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April 08, 2013

Robert Saunders, Ph.D.
Senior Program Officer
Institute of Medicine
500 Fifth St, NW
Washington, DC 20001

Dear Dr. Saunders:

The American Nurses Association (ANA) appreciates the opportunity to provide comments on the Institute of Medicine's (IOM) study panel to identify core measure sets based on the Triple Aim of better health, better care, and lower cost, and to assess progress towards these aims. The triple aim was developed by the Institute of Healthcare Improvement (IHI) and is the cornerstone of the National Quality Strategy (NQS), the nation's guide star for healthcare quality improvement.

The importance of this endeavor is self-evident. The challenge will be insuring that all stakeholders, especially licensed clinicians besides physicians have an equal opportunity for input. It is imperative that the IOM seek input from registered nurses and clinicians, such as physical therapists and social workers, to ensure proper representation of their unique perspectives on quality measurement. The interprofessional team is most powerful when all team members' contributions to address patients' needs are measured consistent with the clinicians' scope of practice and expertise. ANA expects that nursing will be represented on this panel. We would be pleased to support the identification of a nurse who is suitable for this study panel.

The ANA's specific comments on the charge to the study panel:

1. Consider candidate measures suggested as reliable and representative reflections of health status, care quality, and care costs for individuals and populations:

The National Quality Forum (NQF) has identified rigorous measures for accountability programs related to the triple aims. The most expedient route to achieving these aims is through consideration of rigorous measures that address the NQS priorities and high impact conditions for care settings and programs. It is also critical that this work drive toward harmonized cross cutting measures for use across care. The IOM has already identified criteria to evaluate measure importance, which includes impact, improvability, and inclusiveness. These criteria should be applied to prioritize rigorously tested measures for inclusion in the core sets.

As part of the Measure Application Partnership's (MAP) Coordinating Committee and a partner in the National Priorities Partnership (NPP), ANA has articulated the need for team-based accountability measures with attribution to specific team members. Team-based measures are critical to support a learning health system (LHS). The IOM identified that a LHS is essential to meet the NQS priorities, aims, and goals and to ensure the inclusion of the six aims for improvement (safe, equitable, effective, patient-

centered and timely). Team-based accountability measures with attribution can inform a LHS as to the appropriate staffing and skill mix of interprofessional clinicians and other team members that yields the best outcomes at the lowest cost. This data is important as teams evolve to support each team member to function at the top of their license, skill, and education. Such a high functioning team can better address long-standing poor outcomes such as high rates of avoidable hospital readmissions, healthcare acquired conditions, and poor maternity outcomes.

The MAP has identified families of measures and core measure sets for the Centers for Medicare and Medicaid Services' (CMS) transparent reporting and pay for quality programs. These measures can improve care within settings and in transitional care between settings, as well as to address the needs of vulnerable populations across settings. ANA recommends that the IOM consider the MAP's recommendations for the core safety set for use in hospitals. For example, ANA supports key safety measures such as the National Healthcare Safety Network (NHSN) healthcare associated infection measures. ANA is working toward direct upload of such measures at the unit-level into its National Database of Nursing Quality Indicators[®] (NDNQI[®]). Hospitals can then use this data within unit-based dashboards that also includes core structural measures (e.g., staffing and skill mix), processes of care measures (e.g., evidence-based prevention practices), and other outcome measures (e.g., hospital acquired conditions [HAC]).

2. Identify current reporting requirements related to progress in health status, health care access and quality, costs of health care, and public health:

The PfP has reported progress in core safety areas across areas of harm (HACs, maternity harm, and avoidable readmissions) due to required reporting through the Hospital Engagement Networks (HEN). The HENs are using a core set of NQF-endorsed measures, including the NQF falls and pressure ulcer measures approved for hospitals. These metrics are effective in measuring progress in reducing harm.

3. Identify measurement and data systems currently used to monitor progress on these parameters at national, state, local, and institutional levels:

The ANA urges the study panel to make recommendations related to interoperable systems. At present, a lack of interoperability prevents broad sharing of important patient information within and among health care systems, provider groups, external resources (e.g., laboratories), and payers. This gap also affects the development, growth, and ultimate maximization of the benefits of a LHS. There are significant barriers to meeting consumers' needs through interoperability among systems, including the competition of required "standards" and the inability to share some data due to patented and copyrighted intellectual property.

4. Propose a slate of core metrics to track progress in care, costs, and health at national, state, local, and organizational levels:

Safety is the first attribute for quality care identified by the IOM and is a NQS priority. Therefore, ANA recommends safety measures as a logical first core set the NQF-endorsed safety measures available are more robust. The ANA supports the MAP core sets of safety metrics for implementation at the national, state, local, and organizational

levels for hospitals, as well as the falls and pressure ulcer measures previously discussed for transparent reporting.

The NQF has identified patient reported outcomes as a first step in patient engagement. This includes screening, assessment and timely evidence-based, patient-centered interventions for prevalent unaddressed or poorly addressed conditions such as depression, dementia, and urinary incontinence. The measures chosen in this area should be broadened to be team-based metrics with attribution to the specific type of clinician on the team. This will inform a LHS as to the best staffing and mix of clinicians for a specific population at risk to maximize positive patient care outcomes through timely care access.

Appropriate care coordination measures continue to be a significant gap. ANA has convened a Care Coordination Quality Measure Panel to identify a framework and conceptual model to advance care coordination conceptualization and measurement.

5. Identify needs, opportunities, and priorities for developing and maintaining the measurement capacity (as above) necessary for progress on these candidate metrics:

ANA considers the issue of maintenance and sustainability to be related to poor interoperability among systems. As noted above, ANA urges the study panel to make recommendations related to interoperable systems.

6. Recommend an approach to continuously refining and improving the metrics and the associated measurement capacity at all levels:

ANA recommends that IOM propose an increased investment in quality measurement consistent with its level of importance. Sources of that investment could include government investment, but should equally or preferentially include the for-profit and non-profit private sectors as the development of a market for high quality health care will result from valid and reliable measurement. The demand for measurements of quality will increase the development of effective quality measures at a greater and more sustainable rate than will a legislated mandate. Health care organizations will invest in quality improvements more readily and more zealously if health care consumers demand it. To support the consumer's desire for information about quality it is critical that the health care industry move toward more transparency. This will help to overcome the market failure of information asymmetry resulting from eligible professionals and hospitals failing to share with consumers and payers information about the quality of care they provide. This forced transparency could occur in response to legislated mandates, awareness campaigns promulgated by consumer groups, or by other means. Each of these possibilities could build from the development of a LHS.


Examples of methods to report on quality deficiencies abound in health care, as well as in other industries. The Consumers' Union builds interest in consumer products by rating them in its Consumer Reports publication. Consumers seeking information on plumbers and other tradespeople use Angie's List. The U.S. government reports hospital and eligible professional quality metrics on Hospital Compare and Physician Compare, respectively. IOM should recognize that while the altruistic nature of many clinicians

supports measurement, the business of health care has concerns about sharing information about the quality of care it provides

Increasing the number, availability, and accessibility of public quality reporting by decreasing the barriers to reporting and strengthening transparency of the reporting organizations ought to build demand for such reports. Consumers need to understand and should be able to identify when they are receiving high quality care. Reporting facilitates accountability and acknowledgement of all stakeholders, regardless of industry.

Thank you for the opportunity to provide input on this important work. ANA looks forward to closely working with the study panel as it deliberates. We look forward to the opportunity to collaborate on the appointment of a nursing representative to this panel. For additional information and future comments, please contact Dr. Maureen Dailey at 301-628-5062 or Maureen.Dailey@ana.org.

Sincerely,

A handwritten signature in cursive script that reads "Marla J. Weston".

Marla J. Weston, PhD, RN, FAAN
Chief Executive Officer

cc: President Karen A. Daley, PhD, MPH, RN, FAAN