



March 8, 2011

Donald M. Berwick
Administrator, Centers for Medicare and Medicaid Services

Secretary Sebelius,
Secretary

Department of Health and Human Services
Attention: CMS -3239-P
P.O. Box 8010,
Baltimore, MD, 21244-8010

Submitted electronically to [Http://www.regulations.gov](http://www.regulations.gov)

Re: Medicare Program; Hospital Inpatient Value-Based Purchasing Program
CMS-3239-P; RIN 0938-AQ55; 76 Fed. Reg. No. 9, January 13, 2011.

Dear Administrator Berwick, Secretary Sebelius:

The Nursing Alliance for Quality Care (NAQC) welcomes the opportunity to offer comments on this proposed rule. NAQC is a partnership among the nation's leading nursing organizations to advance the highest quality, safety and value of consumer-centered health care for all individuals-patients, their families, and their communities. NAQC works to ensure that: patients receive the right care at the right time by the right professional; nurses actively advocate and are accountable for consumer-centered, high quality health care; and that policy makers recognize the contributions of nurses in advancing consumer-centered, high quality health care.

NAQC applauds the efforts by the Centers for Medicare and Medicaid (CMS) to create a methodology for implementation of the Hospital Value-Based Purchasing program, as a worthy next step in the agenda to improve the quality of care. We believe that supporting the achievement and rewarding of high quality care should be the goal, rather than the attempt to simply limit negative outcomes. We strongly support the forward movement of this agenda.

Section IIC. Proposed Measures:

Nursing-sensitive measures: As an alliance of nursing organizations however, NAQC is disappointed that there is no stronger provision in the proposed rule for the upcoming years to include each of the NQF-endorsed nursing-sensitive quality measures, first in Hospital Compare, then in the calculation of the level of quality provided by each institution participating in the VBP program. We believe that the nursing-sensitive measures provide process and outcome measures that are

NAQC Board

AARP

American Association of
Colleges of Nursing

American Academy of
Nursing

American Academy of Nurse
Practitioners

American College of Nurse-
Midwives

American Nurses
Association

Association of Nurses in
AIDS Care

Association of periOperative
Registered Nurses

Consumers Advancing
Patient Safety

National League for Nursing

American Organization of
Nurse Executives

Mothers Against Medical
Error

National Council of State
Boards of Nursing

National Organization of
Nurse Practitioner Faculties

National Quality Forum



THE GEORGE
WASHINGTON
UNIVERSITY
MEDICAL CENTER
WASHINGTON DC

School of Nursing

For information: Tel. 202.994.5083 Fax: 202.994.2777

Email: NursingAlliance@gmail.com Web: www.NursingAQC.org

Support for this initiative was provided
by a grant from the Robert Wood John-
son Foundation



Robert Wood Johnson Foundation

meaningful beyond the limits of HCAHPS data on patient satisfaction and that these are important to hospitals overall performance scores. With over 1700 hospitals currently compiling these data quarterly, the level of benchmarking proposed for the VBP program is certainly available. These measures along with the endorsed structural measures, give a far better picture of an institution's capacity to provide safe, effective quality care with positive outcomes for patients. We would urge adoption of the full portfolio of structural, process, and outcome measures to complete the picture of a hospital's quality performance.

Therefore, we would recommend the fast tracking of the full portfolio of NQF-endorsed nursing sensitive measures into the Hospital Compare process, in order to gain their inclusion into future years' payment determinations.

We also note that the proposed rule refers to the NQF-endorsed measures as AHRQ measures. This in fact is not the case, as the only nursing-sensitive measure where AHRQ is the measure developer or the measure steward is the Failure to Rescue Measure, which was merged with the Death among Surgical Patients with Serious Treatable Complications. The other eleven NQF-endorsed measures have different measure stewards and are not considered to be AHRQ measures. We would ask the rule to be corrected on this point. These other measures include:

- Nursing Staff Skill Mix
- Nursing Hours per Patient Day
- Catheter-Associated Urinary Tract Infection Rate
- Central Line-Associated Blood Stream Infection Rate
- Fall Rates
- Injury Fall Rates
- Hospital/Unit Acquired Pressure Ulcer Rates
- Nurse Turnover Rate
- Physical Restraint Prevalence
- Practice Environment Scale
- Ventilator-Associated Pneumonia Rate

Topped out measures need further evaluation in some instances: The proposed rule speaks to measures that have topped out e.g. those measures that have seen consistently high levels of success, such that the differences between the 75th and the 90th percentiles are indistinguishable. One such example was used, that of the smoking cessation measures. While NAQC would agree that resources are best spent on those measures that perform well in distinguishing high performing hospitals, and that continue to drive positive changes for care to consumers, we remain concerned that in some cases, such as that of smoking cessation, the measure may have not measured a clinically significant aspect of the issue it was designed to address. While it may be that hospitals have figured out a way to ensure that every patient who reports smoking gets a brochure on how to quit, the real purpose, to provide intervention that leads to a significant reduction in smoking, has yet to be achieved. Instead of an automatic method for eliminating those measures with high rates of success, we would strongly urge that the system include an evaluation component for determining if the real goal of improving care

to the consumer was in fact met, or if it only looked that way because the measure did not perform properly.

Periodic reevaluation of topped out measure areas: As a second concern, how will measures that have topped out be reassessed periodically to ensure that slippage has not occurred? We would urge CMS to consider a mechanism that provides for a periodic assessment or spot monitoring of areas no longer being measured on a quarterly basis.

Section II. E. 5.a. Proposed Methodology for Calculating the Total Performance Score

Calculation of consistency points: We appreciate that you have included this in your scoring of the HCAHPS Hospital VBP score. It would be helpful to have included an example demonstrating a calculation of the consistency score for a sample hospital, as you have done for some of the other components.

Section II. F. Applicability of the Value-Based Purchasing Program in Hospitals

Exclusions from hospital total performance any measures in which there are fewer than 10 cases; This particular decision appears to significantly impact rural and small hospitals under 100 beds, representing almost 50 % of all hospitals in the U.S., and thereby contributing to the predicament already often cited regarding care in rural communities, that of disparities in care quality. While recognizing the issue of statistically reliable performance scores, there is also a need to encourage and recognize hospitals in rural communities who do provide high levels of care. We would recommend that these hospitals be given an alternative, such as demonstrating 100% of data on each measure, allowing them the opportunity to quantify their performance and make them eligible for subsequent incentives.

Section II. G. The Exchange Function

Exchange function options: Based on its stated trajectory of incentivizing all hospitals similarly for continual improvement, we would support your recommendation of utilizing the Linear Exchange Function for the purpose of calculation of a value-based incentive payment percentage for all participating hospitals. We believe that the opportunity for incentives to improve quality should be provided equitably across hospitals.

Section II. L. QIO Quality Data Access

Disclosure of QIO information to researchers:

We would reaffirm the importance of a secure and consistently applied policy and process for requesting and managing the use of confidential QIO quality improvement data by researchers. We recognize the need for researchers to have greater opportunity to analyze quality improvement data without lengthy and often discouragingly cumbersome processes in place. At the same time, given the potential for privacy violations, we would expect some process akin to that employed by investigational review boards, efficiently operated and incorporating tightly managed data use agreements would need to be applied equitably within each QIO's jurisdiction.

Conclusion:

On behalf of the Nursing Alliance for Quality Care, we appreciate the opportunity to comment on this very important rule. If we can be of any further assistance, or if you have questions or comments, please feel free to contact me at sonmjs@gwumc.edu or at 202-994-3484.

Sincerely,

Mary Jean Schumann, DNP, MBA, RN, CPNP
Executive Director
Nursing Alliance for Quality Care