pneumonia measures (if developed) would duplicate NHSN VAP surveillance

- **Catheter-associated urinary tract infections (CAUTI) are established NHSN measures**: NHSN's CAUTI surveillance uses standardized definitions with clinical validation and real-time reporting, providing more accurate and actionable data than administrative code-based PSI measures. The NHSN CAUTI module also includes device utilization ratios and allows for risk stratification by patient population and unit type.

- Surgical site infections are extensively covered by NHSN with procedure-specific definitions. NHSN's SSI surveillance employs detailed, procedure-specific criteria with post-discharge follow-up capabilities that capture infections missed by administrative data alone. The system provides standardized infection risk index calculations and allows for meaningful benchmarking across similar procedures and patient populations.

Critical differences in measurement methodology

The fundamental difference between PSI and NHSN methodologies creates significant issues. PSIs rely solely on billing codes, which may miss a significant number of actual patient safety events and lack important clinical context and severity assessment. Additionally, PSIs do not incorporate important laboratory results or clinical indicators and are subject to coding variations and limitations.

Meanwhile, NHSN measures incorporate laboratory results and clinical indicators, standardized definitions developed by clinical experts, timeline-specific criteria that better reflect causation and regular validation and refinement processes.

Specific challenge: surgical site infections

Surgical site infections (SSI) are becoming increasingly challenging to measure using only

inpatient billing data because many procedures are now performed in outpatient settings and most SSIs occur after hospital discharge. Additionally, only the most serious SSIs result in readmission and unfortunately, billing codes cannot capture the complexity of SSI risk factors and prevention measures.

Recommendations

Based on these concerns and the need for more effective, non-duplicative patient safety measurements, IDSA recommends the following actions:

1. **Align HHS measurement efforts:** Rather than developing new PSIs that duplicate NHSN measures, AHRQ should coordinate with CDC to ensure a single, authoritative definition for each type of healthcare-associated infection within HHS.

2. **CDC mortality measure:** AHRQ should consider retiring PSI-13 (sepsis rate). The mortality outcome measure in development by the CDC will serve as a more meaningful quality measure. Currently, PSI-13 relies on administrative billing codes (ICD-10-CM) which can result in incomplete performance assessments. These codes were designed for reimbursement purposes, not for clinical quality measurement, which can lead to significant variations in coding practices across institutions.

3. **Avoid creating new duplicative measures:** Do not develop new PSIs for *C. difficile*, CAUTI, or additional SSI measures where robust NHSN measures already exist.

4. **Leverage existing infrastructure:** Given that many hospitals already report to NHSN and some states mandate this reporting, building upon this existing infrastructure would be more efficient than creating parallel measurement systems.

5. **Focus PSI development on true gaps:** Direct PSI development efforts toward patient safety areas where comprehensive measures do not already exist, rather than duplicating existing surveillance systems.

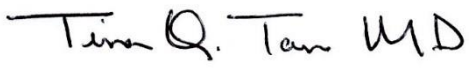
6. **Improve methodological analysis:** Any retained or new PSIs should incorporate more robust data sources beyond billing codes alone to provide accurate measurement of patient safety events.

Conclusion

IDSA supports efforts to improve patient safety measurement and strongly encourages AHRQ to eliminate redundancy with existing CDC/NHSN measures and focus on areas where meaningful gaps truly exist. Healthcare systems benefit from coordinated, nonduplicative measurement efforts that provide accurate, actionable information for quality improvement.

We appreciate AHRQ's consideration of these comments and would welcome the opportunity to provide additional input as the PSI update process continues. If you have any questions or concerns, please feel free to contact IDSA's Clinical Affairs team at clinicalaffairs@idsociety.org.

Sincerely,



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