



June 13, 2017

Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1677-P
P.O. Box 8011
Baltimore, MD 21244-1850

Submitted electronically to <http://www.regulations.gov>

Re: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices
[CMS-1677-P; RIN 0938-AS98]

Dear Administrator Verma:

The American Nurses Association (ANA) welcomes the opportunity to provide comments to the proposed Medicare rule referenced above. Our comments focus primarily on the following issues: ANA's support for the inclusion of critical safety structural measures (nurse staffing and skill mix) for public reporting in the Centers for Medicare & Medicaid (CMS) Inpatient Quality Reporting (IQR) Program; ANA's support for the continued implementation and expansion of various care coordination models and the expansion of the role of the registered nurse within such models; and ANA's request for CMS to adopt a *falls with injury* measure in the IQR Program to support the Hospital Acquired Conditions Reduction Program. ANA also notes support for the collection of standardized patient assessment data under the Long-Term Care Hospital Quality Reporting Program, and the proposed revisions to the application and re-application procedures for national Accrediting Organizations, provider and supplier conditions, and posting of survey reports and acceptable Plans of Corrections. ANA also notes our conditional support for modified pain-management questions as they pertain to opioid prescriptions and the role of the paraprofessional in the health care delivery system.

The American Nurses Association (ANA) is the premier organization representing the interests of the nation's 3.6 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public.

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RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse roles (APRNs): nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs) and certified registered nurse anesthetists (CRNAs).¹ ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

I. ANA strongly endorses the inclusion of two critical safety structural measures (nurse staffing and skill mix) to the CMS Inpatient Quality Reporting Program

ANA commends CMS for identifying in Section IX.A.9.c. *Potential Inclusion of Two Nurse Staffing Measures*, that the transparent public reporting of two nurse staffing measures – (1) Skill Mix Measure (NQF #0204) and (2) Nursing Hours per Patient Day Measure (NQF #0205) - through the Inpatient Quality Reporting (IQR) Program presents *all* hospitals with the opportunity to improve quality and the value of care. By requiring this information to be reported on *Hospital Compare*, a consumer oriented website, it will provide patients and their families with information on how comparable hospitals are prepared to provide high quality and safe care. More than half of all hospitals in the United States have adopted these measures. ANA first championed these nurse-sensitive measures in 1994 and continues to affirm the correlation of these quality measures on the impact appropriate nurse staffing levels play in patient safety and the value of care provided. In August 2005, and again in December 2015, both measures were fully endorsed as a priority for *Hospital Compare* by the National Quality Forum (NQF), a non-partisan organization that endorses valid, evidence-based quality measures. NQF is the gold-star seal of approval for quality measures. In addition, the proposed rule affirms the growing body of research demonstrating the link between nurse staffing on patient safety and outcomes; those studies substantiate the importance of requiring this data be reported on *Hospital Compare*. In fact, studies continue to find that inadequate registered nurse staffing is associated with increased mortality and multiple types of avoidable adverse events causing patient harm, reinforcing the need to match staffing and skill mix to patients' need for nursing care. ANA strongly supports the inclusion of both measures in the final hospital payment rule.

Nurses are critical to patient safety in hospital settings and, according to the most recent Gallup Poll; nurses have been ranked for the 15th consecutive year as the professionals with the highest honesty and ethical standards (Gallup 2016). In fact, there is a direct correlation between nurse staffing, patient satisfaction, readmissions, and adverse events. Currently patients and their families compare hospitals

¹The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

on a number of factors on the website *Hospital Compare*, but they are unable to access information on how many nurses are staffing the unit to which they may be admitted or the staff skill mix, both of which ultimately impact patient outcomes. Skill mix is part of the formula for appropriate staffing. Proper use of support personnel improves nurses' workflow, permitting nurses to fully apply their professional knowledge and skill.

The measures included in the proposed IPPS rule represent key indicators of patient safety in a hospital. Reporting these data is not a paperwork burden to hospitals, nurses or other clinicians. This information is not necessarily being newly collected in hospital settings, but rather newly reported—the measures utilize electronic data already included in more than half of all hospital databases. Transparent access to this data contributes to safer, more effective interdisciplinary teams across the hospital setting. In the instances where this data is not being collected the estimation is that, depending on the number of beds, number of units, as well as patient acuity, it may take one to three days to create the data reporting system, but ongoing reporting effort would be minimal. In most hospitals, staffing data is routinely and on a real-time basis sent to the Chief Nursing Officer, managers, and administrations in order to make day-to-day decisions. Furthermore, during the NQF endorsement process, ninety-three percent of the 508 hospitals that provided feedback on these two measures and data collection reported that they used some form of electronic reporting, presenting minimal effort and minimal burden.

ANA affirms the importance of health care organizations adopting a culture of safety that is integrated at the team level and is used as a publicly reported measure. Safe staffing and the creation of a positive work environment are important in improving safety outcomes for patients (McHugh, 2016). This is borne out in recent survey research reported at the National Academy of Medicine (NAM). During a NAM meeting focused on safety, a researcher (McHugh, 2015) presented safety research findings that added to the growing body of evidence linking the safety climate and safe staffing to patient safety. Dr. McHugh reported that the organizational safety attributes of safety culture/climate and staffing improve patient outcomes. He noted that critical organizational safety attributes, safety climate, and safe staffing, work in tandem as critical safety structures of care. As noted, missed care is also associated with both safety climate and staffing (workload) variables (Jones et al., 2015, p.121). By including these staffing measures, CMS will create transparent, public reporting of both critical structures of care.

ANA recognizes that hospitals share a commitment to patient safety and ANA understands hospitals seek continued flexibility regarding staffing decisions. However, nothing in these measures will require hospitals to implement rigid staffing patterns. The purpose of collecting the data will allow all hospitals to make informed decisions on safe, appropriate care that meets the needs of their patient acuity. The public reporting of these data on *Hospital Compare* will highlight which hospitals have lower staffing and skill mix patterns so that consumers are empowered to make informed choices. The data reporting will not reveal a hospital's individual staffing pattern. ANA believes hospitals investing in appropriate nurse staffing and skill mix will be meeting the needs of their patients, and will thus receive higher ratings. *Hospital Compare* generally ranks hospitals using the data from these measures to award up to 5 stars. A

hospital with strong nurse staffing and skill mix level will receive a higher star rating and will stand out strongly in an apples-to-apples comparison with hospitals which are not investing in appropriate nurse staffing.

Nurse staffing and skill mix metrics are important, efficient, understandable, broad hospital safety summary metrics. These metrics promote transparency and support the opportunity for informed decision making by consumers, payers and other stakeholders. Low levels of nurse staffing and skill mix are associated with multiple HACs and increased mortality across broad populations. The revised Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI-90) composite, now known as the Patient Safety for Selected Indicators (modified version of PSI-90), continues to have significant limitations and there have been multiple weaknesses identified with this composite, including serious under-reporting (Winters et al., 2016). Thus, while the modified PSI-90 is a composite of outcome measures, it is not suitable as a timely, efficient, robust summary safety metric for public reporting for use across broad vulnerable acute care hospital populations. The staffing and skill mix safety measures can best serve as robust safety summary measures and it is critically important that they be added timely to the IQR.

Nurse staffing plays an important role by ensuring that the nurse is provided adequate time and resources to prepare each patient for discharge. Lower nurse-to-patient ratios hold promise for preventing unnecessary hospital readmissions for all patients through more effective pre-discharge monitoring of patient conditions and improved discharge preparation (Tubbs-Cooley HL, Cimiotti JP, Silber JH, Sloane DM, Aiken LH, 2013):

- Each additional patient added to a nurse's average case load increases odds of 30-day readmission 6-9% due to poor nurse working environment and staffing (McHugh MD, Ma C, 2013 & Mitka M, 2015). Conversely, patients who receive care in "better" nurse work environments have lower odds of readmission (Ma C, McHugh MD, Aiken LH, 2015).
- Hospitals staffed with 8 RN hours per adjusted patient day have 25% lower odds of receiving readmissions penalties when compared to similar hospitals staffed with 5.1 RN hours per adjusted patient day (McHugh MD, Berez J, Small DS., 2013).
- Missed standard nursing care activities during a patient's hospitalization, such as teaching, care-coordination, care planning, and treatments, are associated with increased odds of readmission of 2-8%, after adjusting for patient and hospital characteristics. This suggests that providing nurses with sufficient time and resources to address various patient needs can help reduce readmission rates (Carthon JMB, Lasater KB, Sloane DM, Kutney-Lee A, 2015).
- Higher RN non-overtime staffing decreased the odds of readmission of medical/surgical patients by 50% and reduces post-discharge emergency department visits. Hospitals could potentially reduce post-discharge utilization costs and readmissions by increasing investment in nursing care hours to better prepare patients to manage their care at home prior to discharge (Weiss ME, Yakusheva O, Bobay KL, 2011).

In the proposed rule, CMS asks whether the measures should be limited to a more narrow number or specific hospital units. ANA reminds CMS that during the deliberative endorsement process, NQF approved these measures requiring that the measures include specific types of units. During that process, the studies cited demonstrated a clear link between the skill mix and adverse outcomes; outcomes were positively impacted by measure reporting regardless of unit type. Patients also would not benefit from narrowing the measures. Finally, as stated above, in most hospital staffing data is routinely, and on a real-time basis, sent to the Chief Nursing Officer, as well as managers and administrators, to make day-to-day decisions.

These two staffing measures are the touchstones of all measures of nursing performance and impact on care. ANA concurs that there are a series of nursing sensitive outcome measures that are identified as nursing sensitive because they are correlated with hours/patient day or nursing skill mix, or both. However, those measures in current use do not reflect the entirety of the impact of nursing, and some of the existing measures are influenced by other factors. These two proposed nurse staffing measures provide the clearest guidance to patients on the quality of the nursing service at hospitals and it is imperative for all patients and their families that CMS include both NQF-endorsed measures in the final rule.

II. ANA strongly encourages the continued implementation and expansion of care coordination models and urges CMS to elevate the central role of the registered nurse

In Section XIII.C. *Request for Information on CMS Flexibilities and Efficiencies*, CMS asks the public to submit ideas for regulatory, sub-regulatory, policy, practice, and procedural changes which might improve the health care delivery system. ANA is committed to partnering with CMS in transforming the health care delivery system. We agree that transformation hinges on patient-centered care and patients' relationships with all providers. Care coordination is one area where change is achievable in the near term. Care coordination payment should be expanded for consistency across all qualified health professionals delivering high-value care coordination activities, including bachelor's-prepared nurses. All qualified providers should be able to perform a common set of tasks with supporting documentation. All members of the health care team should be accountable and transparent.

Extending care coordination payment to bachelor's-prepared nurses will increase CMS' flexibility and increase efficiency throughout the Medicare program. In addition, bachelor's-prepared nurses will increase the quality of care to patients while simultaneously improving program integrity and making the health care system more effective, simple, and accessible.

CMS has a number of care coordination initiatives currently under way. ANA encourages CMS to continue the implementation of these innovative models while simultaneously working to enhance and/or expand them. We strongly believe that these innovative care coordination models have the potential to transform the health care delivery system and that the registered nurse has a distinct and crucial role in that transformation. There are several proposals related to the current Medicare fee-for-

service (FFS) program which are in place under current provisions of Medicare law and regulations. In addition there are models or experiments where the Center for Medicare & Medicaid Innovation (CMMI) has authority under section 3021 of the Affordable Care Act to waive current provisions of law and regulations. ANA believes that the following models recognize or have the potential to demonstrate the value of bachelor's-prepared nurses as well as Advanced Practice Registered Nurses in providing high quality patient care, increasing access to care and demonstrated value in care coordination initiatives. Therefore, ANA urges CMS to elevate the role of the bachelor's-prepared nurse as well as the Advanced Practice Registered Nurse in these care coordination activities.

Comprehensive Primary Care Initiative

The Comprehensive Primary Care Initiative (CPCI) was a four-year multi-payer initiative designed to strengthen primary care. The initiative tested whether population-based care management fees and shared savings opportunities supported by multiple payers can achieve improved care, better population health outcomes, and lower costs. The program began in 2012 and ended in 2016. The monthly payment from Medicare averaged \$20 per beneficiary per month during years 1 to 2 of the initiative (2013-14), and decreased to an average of \$15 per beneficiary per month during years 3 to 4 (2015-16). Practices also received monthly fees from other participating CPCI payers and are expected to combine CPCI revenues across payers to develop a whole-practice transformation strategy. CPCI was limited to practices in Arkansas, Colorado, New Jersey, Oregon, and parts of New York, Ohio, Kentucky, and Oklahoma.

CPCI provided an opportunity for nurses to be involved in care coordination and the management of patients' needs. CMS indicated that practices have the discretion to use enhanced non-visit compensation to support "care teams (e.g. case managers, social workers, health educators, pharmacists, nutritionists, behavioralists) embedded in the practice." Further, CMS indicated the monthly per patient per month fee can be used to support "community health teams" (CMS, 2012). In its first year, Comprehensive Primary Care (CPC) achieved gross savings and was nearly cost neutral, with positive quality results.

CPCI provided an opportunity for the involvement of nurses in care coordination. Indeed, Mathematica Policy Research indicates in its third-year evaluation of the program that "care managers, who are predominantly nurses, tended to focus on patient education, coaching, and monitoring for chronic conditions, management of care transitions, post-discharge contact, and care plan development (Mathematica, 2016)." The Mathematica report further indicates that nurses were used as on-call staff to triage patient issues after hours and address patient needs by telephone (Mathematica, 2016).

Comprehensive Primary Care+

Comprehensive Primary Care+ (CPC+) is a five-year model that will be in place from 2017 through 2021. Like CPCI, the program is multi-payer. CPC+ is designed to transform primary care practices and build

capabilities and care processes to deliver better care. Participation in CPC+ is voluntary. CPC+ is open to practices in the same areas that were eligible to participate in CPCI plus Hawaii, Michigan, Montana, all of Ohio, all of Oklahoma, Rhode Island, Tennessee, and the Greater Philadelphia Region.

CPC+ practices will receive a risk-adjusted, prospective, monthly care management fee for Medicare fee-for-service (FFS) patients who are attributed to their practice (a patient is attributed to a practice if that practice is where the patient receives the plurality of his/her primary care services). In addition, CMS will prospectively pay a performance-based incentive payment, which practices may keep if they meet annual performance thresholds.

CPC+ is comprised of two different tracks. CMS will provide larger performance-based incentive payments in Track 2 than in Track 1. There are four risk-adjusted tiers in Track 1 and five risk-adjusted tiers in Track 2. Practices will use this enhanced, non visit-based compensation to augment staffing and training in support of population health management and care coordination. Track 1 practices will receive a care management fee that averages \$15 per beneficiary per month (PBPM) to support their transformation efforts. Track 2 practices will receive an average of approximately \$28 PBPM. Any practices that do not meet the annual thresholds would be required to repay all or a portion of the prepaid amount. CPC+ may not bill for CCM for patients attributed to their practice.

In Track 1, practices will also continue to receive regular Medicare FFS payments for covered evaluation and management services. In Track 2, CMS is introducing a hybrid of FFS and Comprehensive Primary Care Payment (CPCP). This hybrid payment will pay for covered evaluation and management (E&M) services, but allows flexibility for the care to be delivered both in and out of an office visit. Track 2 practices will receive a percentage of their expected Medicare E&M payment upfront in the form of a CPCP and a reduced FFS payment for face-to-face E&M claims.

Eligible applicants are primary care practices that provide health services to a minimum of 150 attributed Medicare beneficiaries. A “primary care practitioner” includes physicians, NPs, and CNSs with primary specialty designation of family medicine, internal medicine, or geriatric medicine. There appear to be significant opportunities in this model for advanced practice nurses providing care. Care management fees and performance-based incentive payments under this model may also indirectly support the activities of other nurses in practice transformation and other activities to improve quality and lower costs for patients in need of multiple services.

Oncology Care Model

Under the Oncology Care Model (OCM), practices have entered into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients. CMS is also partnering with commercial payers in the model. The practices

participating in OCM have committed to providing enhanced services (such as care coordination, navigation, and national treatment guidelines for care) to Medicare beneficiaries. OCM provides an incentive to participating practices to comprehensively and appropriately address the complex care needs of the beneficiary population receiving chemotherapy treatment, and heighten the focus on furnishing services that specifically improve the patient experience or health outcomes. Like CPCI, OCM practices receive a monthly payment (\$160 per beneficiary) and the opportunity to implement performance-based incentives based on lowering the total cost of care and improving quality. OCM focuses on Medicare FFS beneficiaries receiving chemotherapy treatment and includes the spectrum of care provided to a patient during a six-month episode that begins with chemotherapy. OCM is a five-year model that began on July 1, 2016, and runs through June 30, 2021.

OCM includes care coordination activities that are well suited to the skills of nurses and it seems likely that OCM provides enhanced opportunities for nurses to participate in care coordination. CMS indicates that these care coordination activities may include:

- Coordinating appointments with providers within and outside the oncology practice to ensure timely delivery of diagnostic and treatment services;
- Providing 24/7 access to care when needed;
- Arranging for diagnostic scans and follow-up with other members of the medical team, such as surgeons, radiation oncologists, and other specialists who support the beneficiary through his/her cancer treatment;
- Making sure that data from scans, blood test results, and other tests are received in advance of patient appointments so that patients do not need to schedule additional visits; and
- Providing access to additional patient resources, such as emotional support groups, pain management services, and clinical trials.

Bundled Payment for Care Initiative

Bundled Payment for Care Initiative (BPCI) comprises four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare. Only models 2 to 4 continue to be active. The models are voluntary and allow participants to select among one of 48 different types of clinical episodes.

Models 2 and 3 are retrospective payment models in which Medicare continues to make regular FFS payments that are then compared to the target price; a payment or recoupment amount is then made by Medicare reflecting the aggregate expenditures compared to the target price.

In Model 2, the episode includes the inpatient stay in an acute-care hospital plus the post-acute-care and all related services up to 90 days after hospital discharge. In Model 3, the episode of care is

triggered by an acute-care hospital stay but begins at initiation of post-acute-care services with an SNF, inpatient rehabilitation facility, long-term care hospital, or home health agency.

In Model 4, CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay. Physicians and other practitioners submit “no-pay” claims to Medicare and are paid by the hospital out of the bundled payment.

BPCI establishes the basic model by which other episode bundling projects are constructed, such as Episode Payment Models. The major difference between BPCI and the care coordination initiatives is that the prior models are practitioner-based and include a specific payment for care coordination. BPCI does not include a specific payment for care coordination and is for institution-based care (although Model 4 includes physician payments). BPCI is focused on episode-based care coordination among hospitals, physicians, and post-acute-care providers (Model 2), post-acute-care providers and physicians (Model 3) and hospitals and physicians (Model 4) to achieve improvements in quality and shared savings. Nurses could be involved in care coordination through the Awardee, which is the risk-bearing entity (generally a hospital in Model 2, an SNF or home health agency in Model 3, and always a hospital in Model 4, which has 10 participants).

Care coordination will continue to be a major policy tool in health care transformation. ANA strongly believes that expanded care coordination, as demonstrated through the models above, presents an invaluable opportunity to achieve greater value in care, improved patient health outcomes, and lower health care costs. ANA also strongly believes that the bachelor’s-prepared registered nurse and the Advanced Practice Registered Nurse have a central role to play in any care coordination model. And as noted under Section I of this comment letter, nurse skill mix and adequate staffing contribute positively to patient outcomes. As such, we urge CMS to continue to implement and expand care coordination models with an eye toward the central role of the registered nurse.

III. ANA supports the adoption of a *falls with injury* measure in the IQR Program to support the Hospital Acquired Condition (HAC) Reduction Program

Section V.K.4. *Request for Comments on Additional Measures for Potential Future Adoption* asks for public comment on additional measures which might reduce the incidence of three specific Hospital Acquired Conditions (HACs). ANA strongly supports the adoption of a *Falls with Injury* measure to be included in CMS’ IQR Program to support the Hospital Acquired Condition Reduction Program. The central goal in healthcare must be to provide high-value care for patients, with value defined as generally a function of outcomes relative to costs.

ANA recognizes the adverse impact that HACs have from both a patient health outcome standpoint and from a financial standpoint. As it pertains to this proposed IPPS rule, ANA supports the adoption of a measure which evaluates *falls with injury*. With the adoption of such measure, however, ANA strongly

urges CMS to recognize the important role the registered nurse plays in the reduction of such HACs. In particular, falls are a significant cause of morbidity in hospitalized patients:

- It has been estimated that 2-12% of hospitalized patients will fall during their admission and that almost 1 in 4 will suffer an associated injury (Staggs V, Mion LC, Shorr, RI, 2014).
- A study using National Database of Nursing Quality Indicators reported fall rates decreased by 2% with each additional RN hour per patient added (Lake, E.T., Shang J., Klaus S., Dunton N.E., 2010).

Appropriate nurse staffing is associated with better patient outcomes. Recent evidence supports the role of nursing in the prevention of HACs and the promotion of higher quality care. For example, systematic nurse surveillance is a critical aspect of patient safety leading to prevention of medication errors, rescue situations, patient deterioration and death (Henneman E. A., Gawlinski, A., Giuliano K. K., 2012).

Less exhaustion and the ability to perform tasks completely were cited as possible reasons for the link between higher staffing rates and fewer HACs. Between 2010 and 2013, there were an estimated 121 HACs per 1,000 acute care hospital discharges. This translates to roughly 10% of inpatient stays resulting in at least one HAC (AHRQ, 2015). Costs associated with HAC's have a considerable financial impact on the healthcare system. The overall direct costs of HACs to U.S. Hospitals range from \$28 billion to \$45 billion per year (AHRQ, 2015).

With the increased focus on value-based care, optimal nurse staffing is essential to delivering high-quality, cost-effective care. Implementation of a regulatory model will help set basic staffing standards, and encourage transparency of action through public reporting and imposing penalties on institutions that fail to comply with minimal standards (Avalere, 2015). As such, it is critical not only that CMS adopt a *falls with injury* measure, but that it also recognizes and elevates the role of the registered nurse in preventing adverse outcomes associated with HACs.

IV. ANA strongly supports the collection of standardized patient assessment data under the Long-Term Care Hospital Quality Reporting Program

ANA strongly advocates for interoperability and inclusion of recognized terminologies supporting nursing practice and person-centered care within electronic health records (EHR) to achieve shareable and comparable data and improve outcomes. Adopted in March 2015, the ANA Position Statement, "Inclusion of Recognized Terminologies Supporting Nursing Practice within Electronic Health Records and Other Health Information Technology Solutions" reaffirms ANA's support of the use of recognized terminologies supporting nursing practice as valuable representations of nursing practice, and to promote the integration of those terminologies into information technology solutions.

ANA commends the intent of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 to report "standardized patient assessment data with regard to quality measures, and patient assessment instrument categories. It further specifies that the data "... be standardized and

interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes..." ANA has previously submitted recommendations to Academy of Medicine's Committee on Vital Directions for Health and Health Care that calls for, "the need to escalate steps to achieve interoperable, inter-professional, patient-driven care plans that are longitudinal in nature reflecting the lifespan of the patient and family" (ANA, 2016).

In a letter from ANA to the National Coordinator, Office of National Coordinator for Health IT (ONC), regarding comments on "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1.0," dated April 2, 2015, the following is noted, "ANA does not support limiting near-term measurement to one group of eligible providers using a subset of a core set of measures. It is important that an evaluation of the capability to exchange data in an interoperable manner include all clinicians on the inter-professional care team, particularly as it relates to care coordination, including transitional care. ANA agrees with inclusion of organizations in long term care and behavioral health settings with the capability to exchange. This is essential to improve patient safety and reduce excessive cost due to avoidable health care acquired conditions and 30-day readmissions. We agree that the exchange of data between providers and all health care settings is essential."

Drawing on the paradigm to "collect once, use many times", ANA recommends that CMS consider the potential burdens associated with the collection and reporting of the identified assessment data and/or any new data. Specifically, the public comments submitted by nursing stakeholders and other clinician groups concerning the potential impacts to clinicians' workflows and the administrative burdens associated with increased documentation times for collecting and reporting of these assessment data elements. Moreover, ANA supports that data should be created and collected seamlessly during the routine provision of care, alleviating the need for duplicate entry of data. ANA welcomes the opportunity to discuss these issues for future consideration.

V. ANA supports proposed revisions to the application and re-application procedures for national Accrediting Organizations (AOs), provider and supplier conditions, and posting of survey reports and acceptable Plans of Corrections (PoCs)

ANA strongly supports the CMS proposal under Section XI.A. *Proposed Revisions to the Application and Re-Application Procedures for National Accrediting Organizations (AOs), Provider and Supplier Conditions, and Posting of Survey Reports and Acceptable Plans of Corrections (PoCs)*, to require Accrediting Organizations (AOs) with CMS-approved accreditation programs to post final accreditation survey reports and acceptable Plans of Correction (PoCs) on a public facing web site. CMS-approved AOs survey and certify that providers are compliant with the Medicare Conditions of Participation (CoPs). If approved, the health care organization is then eligible for Medicare and Medicaid reimbursement. ANA concurs with CMS that adding a standard for posting both accredited and non-accredited provider and

supplier survey reports, which would include initial and recertification surveys, as well as acceptable PoCs, would expand transparency for consumers and provide information for patients and decision makers in choosing a health care facility. ANA strongly recommends that the AO-designed web page should be approved by CMS to ensure transparency and usability of the information reported. Currently, all AOs with CMS-approved accreditation programs have web sites that inform the general public about the AO. Establishing the standard for posting both accredited and non-accredited provider and supplier survey reports, which would include initial and recertification surveys, as well as acceptable PoCs, would expand transparency even further.

ANA strongly supports all types of public reporting of information that stands to increase patient safety and value of care. Currently, healthcare organizations only disclose findings when there is a subset of complaint activity. Expanding these proposed requirements through the posting of all survey reports and acceptable PoCs would depict a more comprehensive picture of a provider's or supplier's compliance with all health and safety requirements.

ANA strongly supports CMS' proposal to alter the "Termination Public Notice Requirements" for certain providers and suppliers. Currently, CMS may terminate an agreement with a provider or supplier if the government determines that the organization is not in substantial compliance with applicable Medicare requirements. Certain providers and suppliers that voluntarily terminate their agreement with the federal government are required to publish termination notices in the local public newspaper; this is an outdated method of communication. ANA supports CMS' proposal to change to allow CMS Regional Offices and providers and suppliers more media platforms in which to publish termination notices, both voluntary and involuntary, with the intent of making these notices more visible and effective.

VI. ANA supports modified pain management questions focused on shared decision-making, discussion of treatment options, patient understanding, and patient engagement, with caveats

ANA highlights the comment in Section IX.6.a. *Refining the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166) Measure for the FY 2020 Payment Determination and Subsequent Years*, that a number of commenters recommended modified pain management questions focused on shared decision-making, discussion of treatment options, including non-opioid pain management therapies, patient understanding of pain management options, and patient engagement in their care. Indeed, commenting in August 2016 on the *Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs* proposed rule, ANA supported the removal of pain management dimension survey questions from the scoring methodology of the Hospital Value-Based Purchasing Program and supported the development of modified pain management questions through the standard survey development process to remove potential ambiguity concerning these questions and to evaluate unintended consequences linking opioid prescribing practices and the pain management dimension.

Unfortunately, neither previous, existing HCAHPS Survey pain management questions nor proposed changes adequately capture pain management in the hospital setting. Besides proposed changes, there are other points to consider:

- Patient's pain level and circumstances prior to hospital admission?
- Did medication reconciliation occur at hospital admission?
- If patient was on pain medication(s) prior to hospital admission, was medication(s) prescribed sufficient to manage pain?
- What other treatment modalities were effective for pain management in the past?
- Was patient prescribed pain medications in the hospital? The Goldilocks question: too much, too little, or just right?
- Was pain management discussed routinely throughout hospital stay with patient and/or family?
- Did the patient previously experience chronic pain before illness and/or most recent hospitalization?
- Was pain management discussed as part of discharge planning? How was discharge instructions provided? Were you contacted by the Healthcare team (hospital, PCP office, etc.) within 48 hours of discharge?
- Was patient/family apprised of types of pain patient may experience during and post hospital stay and what concrete steps to minimize pain?
- Was medication reconciliation part of discharge planning?
- Could you pay for the pain medication(s) prescribed?
- Were the pain medication(s) prescribed post discharge too much, too little, just right?
- Did you/your family understand the discharge instructions?

In order to truly understand the complexity of the current opioid epidemic, CMS must evaluate all existing avenues in the delivery of care continuum in which a breakdown in quality, safe care led to seeking alternative pain relief, particularly through opioids. The Communication About Pain (MUC16-263) composite measure could be expanded to include: Medication Reconciliation at Admission, MUC16-49, Median Time to Pain Management for Long Bone Fracture, MUC16-56; and Average change in back pain following lumbar discectomy and/or laminotomy, MUC16-87; Average change in back pain following lumbar fusion, Much16-88, and Average change in leg pain following lumbar discectomy and/or laminotomy, MUC-16-89. ANA urges CMS to evaluate these measures and to reevaluate the pain management questions in order to mitigate potential unintended consequences as they relate to the prescription of opioids; it goes without saying that this is critical given the severe, ongoing opioid crisis. ANA also recommends that CMS distinguish between hospice and palliative care, the latter of which could occur anywhere during the life spectrum, whereas hospice care occurs in the last 6 months of life.

VII. ANA supports the defined role of paraprofessionals in the health care delivery system within the boundaries of their scope of practice

Section XIII.C. *Request for Information on CMS Flexibilities and Efficiencies*, asks about improvements that can be made to the health care delivery system. ANA believes that every patient deserves access to safe, quality care from all healthcare providers. Successful health system transformation requires a rethinking of the use of existing resources. Creation of new or expansion of existing paraprofessional roles are appropriate but should not be done as a replacement for existing professionals; rather to address gaps in services and/or supplement existing provider care. Equally important is ensuring that education and training is appropriate to the expected functions. Ultimately, all health care personnel should be permitted to function at their full scope of practice, consistent with their education and training.

Currently there exists an overlap of responsibilities between professionals. Increasing paraprofessional functions makes role clarity, transparency, and strong communication and coordination even more critical. Adding new roles without effective coordination of care can result in untoward outcomes, complications, and increased cost, contrary to the goals of the Institute for Healthcare Improvement's "triple aim". Patient-centered care coordination is a core professional standard and competency for the practice of registered nursing. Generally, care coordination involves ensuring that a patient's needs and preferences for health services and information are communicated and delivered effectively across health care providers, functions, and settings over time. This stresses the need for an understanding of the paraprofessional's capabilities and contributions for greatest effectiveness, safety and quality.

Finally, emerging roles should have ongoing evaluation to determine value and inform health care professionals and policy makers as to needed changes and appropriateness of educational preparation and regulatory models. As noted in Section II, ANA strongly supports the use of care coordination in health care delivery systems. The efficient implementation of such care coordination delivery systems must ensure that all members of the care delivery team are able to practice at the full scope of their training, while at the same time ensuring that roles are clearly delineated and that paraprofessional roles are not artificially expanded beyond their level of education and training to replace the functions of the professional. Allowing paraprofessionals to practice at a scope of practice beyond their level of education and training would indeed negate the benefits proffered through care coordination models and would lead to adverse outcomes.

We appreciate the opportunity to share our views and current evidence related to the IPPS FY 2018 proposed rule-making and welcome the opportunity to discuss these issues in greater detail. If you have

questions, please contact Mary Beth Bresch White, Director, ANA Health Policy, at 301.628.5022 or marybreschwhite@ana.org.

Sincerely,



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Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer

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