



8515 GEORGIA AVENUE, SUITE 400
SILVER SPRING, MARYLAND 20910-3492
301 628-5000 • FAX 301 628-5001
www.NursingWorld.org

KAREN A. DALEY, PhD, MPH, RN, FAAN
PRESIDENT

MARLA J. WESTON, PhD, RN
CHIEF EXECUTIVE OFFICER

May 7, 2012

Honorable Marilyn B. Tavenner, MHA, RN
Acting Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services (CMS)
Department of Health & Human Services
Attention: CMS-0044-P
P.O. Box 8013
Baltimore, MD 21244-8013

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

Re: **Medicare and Medicaid Programs; Electronic Health Record Incentive Program—
Stage 2. Proposed Rule. 77 Fed. Reg. 13698 (March 7, 2012). CMS-0044-P/RIN
0938-AQ84.**

Dear Administrator Tavenner:

The American Nurses Association (ANA) welcomes the opportunity to offer comments on the proposed rule specifying the meaningful use (MU) Stage 2 criteria, which eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) must meet in order to qualify for Medicare and/or Medicaid electronic health record (EHR) incentive payments. The ANA is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses through its constituent/state member associations (C/SNA), organizational affiliates (OA), specialty nursing associations, and individual members.

Registered nurses are the largest group of healthcare professionals serving in multiple direct care, care coordination, and administrative leadership roles across healthcare settings. Nurses are engaged in developing and implementing EHR systems in hospitals and other settings, as nurse informaticists, chief nursing informatics officers, etc. Nurses serve as healthcare performance improvement, clinical, and informatics experts on federal advisory panels for CMS, the Agency for Healthcare Research and Policy (AHRQ), the Office of the National Coordinator (ONC), and other key National Quality Measurement Enterprise Committees, Technical Advisory Panels (TEP), and Advisory Groups. Moreover, nurse informaticists are leading and coordinating teams composed of quality, clinician, vendors and other key stakeholder members to evaluate eMeasure specifications and plan, implement, and evaluate eMeasure piloting and integration into complex clinician office and hospital setting systems.

ANA supports the proposed rule's vision of Meaningful Use (MU) Stage 2, to advance healthcare information technology (HIT) integration as a promising tool and lever to improve quality of care, including patient safety, while seeking greater efficiencies and savings. The ANA has worked collaboratively to develop ANA's comments on this proposed rule with support from nurse informaticists, including the Alliance of Nursing in Informatics (ANI), as well as the nursing informatics working groups at AMIA and the Healthcare Information and Management Systems Society (HIMSS), and interprofessional experts across the national quality enterprise. ANA has evaluated these complex proposed regulations using the lens of the nation's

tri-part aim (i.e., better care, healthier people/communities, and lower cost) to improve healthcare and goals related to the six priorities articulated in the National Quality Strategy (NQS) and the Measure Application Partnership (MAP) recommendations as the overarching evaluation criteria.

General ANA Comment: Clinician Neutral Language and the Future of Nursing

In the IOM Future of Nursing Report: Leading Change, Advancing Health, the Institute of Medicine (IOM) discussed “nursing serving in leadership roles as full partners in redesigning the organization, financing, and delivery of the health care system.”¹ⁱ. As full partners, the ANA requests on behalf of nursing that the final rule’s language meet an appropriate standard of provider neutrality. As outlined by CMS, EPs include non-physicians, such as Nurse Practitioners (NPs) and Certified Nurse-Midwives (CNMs).

The current language of the NPRM includes multiple examples of physician-centric language, the first of which appears on page 13698 in the acronyms’ definitions. That list incorrectly defines CPOE as Computerized Physician Order Entry (CPOE), a physician-centric term, instead of the provider neutral term Computerized Provider Order Entry. Further, the following measures include physician-centric language that ought to be provider neutral: NQF 0097, NQF 0024, NQF 0045, NQF 0089, NQF 0322, NQF 0519, and NQF 0561. While other examples exist, the final example we present appears on page 13708, which in the second paragraph states, “An office visit is defined as any billable visit that includes: (1) Concurrent care or transfer of care visits; (2) consultant visits; or (3) prolonged *physician* service without direct, face-to-face patient contact (for example, telehealth)...” (emphasis added). This example is particularly problematic, as it outlines an important aspect of billing that could cause NPs, CNMs, and other EPs difficulty in obtaining incentivized payment from Medicaid. The ANA recognizes that there are appropriate instances for physician-centric language written into this NPRM. However, the instances identified above are not among them. Therefore, ANA requests that the appropriate provider neutral language supplant the errant terminology.

Beneficiary access to healthcare services should be of paramount importance in any regulation proposed by CMS. Care provided by Advanced Practice Registered Nurses (APRNs) is underrepresented in this NPRM. The existing MU criteria for EPs results in the exclusion of a considerable proportion of APRNs that we urge CMS to consider as eligible providers. The existing criteria completely exclude the thousands of APRNs who are enrolled as Medicare providers and bill Medicare directly. The ANA recognizes that Congress sets the definition of EPs, and changes are outside CMS’ control. However, we urge CMS to act in the interests of its beneficiaries by working with Congress to remedy this oversight. APRNs face the same requirements for MU as their physician colleagues, including similar investments of time and money to meet these requirements; however, the MU criteria limit them from obtaining similar incentives for MU. Additional expenditures of time and money without concomitant incentives could effectively limit beneficiary access to these highly effective healthcare providers.

As legislated, the only APRNs that bill Medicaid are eligible for MU incentive. Further, APRNs who receive reimbursement from Medicaid must meet the considerable restrictive criteria. Their practices must consist of at least 30% Medicaid patient volume or exist predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) whose catchment

¹ Institute of Medicine. 2011. *The Future of Nursing: Leading Change, Advancing Health*, 375. Washington, DC: The National Academies Press.

includes at least 30% needy individual patient volume. Additionally, they must not be hospital-based. Unlike most EPs, APRNs predominantly exist in practices affiliated with EHs and CAHs. The ANA believes these limitations to be unduly limiting. In December 2011, only 2,432 of more than 150,000 Nurse Practitioners and 312 of more than 7,000 Certified Nurse-Midwives in the U.S. met criteria and received Medicaid EHR incentives. Reducing the restrictions placed on APRNs by allowing them to participate in the Medicare EHR incentive program would support patient access to the important services they provide, and improve their ability to compete fairly in appropriate parts of the healthcare marketplace.

Summary of ANA Comments

The ANA supports CMS' proposed new core and menu set criteria for Meaningful Use Stage 2, particularly the focus on care coordination and patient engagement. Care coordination is a building block upon which teams can achieve targeted performance improvement goals, such as reductions in avoidable adverse events (e.g., falls, pressure ulcers, infections adverse drug events, and readmissions), care disparities, and costs of care. Care coordination and patient/caregiver engagement are core competencies for the nursing profession. This is what nurses do, both individually and as members of interprofessional teams, within various care settings and between settings during care transitions. Patient-centered care coordination and patient/caregiver engagement are essential to achieving the tri-part national aims for healthcare, truly integrating patient/caregivers to identify care goals, engage in longitudinal care planning, and act as true participant in their healthcare team. The ANA has articulated registered nurses' leadership roles in care coordination and patient engagement in previous comments on proposed rules (e.g., Accountable Care Organizations). Appendix 1 provides details articulating registered nurses' key leadership roles and contributions in care coordination and patient/caregiver engagement related to Meaningful Use and HIT, including eMeasure development and integration.

The ANA comments on this proposed rule focus on:

- Suggested criteria for proposed core/menu objectives, harnessing the national healthcare information technology (HIT) infrastructure to support more robust eMeasurement integration for multiple purposes.
- Concerns shared by nurses and other multi-stakeholder groups regarding patient safety and usability, related to MU stage 2 integration and requests for clarification to ensure efficient team-based practice (e.g., practice to the top of the license) is supported.
- Evaluation of the proposed clinical quality measures and reporting for EPs and EHs/CAHs.
- Gaps in care quality measures (CQMs) for MU stages 2 and 3, which are essential to support high performing teams and improved outcomes.

Key Care Data Exchange

The ANA supports moving from merely developing lists (e.g., problem, medication, and allergy), in a structured format, to putting this key data "into production" electronically to improve healthcare information exchange between settings of care, providers, and patients/caregivers. The ANA supports one of the ultimate goals for MU, which is real-time or near to real-time, high-quality data capture in standardized format, as well data exchange with accuracy, completeness, and efficiency (e.g., wound data or risk data exchange in transition of care or for expert nurse consultation). The ANA supports proactive offering to patients, and their approved caregiver(s), their own health information through secure electronic means, in

order to engage them in action. ANA has taken the pledge to support the ONC's campaign "Putting the I in HIT". ANA catalyzes nurses to use personal health records to educate their patients about the value of HIT.

**Core Objective addressing quality, safety, efficiency, and reducing health disparities:
Leverage CPOE for medications, lab, and radiology orders**

Objective: Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.

Measure: More than 60 percent of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

The ANA supports the comments of the ANI regarding CPOE including:

- Request that CMS not include in the measure any data entry by clerical staff, including scribes. Rather, only licensed healthcare professionals with practice authority should be included in the measure to ensure patient safety is not compromised.

The ANA also suggests CMS reconsider the performance threshold for CPOE, and modify it to state:

- CPOE is a total system change that's crucial to patient safety and should not be selectively offered to patients. For EHs that convert to CPOE, the threshold should be 80% (with a goal to strive for 100%).

Core Objective to improve quality, safety, efficiency, and reduce health disparities: Five Clinical Decision Support Interventions

Objective: Use clinical decision support to improve performance on high-priority health conditions.

Measure: Implement 5 clinical decision support interventions related to 5 or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period."

The ANA fully supports ANI's comments that Meaningful Use Stage 2 at point of care should (can) be used to improve care for high priority conditions through patient/caregiver healthcare information access and electronic data exchange, ANA agrees with:

- CMS redefining clinical decision support (CDS) to clinical decision support intervention (CDI), which are cued seamlessly to the clinician at the point of care in a standardized, user friendly format.
- Provision of individually identified CDI cues which are linked to an evidence-based (E-B) source(s) (e.g., content vendor and/or academic source), along with ANI's position

that an identified date of release/revision be included, rather than detailed information provided by the Certified EHR Technology (CEHRT) at each level.

- The rule that CDI be presented via the CEHRT to a licensed healthcare professional who will exercise judgment about the CDI before the action is processed.
- ANI's specific request for CMS to provide "explicit clarity and understanding that a 'licensed healthcare professional' is any member of the interprofessional team for which the intervention is relevant to their scope of practice; for example the following licensed healthcare professionals are identified with the current clinical quality measures: registered nurses, pharmacists, RN lactation specialists, and respiratory therapists."

The ANA also supports broadening MU Stage 2. ANA agrees with ANI's comments supporting:

- Specific E-B order/care coordination sets (e.g., diagnosis and condition-specific), which are tied to patients' admitting or current diagnoses/conditions (e.g. identified risk or other problem).
- Dosing (e.g., renal dosing, dosing adjustments related to drug interactions).
- The use of preformatted diagnosis/condition-specific forms/templates that provide point of care prompts to users based on previous responses (i.e. requiring justification reason when E-B care is not ordered such as pressure reducing mattress for identified immobility risk or antiembolytic therapy for confirmed ischemic stroke care).
- Patient-specific pertinent clinical information should be displayed seamlessly during the ordering or data entry process. For example, display of lab data or weights during medication ordering.

The ANA also supports mature eMeasure/HIT use integration with attributes/considerations such as:

- Display patients' preferences as well as data as to what's not worked in the past during order entry to avoid nontherapeutic, unwanted, or wasteful care.
- CDI feeding into patient-centered, E-B algorithms for continuity and E-B discharge planning.
- Enhancement of eMeasure attributes (eg., data elements) that best support efficient, effective, and usable patient-centered, longitudinal care plans to enable patient/caregiver engagement and interprofessional teams achieving improved patient outcomes.
- Provide adequate time for eMeasure regulation implementation cycle (e.g., 6-9 months after final regulation) to ensure proper eMeasure analysis and planning, evaluation of usability of systems for eMeasurement, as well as support (e.g., library of best practice order sets) for EPs and EHs/CAHs during eMeasure piloting given the differences in system capabilities.
- Capture usability data for interprofessional team members to evaluate the impact of advancing MU on patient care time, etc.

Information Exchange to improve quality, safety, efficiency, and reduce health disparities: Patient/Caregiver Online viewing, download, and transmit access to their health information.

Objective: EP: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and medication allergies) within 4 business days of the information being available to the EP. EH: Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request.

The ANA supports patient and caregiver access and engagement to support the ONC pledge. The recommendation by ANI to remove the phrase “as appropriate” is supported by ANA, as access should be universal. ANA also supports CQM’s proposed threshold for this measure (10%) with the goal of increasing participation rates rapidly to improve self-care activation.

Core Objective - EP Demographics

Proposed EP Objective (at page 13711 and Table 4 page 13734): “Record the following demographics: Preferred language, gender, race and ethnicity, and date of birth.”

ANA supports the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) Recommendation: Demographics for women should include whether they are pregnant or not pregnant. There is under-reporting of pregnancy status. This data is important to make the connection between pregnancy and mortality and morbidity data.

Core Objective - EP Vital Signs

Proposed EP Objective (at page 13712, Table 4 page 13735): “Record and chart changes in the following vital signs: Height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0–20 years, including BMI.”

The ANA supports the AWHONN’s recommendation that the proposed set of vital signs should include pre-pregnancy weight if the patient is a woman and the patient is pregnant. The AWHONN noted “Given the fact that the United States ranks 50th in the world for maternal mortality and the known connection between obesity and poor pregnancy outcomes, more data are needed on whether the poor outcomes are related to pre-pregnancy or during-pregnancy weight gain.”

Population Health

CMS proposes to make reporting to immunization registries a "core" and required public health objective for Stage 2. In contrast, this was an optional “menu” objective choice for Stage 1. ANA joins other immunization advocacy groups in supporting the proposed change. This will enhance broad use of the registries, and ensure a robust information system. Immunization registries that are widespread, accessible, and robustly populated will greatly reduce vaccine duplication and cut costs. As stated by CMS, the inclusion in the core set will enhance submission of electronic immunization data, and remove any vagueness from varying laws or practice recommendations.

Advance Directives

The ANA supports the HIT Policy Committee suggestion to add advanced directives (> 65) to the core set. This is essential to promote honoring patients wishes (eg., avoid unwanted, futile care and ensure patient-centered palliative and end of life care), as well as avoidable costs (e.g., readmissions). Thus, ANA does not agree with the CMS proposal (at page 13706) to keep advanced directives in the menu set, given CMS’s concerns regarding potential conflicts between

storing advance directives and existing State laws. ANA suggests either storage of an electronic copy of the advance directive in the CEHRT, or linking to an electronic copy of advance directive for eligible hospitals and CAHs in Stage 2 (p. 1371) by the EP and EH/CAH. It is imperative that the healthcare proxy information be included and accessible in the EHR.

Proposed Clinical Quality Measures (CQM) for Eligible Hospitals (EH) and Critical Access Hospitals (CAHs)

The ANA supports the MAP recommended harmonization of CQMs that would apply for both Medicare and Medicaid for use across Federal Programs, to avoid duplicative requirements as recommended by the MAP.

The ANA also considers the choice of CQM National Quality Strategy (NQS) categorization appropriate: 1) high impact priority conditions, 2) CMS public health campaigns (e.g., Million Hearts Campaign and Healthy Start), and 3) the campaign to reduce avoidable harm (hospital acquired conditions [HAC] and cost (eg., readmissions), the Partnership for Patients.

CQM's Proposed for Eligible Providers for FY 2014

Appendix 2, Table 1 provides for ANA's analysis of individual QCM's for EPs: 1) support decision, 2) areas of strengths and weaknesses, and 3) recommendations for improving the measure or a replacement measure.

Clinical Quality Measures Proposed for EHs and CAHs for FY 2014

Appendix 2, Table 2 provides ANA's analysis on individual QCMs for EHs and CAHs: 1) support decision, 2) comments on strengths and weaknesses, and 3) recommendations for improving the measure or a replacement measure.

CQM Reporting Options

EPs:

The ANA supports option 1a with the choice of 12 CQMs to report, at least one from each of six domains. Option 1a will provide EPs increased choice in CQMs, which will allow for meaningful measures relevant to their practice population. ANA also supports consideration of an alternative approach with the EP reporting on CMS defined core eMeasures plus 4-5 delineated specialty eMeasures.

Measure Gaps:

Overall, the finite set of discipline-centric retooled measures (NQF, 2011) and limited subset of eMeasures in the NQF portfolio, have limited the selection of cross cutting measures for MU Stage 2. Cross cutting eMeasures are necessary to evaluate the quality of care provided by interprofessional teams. The ANA supports core sets of measure for use across settings of care and interprofessional teams as outlined by the MAP final reports to the Department of Health and Human Services in 2012, and draft reports put out for comment in 2012. A common theme identified by the MAP Workgroups and Coordinating Committee is the interprofessional nature of care coordination and patient engagement, particularly for populations that require complex care (e.g., those with multiple chronic conditions, the frail elderly, and the dual eligible).

Mature team-based eMeasures that efficiently capture data at the point of care should be implemented in both Stage 2 and 3. These eMeasures should include all the interprofessional

team members, including attribution, to capture data necessary to provide CDI, while informing the best E-B practice and research as well as the best interprofessional team mix and staffing that yields the best outcomes. Registered nurses perform the bulk of assessments and screening in hospitals and often perform them in the office setting in lieu of the EP (e.g., APRN, MD, or physician assistant). Moreover, nurses and other professionals participate and lead care planning and provide direct care, patient/caregiver engagement and education, care coordination, and key aspects of care.

The CQM's for EPs and EHs in the proposed rule largely disregards the contributions of interprofessional team members given the discipline-centric available eMeasures. For example, the work of registered nurses on teams is not included, other than APRNs as EPs for Medicaid. As a result, CMS is missing the opportunity to capture and cue E-B clinical practices, care coordination, and achieve sustained real cost savings in office and hospital settings. Thus, measure development funding is urgently needed to develop these team-based, cross cutting measures in priority areas (e.g., safety, care coordination, patient/care engagement) in eMeasure format.

The ANA has identified the significant E-B measure gaps in the priority areas including patient safety, care coordination, and patient engagement related to the lack of eMeasure development in these key areas. (Some concepts were identified by ONC for Stage 2 and others for Stage 3.) The ANA agrees with the ONC's Policy Quality Measures Workgroup that the measure domain at greatest risk of under-representation in Stage 2 mature care coordination measures. It is also important to note the NQF Care Coordination Maintenance Steering Committee had no new measures submitted in response to the call for measures this year. It is essential that both the HIT infrastructure to support mature care coordination measures is developed and eMeasure development funding be prioritized in order to fill care coordination measure gaps and address barriers to implementation.

The ANA suggests broadening of future team-based eMeasures to include:

- Mature composite care coordination measures with potential to reduce significant suffering, harm, and costs (i.e., structure, process, and outcomes for high volume, problem prone conditions such as comprehensive pressure ulcer and falls risk assessment, risk interventions, and incidence; and assessment of existing ulcers).
- Mature care coordination measures beyond diagnosis and condition-centric areas such as key areas important to patients/caregivers (e.g., functional status maximization).
- Mature measures of effective patient-centered care planning (a forward-looking care view as opposed to transfer or discharge summaries, a retrospective view).
- Mature patient engagement measures beyond consumer satisfaction, experience, and teaching effectiveness to capture specific attributes of successful patient/caregiver engagement (e.g., effective self-care activation level and advancement) and achievement of self-care integration (e.g., medication, weight monitoring and appropriate follow-up actions etc.).
- Robust Medication transition of care (TOC) safety measures for EHs beyond simple reconciliation and drug-drug interaction checks, to include full reconciliation pre-discharge prior to patient discharge (i.e., seamless "Triple electronic Check": TOC order, prescriptions, and TOC documents (i.e., patient/caregiver instructions, primary care, as well as post acute care/long term care provider – home healthcare, nursing home, etc.);

and patient/caregiver instructions and ascertain patient/caregiver understanding, including purpose, dose, route, frequency, side effects and appropriate action, and importance of adherence).

- Targeted specific medication safety process and outcome measures (e.g., warfarin safety including INR testing, patient education, etc.) for medications responsible for high volume avoidable emergency care, integrating interprofessional team-based models (e.g., nurse managed Coumadin centers/clinics) with attribution.

Comprehensive Care Planning Measures

Another key care coordination area for MU integration in Stages 2 and 3 should be comprehensive, patient-centered, interprofessional, longitudinal care plans. The essential care planning components (e.g., problems/diagnoses, interventions/orders, and expected outcomes/goals) are necessary for mature care coordination quality measurement. The ANA recommends that CMS consider the recommendations in the upcoming report of the National Quality Forum Care Coordination Critical Paths TEP which will assess the ability of existing HIT infrastructure (Quality Data Model [QDM]), Healthcare Quality Measure Format [HQMF], Measure Authoring Tool (MAT), electronic health records [EHRs]) to support the use of a longitudinal patient-centered plan of care, particularly during multiple types of transitions of care for purposes of quality measurement and reporting. This NQF project will specifically address interprofessional care plan measurement concepts related to care coordination. The TEP will then develop critical paths and an action plan to address identified key issues, gaps, and barriers. This work will have a priority focus on the quality reporting data infrastructure requirements related to enhancing care coordination through MU, plus integrating interprofessional care plans effectively and efficiently, during transitions of care. Currently, work-arounds are used to address errors of omission in patient problems lists due to a pattern of single-discipline access to electronic problem lists. This will only be corrected through integration of a robust interprofessional electronic care plan with appropriate interprofessional access (shared governance).

The ANA has provided additional specific measure input and comments on Stages 2 and 3 measure gaps. Please see Appendix 3, Table 1.

Pressure Ulcer Incidence, Risk & Prevention Clinical Quality Measure for Stage 2 & Stage 3: Nursing Leadership

The ANA is providing leadership in patient safety through prevention of avoidable adverse events, such as pressure ulcers. The ANA's National Database of Nursing Quality Indicators (NDNQI ®) includes NQF-endorsed CQMs that are being leveraged in > 8,600 patient care units in > 1,800 hospitals, and multiple health care system levels (e.g., pressure ulcers and falls) to improve patient care outcomes. National-level results in hospitals that use NDNQI include reduction in pressure ulcers (i.e., nosocomial prevalence) and falls rates, achievements recognized during the 4/30/12 CMS Partnership for Patients update hosted by the National Priority Partnership meeting, which Administrator Tavenner attended. The ANA and ANI have highlighted in previous public comments to the ONC's HIT Policy Committee Quality Measures Work Group, the importance of timely development and integration of safety eMeasures. Moreover, it is essential that team-based safety eMeasures, including related care coordination, be developed for timely MU integration.

The ANA is partnering with ANI, HIMSS, and AMIA members, and with the ANA-convened Tipping Point Group (i.e., nurse quality and HIT national experts) to lead in comprehensive

eMeasure development to capture true HAC incidence rates seamlessly at the point of care, while providing CDSI and informing research and the best team mix/staffing. The ANA supports ANI comments regarding the importance of pressure ulcer prevention, including recognizing the leadership call by the Institute for Healthcare Improvement (IHI) in its 5 Million Lives Campaign recommendations. The IHI noted teams can “Prevent Pressure Ulcers . . . by reliably using science-based guidelines for their prevention. The development of pressure ulcers is a painful, expensive, and unnecessary harm event that is all too prevalent in American hospitals. The prevention of pressure ulcers is a key intervention that is not new, not expensive, and has the potential to save thousands of patients from unnecessary harm.” Thus, ANA in collaboration with nurse informatics leaders in ANI, AMIA, and HIMSS, and the Tipping Point Group are supporting an urgent call for support of timely addition of a true eMeasures focused on pressure ulcers. The first outcome eMeasure, an acute care measure of true pressure ulcer incidence, is in development by NDNQI. Lateral work on the pressure ulcer assessment, risk assessment, and E-B prevention aspects included in this comprehensive, team-based data analysis model, will provide a new CQM measure set for integration in Stages 2 and Stage 3 MU under the domain of patient safety.

Future Interprofessional eMeasure Consortium: Upstream Measure Gap Solution

The ANA calls attention to the continued discipline, diagnosis-centric continued pipeline of measures given to NQF for endorsement. We respectfully request CMS’s and Federal partners leadership to fund and support an interdisciplinary eMeasure consortium better suited to fill current key eMeasures gaps. It is important to ensure there is proportional representation of the interprofessional team members on this consortium to change the discipline-centric focus and ensure progress towards the envisioned portfolio of measures, closing the key measure gaps noted in these comments.

Cross Cutting Issues

MU Support Across Settings of Care

The ANA supports the move to a more fully integrated healthcare system, through MU that better supports the interprofessional teams across care settings. In order to achieve the patient-centered NQS goals, additional settings of care (e.g., post acute/long term care) also should receive MU support for their transitions to EHRs to support a continuum of care for MU integration.

Usability and Burden Concerns across Care Settings

The ANA has concerns related to interprofessional team usability of EHRs given the multiple changes occurring. Specifically, patient safety (e.g., reported lower face-face time during EHR change integration) and cost (e.g., clinician productivity) are current issues. The impact of MU integration on usability (e.g., number of clicks) must be evaluated during eMeasure development and piloting in diverse healthcare systems with varying resources, integration support, and HIT/EHR infrastructure systems in place.

Variability in definition of time intervals creates significant reporting burdens for EPs and EHs/CAHs and should include consistent delineations. Current diversity is reflected by the following examples; however, many more variations in reporting timing exist:


- none specified
- most recent office visit
- measurement period

- short term home health episodes
- 14 days after diagnosis

Conclusion

We appreciate the opportunity to provide our views regarding this important proposed rule. If we can be of further assistance, or if you should have any questions or comments, please feel free to contact Maureen Dailey, DNSc, RN, CWOCN at maureen.dailey@ana.org or 301-628-5062.

Sincerely,


Marla J. Weston, PhD, RN
Chief Executive Officer

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

Appendix 1

Nursing Contribution to Care Coordination/Patient Engagement, Core Nurse Competency Areas in Healthcare, including Meaningful Use

1. Registered Nurses provide Evidence-based (E-B) patient-centered care including assessment and screening, risk-based prevention and direct care, care coordination within care settings and in transitional care, engage patients in effective self-care, and provide education to patients and caregivers as core professional nursing standards of practice.
2. Registered Nurses' innovations in unit-based team performance improvement (e.g., use of the NDNQI) and transitional care models, particularly with high risk and vulnerable populations, are essential to spread nationally to meet the tri-part aim and goals related to the six national care priorities.
3. Registered Nurses are integral to longitudinal patient-centered care planning, implementation, and evaluation and their contributions should be recognized and measured along with other team members with attribution.
4. Many advanced practice registered nurses (e.g., nurse practitioners, clinical nurse specialists, and certified nurse-midwives) are essential primary care providers. They should qualify as meaningful users for incentives across payers (e.g., Medicare, Medicaid, and private payers) to improve primary care access, patient/caregiver choice, and reduce care disparities and poor outcomes (e.g., avoidable readmissions).
5. Registered nurses are providing leadership via the ANA Tipping Point Group, in the development of team-based, shared accountability eMeasures (e.g., pressure ulcers) to capture eMeasures beginning with a true measure of incidence, followed by care coordination, which includes transitional care and patient safety processes, in order to seamlessly capture data at the point of care for multiple purposes, including quality measure calculation, clinical decision support intervention (CDI), research, and the best mix of team members and staffing.
6. Nurse experts in clinical, quality, and informatics areas are evaluating eMeasure specifications, and planning, implementing, and evaluating pilots and integration of eMeasures in multiple settings of care, including clinician office and hospitals.

Appendix 2 Table 1

ANA Position/Comments: Proposed Clinical Quality Measures Evaluation Eligible Professionals (EP)			
NQF #/TBD	Measure Concept	ANA Position (Support, Support direction, Do not support)	Comments
0012 & 0014	Prenatal Care	Support	None
0018	High Blood Pressure	Support	Included in Core table 6. Clarify constitutes “adequately controlled.”
0022	High Risk Med for Elderly	Support direction	Action measured should be “stopping high risk meds” since such therapies should be NEVER events.
0024	Weight Assessment & Counseling-child, adolescent	Support direction	Should be outpatient visit with <u>Eligible Provider</u> , not PCP or OB/GYN.
0028	Tobacco Use Screen	Support	Consider lowering age to 13 years.
0031, 0032, 0034	Cancer Screening	Support	Clarify time intervals for each and define “appropriate” colorectal screening methodology.
0033	Chlamydia Screening	Support	None
0038, 0041, 0043	Immunization Record	Support	None
0045	Osteoporosis Communication	Do not support	Should be EP, not physician. Could be encompassed in a revised closed loop communication measure.
0046, 0048	Osteoporosis Screening & Management	Support direction	Combine into one measure. Must be gender neutral as men also need such screening.

NQF #/TBD	Measure Concept	ANA Position	Comments
0050, 0051	Osteoarthritis	Support direction	None
0052	Imaging for Low Back Pain	Support	Need to also capture and contrast number of LBP patients who DID receive imaging studies.
0055, 0056	Diabetes Eye Exam, Foot Exam	Support	Need time interval.
0059	Hemoglobin A1c	Support	Remove poor control in name of measure, need time interval.
0061, 0062, 0064	Diabetic Screens	Support	Need time interval.
0060	Pediatric HgbA1C	Support direction	
0066	CAD	Do not support	Diabetes or LVEF dysfunction patients are not comparable populations and shouldn't be combined into one cohort.
0067	Antiplatelet Therapy	Support	
0068	Ischemic Vascular Disease	Support	Simplify the description of the population.
0382	Oncology Radiation Dose Limits	Support	
0384	Oncology Plan of Care for Pain	Support direction	Clarify what is measured-plan of care presence or pain?
0385	Colon Cancer Chemotherapy	Support direction	Delineate receipt, not plans.
0387	Breast Cancer Hormonal Therapy	Support	
0388	Prostate Cancer Radiography	Support direction	Consider availability and cost.
0389	Prostate Cancer Bone Scan for Staging	Do not support	Cannot identify "any time" metric.

NQF #/TBD	Measure Concept	ANA Position	Comments
0399	Hepatitis C:Hepatitis A Vaccine	Do not support	Too burdensome to capture metric because calculation relies on codified documentation and evidence in disparate clinical systems and registries. Measure provides minimal information and doesn't inform important population/public health level decisions
0400	Hepatitis C:Hepatitis B Vaccine	Do not support	Too burdensome to capture metric because calculation relies on codified documentation and evidence in disparate clinical systems and registries. Measure provides minimal information and doesn't inform important population/public health level decisions
0401	Hepatitis C: Alcohol Risk Counseling	Support	
0403	Medical Visits: HIV/Aids	Support direction	Accuracy in tracking as specified is doubtful
0405	PCP Prophylaxis	Support	
0406	Prescribed Potent Antiretrovial Therapy	Support	
0407	HIV RNA Control	Support direction	Clarify if below limits, not below limits, or presence of plan is the metric.
0421	Adult Weight Screen	Support direction	Clarify if metric focus is BMI or plan presence.
0507	Radiology: Stenosis Measurement	Do not support	Department QI issue, not national metric.
0508	Radiology: Probably Benign	Do not support	Department QI issue, not national metric.
0510	Radiology: Exposure Time	Support direction	Need to expand exposure metric to include all radiologic exposure and develop cumulative lifetime value.
0513	Thorax CT	Do not support	Department QI issue, not national metric.
0519	Diabetic Foot Care	Do not support	EP and EH do not complete home health episodes; change to EP rather than physician.
0561	Melanoma Care Coordination	Support direction	Clarify metric-plan of care present or communication; change to EP rather than physician.

NQF #/TBD	Measure Concept	ANA Position	Comments
0564	Cataract Surgery Complications	Support	
0565	Cataract 20/40 Visual Acuity	Do not support	Measure % that don't have value.
0575	Diabetes Hemoglobin A1c	Do not support	Measure % with elevated value.
0608	Pregnant Woman with HBsAG Testing	Support direction	Counting accuracy issues likely with multiple providers
1335	Children with Dental Caries	Support direction	Clarify details of measure-count of assessments or % presence of one or more caries.
1419	Primary Caries Preventions Intervention	Support direction	Use clinical record documentation not billing data for metrics.
1525	Atrial Fibrillation and Atrial Flutter	Support	
TBD	Preventive Care & Screening Cholesterol	Support	Included in Core table 6.
TBD	Falls: Risk Assessment	Support direction	Low-level measure - no evidence to support risk screening in the office setting; need to test comprehensive risk assessment (i.e., full assessment for each identified risk factor to develop risk-based plan). Composite falls prevention eMeasure set is needed.
TBD	Falls: Plan of Care	Support	Should be comprehensive, risk-based prevention plan of care for falls.
TBD	Adult Kidney Disease: Blood Pressure	Do not support	Should be covered by NQF0018.
TBD	Adult Kidney Disease: ESA	Do not support	Too small a population.
TBD	Chronic Wound Care: Wet to dry dressings	Support	Important overuse measure.
TBD	Chronic Wound Care: Education	Do not support	Need to redirect primary focus to ordering of compression therapy, can add education to ascertain of patient adherence measure.
TBD	Rheumatoid Arthritis: Assessment	Support	

NQF #/TBD	Measure Concept	ANA Position	Comments
TBD	Chronic Wound Care: Diabetic Foot Care	Support	Accomplished by non EPs.
TBD	Hypertension: Improvement in BP	Support	eMeasure will be difficult to develop.
TBD	Closing Referral Loop	Support	
TBD	Functional Status Assessment: Knee	Support	
TBD	Functional Status Assessment: Hip	Support	
TBD	Functional Status Assessment: Chronic Conditions	Support direction	Included in Core table 6. Needs to be inclusive of 65 year or older with 2 or more chronic conditions.
TBD	Preventive Care and Screening	Support	
TBD	Hypertension Management	Support direction	Change metrics to not be limited to those with 2 or more anti-hypertensives.
0001	Pulmonary	Support	
0002	Pulmonary	Support	
0004	Substance Use	Support	
0036	Pulmonary	Support	
0047	Pulmonary	Support	
0058	Pulmonary	Support direction	This measure has excellent empirical support for the covered population and should continue in its current state, however, its value does not end at ages < 18 or above 64. NQF 0069 sufficiently addresses antibiotic overuse in pediatric acute bronchitis; however, considerable research also reports antibiotic overuse among the aged.
0069	Pulmonary	Support	None
0081	Cardiac	Support	Recommend combining outcomes with those of NQF 0083 as separate reporting of either measure could result in erroneously reduced sum.
0083	Cardiac	Support	See comment above

NQF #/TBD	Measure Concept	ANA Position	Comments
0103	Mental Health	Support	
0104	Mental Health	Support	
0105	Medication-related	Support direction	This measure excludes several effective treatments for depression, including psychotherapy, electroconvulsive therapy, and treatments with CAM that have long and successful histories. Additionally, other affective disorders including bipolar disorders could be misdiagnosed or documented as MDD. Such diagnoses might respond poorly to antidepressants. Moreover, adolescents aged 12-17 would benefit from this measure as written (assuming appropriate exclusion of bipolar disorders), but with the inclusion of additional monitoring during the period of treatment initiation to decrease the risk of suicide or pro-suicidal actions.
0106	Mental Health	Support	
0107	Mental Health	Support	
0108	Medication-related	Support	
0110	Substance Use	Support	
0112	Mental Health	Support	
0321	Renal Disease	Support	
0418	Mental Health	Support	
0419	Medication-related	Support	
0710	Mental Health	Support	ANA supports this valuable measure, but recommend that EPs with mental health training conduct the PHQ-9 screening.
0711	Mental Health	Support	As above
0712	Mental Health	Support	As above
1365	Mental Health	Support	
1401	Mental Health	Support	ANA supports this valuable measure, but recommend that EPs with mental health training conduct the maternal depression screening.

NQF #/TBD	Measure Concept	ANA Position	Comments
TBD	Dementia: Functional Status Assessment	Support	ANA supports this measure, but recommends that verbiage indicate trend analysis with previous functional status assessments and context with staging and cognitive assessments.
TBD	Dementia: Counseling Regarding Safety Concerns	Support direction	ANA supports this measure, but recommends including caregivers in all discussions, unless the patient is of sound mind and expressly requests their exclusion from counseling.
TBD	Dementia: Counseling - Driving Risk	Support direction	As above
TBD	Dementia: Caregiver Education and Support	Support	
TBD	Adverse Drug Event (ADE) Prevention	Support direction	ANA supports this measure's direction; however, the measure does not go far enough. The adult-only cut point limits the value of this measure to adult care providers only. Further, children and adolescents on chronic medications do not benefit sufficiently from this evidence-based and safety-enhancing measure. ANA recommends removing the age limitations from this measure.

Appendix 2 Table 2

ANA Position/Comments: Proposed Clinical Quality Measures Evaluation Eligible Hospitals (EH) and Critical Access Hospitals			
NQF #	Focus	ANA position: Support, Support Direction, Do Not Support	Comments
0495, 0496, 0497	Emergency Department Throughput Measures	Support	Addressed gaps in measuresCategorized as patient engagement. This measure is important to safety and pt experience (1 st step in engagement).
0435-0439, & 0441	Stroke Measures	Support	
O440	Stroke Measures	Support direction	Documentation education materials given. It lacks assessment of patient understanding and engagement level.
0371-0376	VTE	Support	
0434	Stroke VTE Measure	Support	
0132, 0137, 0142, 0160, 0163, 0164, 0639	AMI	Support	
0143, 0144	Asthma	Support	
0147, 1048	Pneumonia	Support	
0218, 0284, 0300, 0452, 0527, 0528, 0301	Surgical Care Improvement Project (SCIP)	Support	Processes, some measures topped out (e.g., hair removal). Consider National Surgical Quality Improvement Program (NSQIP) outcomes of care measures for high volume surgeries
0480	Exclusive Breast Milk Feeding	Support	Recommendation for nurses to provide breastfeeding support, specifically, per the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) has a Breastfeeding Evidence-Based Guideline.
0481, 0482, 0484	Neonatal	Support	
0469	Elective Delivery Timing	Support	Strong Start Campaign goal

Appendix 3, Table 1

Key CQM Gaps in the Eligible Professionals (EP) and Eligible Hospitals (EHs)/Critical Access Hospitals (CAHs)			
Measure Concept Suggested	EP/EH/CAH	Existing Measure(s)	Gap Comments
Monitoring falls incidence rate	EP, EH, CAH	Existing measure applies to EPs only (EP only): NQF 0101; TBD (Falls: Risk Assessment for Falls); TBD (Falls: Plan of Care for Falls)	Existing measures address prevention for EPs. They do not address EHs or CAHs, nor do they monitor the effectiveness of the measures in preventing falls. ANA suggests implementation of an NQF endorsed measure to address this gap using data collected at the nursing unit level from the National Database of Nursing Quality Indicators (NDNQI®)
Monitoring falls with serious injury incidence rate	EP, EH, CAH	Existing measure applies to EPs only (EP only): NQF 0101; TBD (Falls: Risk Assessment for Falls); TBD (Falls: Plan of Care for Falls)	Existing measures do not monitor prevention measure effectiveness in reducing the incidence of serious reportable events (SREs), including falls with serious injury. ANA suggests implementation of an NQF endorsed measure to address this gap using data collected at the nursing unit level from the NDNQI.
Monitoring pressure ulcer incidence rate	EP, EH, CAH	EP only: TBD (Chronic Wound Care: Use of wet to dry dressings in patients with chronic skin ulcers)	Existing measure addresses overuse of an ineffective curative therapy. ANA suggests implementation of an NQF endorsed measure to address this gap using data collected at the nursing unit level from the NDNQI.
Full thickness pressure ulcer (i.e.: Stages 3, 4, and unstageable) incidence rate	EP, EH, CAH	EP only: TBD (Chronic Wound Care: Use of wet to dry dressings in patients with chronic skin ulcers)	ANA suggests development of a measure to monitor the incidence rate of SREs, including full-thickness pressure ulcers. The suggested measure would amend the existing NQF endorsed measure cited above, which uses data collected at the nursing unit level from the NDNQI.
Hospital Acquired Infections (HAIs)	EH, CAH	N/A	There are no current measures to prevent or monitor HAIs. ANA suggests developing measures to address these gaps using data collected at the unit level from the NDNQI, which includes rates of Catheter-Associated Urinary Tract Infections (CAUTI), Central Line-Associated Blood Stream Infection (CLABSI), and Ventilator-Associated Pneumonia (VAP). Each of these outcomes increases morbidity, mortality, and healthcare costs.

Measure Concept Suggested	EP/EH/CAH	Existing Measure(s)	Gap Comments
All cause readmission rates	EH, CAH	N/A	ANA supports the use of the following measures recently endorsed by the NQF to address this gap: 1768: Plan all-cause readmissions 1789: Hospital-wide all-cause readmission measure The combination of these measures takes an important step toward addressing patient safety, cost, and care coordination.
Team-based, meaningful patient engagement measures to evaluate understanding of patient education related to heart failure	EP	EP: TBD (Functional status assessment for complex chronic conditions) EH/CAH: NQF 0136	The existing measures address two important issues in heart failure management: functional status assessment and discharge instructions. ANA suggests taking those education and assessment measures one step further through the development of a team-based measure to document patient understanding of the importance of heart failure management. This measure would use the following interim outcomes of care to prevent avoidable readmissions and emergency department use by patients with heart failure with weights out of parameter: 1) Patient verbalization of appropriate dietary and lifestyle activities to reduce weight and maintain a healthy weight and 2) Documented weight reduction trends