February 28, 2011

Agency for Healthcare Research and Quality (AHRQ)
Attention: Nancy Wilson, Immediate Office of the Director,
Public Comment: Medicaid Program: Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults
Room 3028
540 Gaither Rd.
Rockville, MD 20850

Electronically submitted via: medicaidadultmeasures@ahrq.hhs.gov

Re: [FR Doc. No: 2010–33038, Federal Register Vol. 75, No. 250 (Thursday, December 30, 2010) [Notices], [Pages 82397-82397]

Dear Dr. Wilson:

On behalf of the American Nurses Association (ANA), the largest nursing organization in the U.S. representing the interests of the nation's 3.1 million Registered Nurses through its state nurses associations and organizational affiliates, please permit us to offer comments regarding the Medicaid Program: Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults

It is ANA's perspective that the overall national quality of health care for adults cannot be estimated and/or evaluated in the absence of data related to the appropriateness and adequacy of the nursing workforce providing care and processes of nursing care. Moreover, Donabedian (1988) noted that structure, process, and outcome measures must be assessed to evaluate the quality of care. The National Database of Nursing Quality Indicators® (NDNQI®) is collecting data nationally from 1737 hospitals evaluating inpatient hospital care. Importantly, participation in a nursing data base registry was added to Hospital Compare as a structural measure in 2010. There are 12 nursing-sensitive measures approved by the National Quality forum (NQF). The NDNQI includes 11 of the 12 NQF-endorsed nursing sensitive indicators and additional important structural measures (e.g., nurse education) to patient quality, safety, and experience of care. Multiple studies have found associations between enhanced structural NDNQI measures (e.g., measures of staffing) with improved patient quality and safety outcomes. Moreover, hospitals use the NDNQI data in ongoing performance improvement to improve patient outcomes through enhancing processes of care (e.g., falls and pressure ulcer risk assessment and interventions), the work environment, and nurse work outcomes (e.g., reduced turnover and job satisfaction). Job dissatisfaction and high turnover in nurses has been associated with increased adverse events and mortality in two decades of research.
ANA supports measures for important health screening, cross cutting measures (e.g., patient safety and care coordination across settings) as endorsed by the NQF, and disease-specific process of care and composite measures for clinicians to improve clinical outcomes (e.g., primary care providers such as advanced practice registered nurses and physicians) as endorsed by the American Medical Association Physician Consortium for Performance Improvement (AMA PCP CI). The National Priorities Partnership (NPP, 2010) has identified eight priorities to improve the quality of care, such as care coordination. Additionally, the NQF (2011) has indentified to Health and Human Services that there are multiple gaps in measures in the pipeline in these priority areas, particularly in the area of care coordination within settings and across settings (NQF, 2011). ANA also notes gaps exist in important measures to evaluate clinician effectiveness in reducing risk for populations at risk for high cost conditions (e.g., pressure ulcers) and those with multiple chronic conditions. These populations require complex care across settings. ANA is developing a composite measure for pressure ulcer prevention for use across settings and working with multiple stakeholders to prioritize measures of care coordination.

The ANA has provided input to the Office of the National Coordinator (ONC) for quality measurement in stage 1, 2 and 3 of meaningful use focused on high cost, problem prone diagnoses (e.g., heart failure, diabetes), complex conditions (e.g., cognitive impairment, immobility, incontinence, dementia), and problematic risk for adverse events and comorbidities. For example, ANA has asked the ONC for the inclusion of screening for pressure ulcer risk and depression screening, as a cross cutting measure, across settings. Nurses are often the clinicians that screen patients for pressure ulcer and depression risk in hospitals, primary care and in long term care (e.g., through the minimum data sets used in nursing homes and home care). Since depression is prevalent in chronic illness and patients can’t effectively engage in self-care if depression is unaddressed, it is important that risk screening and a follow-up plan is measured across clinicians and settings.

The NPP has identified in three avoidable high cost areas (i.e., 30 day readmissions, overuse of emergency department, and medication errors) for improvement (NPP, 2010). For example, NPP identified that reducing medication errors provides a $21 billion dollar cost reduction opportunity in the US (NPP, 2011). It is important that medication reconciliation is done across settings and over time. Continuity in patient and caregiver medication education and prescriptions across settings, checking for errors of commission and omission, and ascertaining patient adherence should be measured. Nurses evaluate patient’s readiness for change, develop patient-centered goals; provide inter-professional care coordination, patient care treatments, and patient/caregiver education; and evaluate progress toward goals in all health care settings, including in the transition zone between hospitals and home (Coleman et al., 2006; Naylor et al., 2004). ANA applauds the inclusion of discharge information transfer, inclusion of specific component in the discharge plan, and supports inclusion of the patient’s perspective of care via the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. However, the CAHPS data should be captured across settings, not just for health plans as disparities exist across settings “related to race, ethnicity, and socioeconomic status still pervade the American health care system” (AHRQ, 2009, p. 2).
Health care that meets the IOM eight domains for quality care and contributes to the “Triple Aim” should be provided across payers. Since disparities in care often exist in the underserved, often those who are impoverished and Medicaid-eligible, it is important to add additional measures. For example, colorectal screening and other measures in the AHRQ “core measure set” should be included to reduce important disparities and follow the guidelines provided by the US Preventative Service Task Force (2009, p. 29). Finally, adults with Medicaid with chronic illness are at higher risk for premature and avoidable institutionalization if their care is not coordinated and evidence-based interventions and treatments are not provided timely. Long term care measures should be evaluated for inclusion, to evaluate the quality of care in home care and inpatient nursing home care.

Thank you for giving ANA the opportunity to provide comments regarding the Medicaid Program: Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults.

Sincerely,

[Signature]

Marla J. Weston, PhD, RN
Chief Executive Officer

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


