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), along with the nursing and provider organizations listed below are writing to confirm and emphasize our strong support of the inclusion of two critical safety structural measures (nurse staffing and skill mix) to the CMS Inpatient Quality Reporting Program. ANA and its CSNAs and OAs commend 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 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. 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.

The signers of this letter affirm 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.

We also recognize 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. We believe that 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).

These two staffing measures are the touchstones of all measures of nursing performance and impact on care. ANA and its C/SNAs and OAs concur 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.

We appreciate the opportunity to share our views and current evidence related to these nurse staffing measures 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,

American Nurses Association, ANA

American Nurses Association Massachusetts, ANA Mass

American Nurses Association Michigan, ANA Michigan

American Nurses Association Rhode Island, ANA Rhode Island

Arizona Nurses Association, AzNA

Maryland Nurses Association, MNA

Missouri Nurses Association, MONA

New Jersey State Nurses Association, NJSNA

Oklahoma Nurses Association, ONA

Oregon Nurses Association, ONA

Pennsylvania State Nurses Association, PSNA

South Carolina Nurses Association, SCNA

Tennessee Nurses Association, TNA

Texas Nurses Association, TNA

Virgin Islands State Nurses Association, VISNA

Washington State Nurses Association, WSNA

West Virginia Nurses Association, WVNA

Academy of Medical-Surgical Nurses, AMSN

American Academy of Ambulatory Care Nursing, AAACN

American Association of Diabetes Educators, AADE

American Association of Neuroscience Nurses, AANN

American College of Nurse-Midwives, ACNM

American Federation of Teachers, Nurses and HEALTH Professionals

Association of periOperative Registered Nurses, AORN

Emergency Nurses Association, ENA

Infusion Nurses Society, INS

National Association of Clinical Nurse Specialists, NACNS

Texas Organization of Baccalaureate and Graduate Nursing Education, TOBGNE