



June 20, 2011

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

Secretary Sebelius,
Secretary, Department of Health and Human Services

Attention: CMS -1518-P
P.O. Box 8011
Baltimore, MD, 21244-1850

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

Re: Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2012 Rates.
CMS-1518-P; RIN 0938-AQ24; 42 Fed. Reg. Part 412, 413, and 476, May 5, 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 is interested in ensuring that the quantity and quality of nurse staffing is captured through meaningful approaches in both prospective payments and in assessing the quality of patient outcomes as part of the prospective payment process. We believe this to be critically important in the expansion of national efforts to reduce harm to patients and prevent complications associated with the care they receive. While we appreciate the interest in focusing on measures reflective of the team of care providers, we would also argue that it is the patient and the nurse who are together in the hospital 24 hours each day. Nurses are ultimately deemed the safety net and final advocate for a patient at the point of care. In that spirit we offer the following comments.

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



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Section III. C. Proposed Occupational Mix Adjustment to the FY 2012 Wage Index for Acute Care Hospitals

NAQC sorted through with great interest the approach used to determine compensation to hospitals for the care provided by the workforce, in particular nursing. We do not oppose this methodology, but would suggest that the additional collection and use of data related to structural measures of nursing, such as NSC-12, direct care measure of nursing hours per patient day (NHPPD*), NSC-13 (Skill Mix*), and NSC-15 (Voluntary Turnover*) be collected along with nursing specific outcome measures, to determine the effectiveness and absence of complications due to the care patients receive. We believe that this additional information, added to the data about occupational mix, would provide a more complete picture of the workforce requirements needed to provide safe effective care, and could lead over time to a different or at least more complete methodology.

It is well known to any clinical nurse manager that the number and skill mix of nursing staff is only part of the picture, and that significant reductions in ancillary staff play a role in the effectiveness of care nurses can deliver, as do frequent turnover in nursing staffing. In the posting of changes there is mention of adjustments that must be made when the occupational mix is deemed to be “too high” or an outlier. We saw no evidence in your methodology for how to determine what other factors may have contributed to these numbers. We recognize that at times this information may have been in error, but we also recommend that a better method of determining the soundness of those figures would be by having additional data via NQF-endorsed measures NSC-12, NSC-13, and NSC-15. In fact such data, in conjunction with data about patient outcomes of care, might indeed paint a far more accurate picture of the quality of the care in that hospital. Rewarding better outcomes might incentivize hospitals to make management decisions about workforce needs in concert with what their own case mix requires for safe effective care.

Section IV. A. Hospital Inpatient Quality Reporting (IQR) Program

NAQC is supportive of the principles for the development and use of measures and scoring methodologies put forth by CMS. We encourage the movement toward outcome-based measures and support the notion of public reporting of such measures. We support the use by CMS of NQF-endorsed measures for use in public reporting. We would go further to urge the inclusion of nursing sensitive measures in public reporting, because of the high degree of importance of 24-hour nursing care in the safety of patients and their outcomes of care.

NAQC supports the use of alternative sources of data such as those collected by nationally-based registries. We believe that the use of such registries has aided acute care facilities to drive toward quality improvement, and that data collected in these registries has significant value for purposes of reporting and payment strategies. We would urge CMS to continue to pursue the use of registry data in this program, including that data coming from nursing sensitive care registries.

NAQC supports the addition of possible measures, as suggested by CMS, for inclusion in future years. We believe that the NQF-endorsed nursing sensitive measures are being successfully collected and utilized by nearly 1800 hospitals and continue to be well-maintained. For reasons already stated, we think they continue to provide useful data about the ability of the health care system to reduce harm and complications, such as infections, decubiti, falls and injuries.

NAQC appreciates the opportunity to comment on this important set of proposed rules. If we can be of further assistance, or if you have any questions or comments, please feel free to contact me at 202-994-3484 or at sonmjs@gwumc.edu

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*NQF-endorsed