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June 27, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1607–P, P.O.
Box 8011
Baltimore, MD 21244–1850.

Sent via email to: http://www.regulations.gov

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program

Dear Administrator Tavenner:

ANA welcomes the opportunity to provide comments with respect to this Request for Information. As the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses, ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of healthcare settings. ANA members include advanced practice registered nurses (APRNs) such as nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs), and certified nurse-midwives (CNMs).

Getting to the Right Measures:

ANA supports the use of a mix of rigorous structural, process, and outcome quality measures (Donabedian, 1988) for inclusion in core measure sets. These measures can be effective tools in transparent public reporting and pay for quality programs. To maximize the impact of these core sets of measures for settings of care, populations, and programs they must be patient-centric and team-based measures, capturing the contributions of nurses to effectively evaluate quality. Quality measures that do not capture nursing data miss a critical data element to improve patient care quality through transparency and accountability. This is of particular concern within the national priority areas of safety, care coordination and patient/family engagement. The continued absence of measures that capture nursing data to evaluate quality in the Centers for

Medicare and Medicaid Services (CMS) accountability portfolio is of great concern to multiple stakeholders including consumers.

Safety, a National Priority

Safety is a National Quality Strategy (NQS) priority that is of primary interest to patients and families, clinicians, and all stakeholders in quality. Nurses are the principal front-line caregivers that provide much of the patient assessment, care, and education that is essential to achieving patient safety. Thus, it is essential that nursing contributions be captured in team-based care to support improvements in patient safety. To that end, nurses have led innovation in acute care patient safety measurement in high impact measures of structure (e.g., staffing and skill mix); process (e.g., pressure ulcer prevention); and outcomes (e.g., pressure ulcer incidence).

Standardized measurement and reporting of clinical data enables the identification and implementation of best practices for high quality, safe, and cost-effective patient care. Research conducted using data from the National Database of Nursing Quality Indicators® (NDNQI®)—the largest national database registry for nursing sensitive care—has informed the work of CMS's Partnership for Patients (PfP). National NDNQI safety outcomes data are provided to PfP for multiple Hospital Acquired Conditions (HACs). For example, a recent Department of Health and Human Services (HHS) report included outcomes calculated employing NDNQI data for three of six HAC outcomes in which reductions were achieved (HHS, 2014, p.2). New evidence-based practice (EBP) knowledge developed through ANA's quality research agenda and NDNQI research has identified effective EBP bundles subsequently shared with the PfP Hospital Engagement Networks. These results contributed to the PfP success in falls and pressure ulcer reduction included in the HHS report.

ANA agrees that future process and outcomes measures within the core sets focused on patient safety should include innovations in clinical quality measurement (e.g., eMeasures) that seamlessly capture real time data during clinical care to inform individual clinicians, teams, and ultimately continuously learning health systems (Smith, Saunders, & Stuckhardt, Editors, 2012). Nursing has lead with innovation in de novo eMeasurement to capture a true measure of pressure ulcer incidence, ePressUlcer^{CI}, which is in pilot testing with EHRs. ANA has separately presented the de novo ePressUlcer^{CI} to many of the relevant stakeholders: CMS's eHealth Summit (May, 2013); the Office of the National Coordinator for Health Information Technology (ONC); Health Level Seven (HL7); NQF-convened MAP Hospital Workgroup (December, 2013); 12th International Congress on Nursing Informatics in Taiwan (June, 2014); and Institute of Medicine Committee on Core Metrics for Better Health at Lower Cost (March, 2014). In the exchange with the IOM Committee the members clearly identified that opportunities for expediting electronic quality measurement were needed to advance innovations to enable rapid and seamless uptake of eMeasures. Moreover, the foundational model for eMeasure

development that ANA created is a resource that can be used efficiently in the development of future measures in patient safety and other national priorities.

As a measure steward and developer, ANA looks forward to collaborating with CMS, ONC, NQF, AHRQ, consumer groups, industry and vendors, other measure developers and all key quality stakeholders in advancing electronic measures that capture the contributions to quality of nurses and other team members. These high impact measures should be straightforward to implement, usable by key stakeholders, and meaningful to clinical teams. They should also be evidence-based, meet rigorous reliability and validity standards, and be of great importance and understandable to consumers to use in decision making for healthcare choices. Patients and their families are powerful resources to improve patient safety through better engagement through the use of understandable accountability measures.

CMS Request for Comments All Harm Electronic (non-claims) Composite Measure:

CMS is inviting comments regarding an electronic all-harm composite in addition to, or to replace the current HAC measures in the HAC Reduction Program for Acute Care Hospitals in the CFR, p. 28144:

> "We are seeking comment as to whether the use of a standardized electronic composite measure of all cause harm should be used in the HAC reduction program in future years in addition to, or in place of, claims-based measures assessing HACs. We welcome any suggestions of specific all-cause harm electronic measures, including detailed measure specifications. Specifically, we invite public comments on the feasibility and the perceived value of such a measure, and what would be the most appropriate weighting of this measure in the Total HAC Performance Score. In addition, we are requesting suggestions on the timeframe for which such standardized electronic composite measure of all cause harm should be proposed.
>
> We intend for the future direction of electronic quality measure reporting to significantly enhance the tracking of HACs under the HAC Reduction Program. We will continue to work with measure stewards and developers to develop new measure concepts, and conduct pilot, reliability and validity testing as part of efforts to promote the adoption of Certified Electronic Health Record Technology in hospitals."

ANA Response:

ANA is open to discussing the appropriateness and timing of a future all-harm composite electronic measure that could be used in addition to rather than replacing individual HAC measures. The science and technology used for electronic, clinically enriched measures that captures the contributions of nurses and other team members

is evolving. The current state of the science and technology does not allow for accurate capture in a reliable and valid composite in the near future. Thus, it is not currently feasible to develop a meaningful all-harm composite electronic eMeasure that is not claims-based.

When it is feasible to develop an all-harm electronic composite measure enriched by team-based clinical data it will be important that the individual HAC measures also continue to be reported. Although a hospital may know its own rates for measures included in an all-harm composite, it will not have access to comparative information on the components. Therefore, without appropriate separately reported individual NQF-endorsed, clinically enriched HAC measures hospitals and unit-based teams have less information for benchmarking and re-basing performance improvement plans. Consumers, clinical teams, hospital providers and other stakeholders should have continued transparent access to individual HAC measures in CMS accountability programs, such as the HAC Reduction Program.

ANA does not support the composite measures calculated using retrospective claims data due to the multiple problems with both the individual metrics and these composites. ANA and the Measure Application Partnership (MAP) Hospital Workgroup have commented on the serious under-reporting of harm (e.g., hospital acquired conditions [HAC]) using retrospective claims measures such as the Agency for Healthcare Research and Quality (AHRQ) composite measure—the PSI-90—as well as individual PSI measures such as the PSI-3 measure of pressure ulcer incidence due to issues inherent to claims-based measurement (Coomer and McCall, 2012; Meddings, Reichert, Hofer, & McMahon, 2013). Moreover, the PSI-90 was not re-endorsed in the 2014 Safety Measures SC (NQF, 2014). ANA does not support "rebalancing" the PSI-90 measure by adding new metrics or shifting weighting to better measures in the composite for future reconsideration by NQF's Safety Steering Committee. Rather, ANA agrees with CMS that non-claims data should be considered for future composites when feasible. First, CMS should focus on supporting development of individual electronic HAC eMeasures with the attributes described above including patient-centric, high impact, team-based measures that include nursing data and capture the contributions of nurses. These HAC measures will more effectively evaluate care quality and represent quality outcomes to consumers and other stakeholders.

CMS is proposing to readopt the PSI–90 measure for FY 2019 Hospital VBP Program and subsequent years (CFR, p.)

ANA does not support readoption of the AHRQ PSI-composite for the VBP for the reasons described above.

ANA looks forward to continuing activities with CMS related to improving the quality of care provided to all in America. We appreciate the opportunity to share our views on this matter. We would be happy to speak with HHS and/or CMS leadership and staff further. Please feel free to contact Maureen Dailey, PhD, RN, CWOCN, Senior Policy Fellow, ANA Health Policy, at maureen.dailey@ana.org, or (301) 628-5062.

Sincerely,

Debbie Hatmaker

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer

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