June 17, 2016

Honorable Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health & Human Services
Attention: CMS–1632–P, PO Box 8013
Baltimore, MD 21244–1850

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

Re: Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to costs to Organizations and Medicare Cost Reports
[CMS–1655–P; RIN 0938–AS77]

Dear Acting Administrator Slavitt:

The American Nurses Association (ANA) welcomes the opportunity to provide comments to the proposed Medicare rule referenced above. Our comments primarily focus on three issues concerning the proposed rule: ANA's recommendation to include critical safety structural measures (nurse staffing and skill mix) for public reporting in the Centers for Medicare and Medicaid Services (CMS) Inpatient Quality Reporting program (IQR); ANA's request for the inclusion of critical safety clinical measures (falls and falls with injury) for public reporting in the CMS IQR program; and ANA's recommendation that CMS retain IQR reporting for participation in a systematic clinical database registry for nursing. We also note our support for the proposal to include the NIH Stroke Scale as a measure of stroke severity in future rulemaking on risk-adjustment.

As the only full-service professional organization representing the interests of the nation's 3.6 million registered nurses (RNs), ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates (nursing specialty organizations), and individual members. RNs serve in multiple direct care, care coordination, research, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, evaluate the patient's response, educate and engage patients, their families and other caregivers as well as the public about effective self-care in various health conditions, wellness, and prevention, and provide expert advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.[1]

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[1] The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

I. **ANA requests the addition of critical safety structural measures (nurse staffing and skill mix) to the CMS Inpatient Quality Reporting Program**

A critical gap in hospital safety measures persists in the CMS Inpatient Quality Reporting (IQR) program. Robust National Quality Forum (NQF)-endorsed structural safety metrics, nurse staffing and skill mix, were not added to FY 2019 or subsequent years in this proposed rule (Table, Proposed Hospital IQR Program Measure Set for FY 2019 Payment Determination and Subsequent Years, p. 25193-25194). The NQF-convened Measure Application Partnership (MAP) vigorously supported the addition of these measures to IQR when the condition of hospital-level endorsement was achieved. ANA's staffing and skill mix measure endorsement at the hospital-level was finalized by NQF in February, 2016 via the work of the NQF's Safety Measures Steering Committee (SC).

Robust support for ANA's safety structural measures (staffing and skill mix) was voiced and documented in the NQF meeting transcript across the majority of MAP Hospital Workgroup members in December, 2014. During this meeting the Workgroup voted conditional support with a 71% vote, pending the condition of NQF endorsement at the hospital level reporting. The MAP Coordinating Committee finalized the "conditional support" vote in January, 2015 and recommended these measures for IQR in the final MAP report to the U.S. Department of Health and Human Services (HHS) in February, 2015.

Consumers, payers, multiple clinical team members and other stakeholders are surprised and concerned that nurse staffing and skill mix metrics have not been included timely by CMS in IQR via regulations as recommended by MAP post NQF's hospital-level endorsement. These stakeholders, including multidisciplinary team members, understand the implications of this serious national patient safety issue. Specifically, wide variance in nurse staffing and skill mix persists, particularly in medical surgical units. The evidence is clear that low nurse staffing and skill is associated with death and harm. AHRQ's Safety Chartbook (2016) reported progress in HAC reduction likely related to national performance improvement innovations (e.g., Partnership for Patients), however, the 2014 overall HAC rate remained high at 121 per 1,000 hospital discharges. Thus, more than one in ten patients is still harmed. AHRQ's NQS Safety newsletter (March, 2016) reiterated that hospital-acquired conditions (HAC) are a significant cause of morbidity and mortality for Americans and lead to lost economic output (James, 2013, Umscheid et al., 2011). Avoidable death and harm due to multiple HACs will continue in hospitals with low nurse staffing and skill mix levels. Although there is not a legislative mandate for CMS to collect these data and publicly report nurse staffing and skill mix safety measures, there is wide consensus that public reporting is an important lever for performance improvement. In the case of these safety measures the evidence is strong that lives will be saved and harm reduced, as well as excessive avoidable cost (Avelere, 2015).

Data exists for immediate implementation of staffing and skill mix measures

It is not necessary to develop the NQF-endorsed nurse staffing and skill mix measures into de novo eMeasures prior to implementation. MAP did not recommend requiring eMeasure development for these structural safety measures in the 2015 MAP deliberations, and we urge CMS to avoid further delay in implementing these measures by requiring retrieval of this data from the electronic health record (EHR). Imposing an e-measurement requirement would create an unnecessary delay in public reporting of these measures.

ANA agrees with CMS that collection of data through EHRs as electronic clinical quality measures (eCQM) is generally preferable for future process and outcome measures. Ideally these clinical data should be pulled seamlessly via EHRs as a byproduct of documenting clinical care when feasible. In this case, however, it is essential to avoid delays in using and reporting on staffing and skill mix measures.

Identifying a timely reporting mechanism to collect national data for public reporting via IQR is critical in order to save lives and prevent harm through the reduction of multiple HACs and death and reduce avoidable cost. ANA therefore recommends implementation of the staffing and skill mix measures through utilization of hospital payroll data that is electronically available in administrative data bases for use in national reporting of nurses staffing and skill mix measures. Such data is already reported efficiently through administrative data bases in hospitals.

The path for timely, efficient national reporting of the NQF-endorsed staffing and skill mix measures, in a standardized format and a common data dictionary, is through a web portal utilizing this electronically available payroll data. Efforts are already underway at CMS to evaluate feasibility of this approach. Following the MAP's 2015 recommendation to the HHS, ANA has worked collaboratively with CMS in 2015 and 2016 to identify a feasible method to collect the electronic data needed to calculate ANA's nurse staffing and skill mix measure. CMS team members working with ANA staff identified a feasible, efficient web portal method of reporting these data utilizing national data standards and a common data dictionary. We understand that the CMS team presented this approach to CMS leadership to consider for adoption. Utilization of a web portal method of reporting data would require no new data base construction.

Ethical imperative for national reporting of nurse staffing and skill mix measures

There is an ethical imperative to ensure safe nurses staffing and skill mix and publicly report these measures (Curtain, 2016). Improving patient safety structures of care, particularly safe nurse staffing and skill mix, is a primary concern of the nation's nurses to keep their patients safe and ensure patient-centered, coordinated care. Hospitals have an organizational accountability to ensure patient safety by creating structures such as safe nurse staffing and skill mix and developing and maintaining a strong safety culture. Dr. Pellegino (2004), who served as the Chair of the President's Council on Bioethics, illuminated the need for organizational and personal accountability for patient safety. He championed the Institute of Medicine's (IOM) six national quality aims: safety, effectiveness, patient centeredness, timeliness, efficiency, and equity. Dr. Pellegrino highlighted safety being the primary aim to first do no harm and understood the personal and organizational accountability to ensure safe, interprofessional, team-based, patient-centered care supported through safety structures and processes (Pellegrino, 2004). Dr. Pellegrino understood the broad moral imperative to prevent not only errors of commission and omission leading to avoidable safety events but broadened the harm to include important errors of omission related to the failure to meet patient-centered goals, particularly in vulnerable populations (e.g., failure to prevent unwanted futile care which leads to suffering and excessive cost). Researchers (Kalisch, Landstrom, & Hinshaw, 2009) found in the development and testing of a conceptual model of missed nursing care that structural factors contributing to missed nursing care include labor resources (i.e., number and types of nursing staff). AHRQ's Safety Primer (June, 2015) cited a systematic review (Jones et. al., 2015) that found that missed nursing care is common:

> Unfinished care is a predictor of: decreased nurse-reported care quality, decreased patient satisfaction; increased adverse events; increased turnover; decreased job and occupational satisfaction; and increased intent to leave (Jones et. al., 2015, p. 1121).

Predictors of missed nursing care in this study include poor safety culture and increased nursing workload (e.g., staffing). The researchers also found that unmet care leaves patients vulnerable to unmet educational, emotional, and psychological needs. There is an ethical imperative for hospitals to achieve and maintain safe levels of nurse staffing and skill mix. An important policy lever to improve patient safety and patient-centered care is CMS public reporting via IQR of ANA's staffing and skill mix measures, a priority recommended by the MAP.

**National reporting of nurse staffing and skill mix measures is
essential to create a safety culture**

The final FY 2016 IPPS rule (CMS-1632-F and IFC, CMS-1632-CN2) CMS added a safety structural measure to IQR. While not NQF endorsed, MAP recommended the measure for inclusion in IQR effective in 2018. ANA affirms 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. In 2016, ANA along with the nation's 3.6 million nurses kicked off a year-long safety culture education engagement initiative.

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 the following 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 about 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 reported that in a 2015 national nurse survey 30% of nurse respondents would give their hospital overall safety grade of C, D, or F, and 50% of nurses responded there were not enough nurses to provide quality care. 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). ANA strongly urges CMS to build upon the new safety structural measure by adding nurse staffing and skill mix measures to IQR. By doing so, CMS will create transparent, public reporting of both critical safety structures of care, that is, culture/climate and skill/skill mix.

**Implementation of the nurse staffing and skill mix measures will
reduce wide staffing variance and empower consumers**

The hospital nurse staffing and skill mix measures have been endorsed by NQF for over a decade, were prioritized by MAP in 2015, and were subsequently endorsed by NQF to be publicly reported. These measures are publicly reported in multiple states. CMS must identify a timely national path for ANA's measures to be publicly reported in IQR which will reduce wide staffing variance and avoidable death and harm. By doing so, the data will empower consumers, payers and other stakeholders to choose wisely.

The lack of national accountability measures that include essential nursing data persists, creating a major quality gap. Nursing continues to be treated as an invisible service line within the hospital rather than a critical core health care delivery service. Quality safety metrics, which evaluate the quality of nursing care through nursing sensitive robust measures, are essential to completing the evaluation of hospital quality (NQF, 2004). ANA supports a mix of structure, process, and outcomes measures (Donabedian, 1988) as indicated in the MAP's Measures Selection Criteria (MAP, 2013). The science supporting these NQF-endorsed safety measures is robust (Avalere, 2015).

Furthermore, the nurse staffing and skill mix metrics are important, efficient, understandable, broad hospital safety summary metrics. These metrics promote transparency and support the opportunity for decision making by consumers, payers and other stakeholders. Low levels of nurse staffing and skill mix are associated with multiple HACs and death 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. Researchers (Winters et al., 2016) have identified multiple weaknesses with this composite,

including serious under-reporting. Thus, while the modified PSI 90 (safety composite) 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 is critically important to be added timely to IQR.

In the current shifting payment environment, it is essential that Medicare as well as diverse stakeholders have accurate, timely data with regard to accurate nurse staffing and skill mix levels. As noted in the Avalere Report:

> As nurses comprise the largest clinical subgroup in hospitals, a common reaction to cost containment pressures is to reduce professional nurse labor hours and their associated costs and reduce skill mix. This strategy, however, is shortsighted as appropriate nurse staffing levels are essential to optimizing quality of care and patient outcomes in this era of value-based healthcare (Avalere, 2015, p 4).

As the health care delivery system continues to undergo change, hospitals make budget allocation decisions including determining how to reduce costs. Now more than ever, transparency of certain measures is intrinsic to monitoring unintended consequences of adopting certain cost cutting measures such as such as reducing nurse staffing and skill mix levels. Lower staffing and skill mix levels has been identified in placing patients at greater risk of death and harm and may ultimately thwart anticipated savings.

Nurse staffing and skill mix measures are critical safety measures for public reporting across care settings. CMS has indicated the importance of nursing workforce metrics for patient safety in skilled nursing facilities (SNFs) by implementing a new Payroll-Based Journal (PBJ) Data Collection System (CMS, 2016). ANA applauds CMS's leadership in patient safety by working with stakeholders to improve the quality of nurse staffing data currently posted on CMS's Nursing Home Compare. ANA is committed to working with CMS to successfully negotiate barriers in order to have ANA's NQF-endorsed staffing and skill mix measures posted timely via CMS's IQR.

In summary, prolonged delay of national reporting via CMS's hospital IQR program of nurse staffing and skill mix measures will impede hospital patient safety performance improvement and will contribute to persistent critical safety gaps resulting in avoidable death, harm, human suffering, and excessive avoidable cost. As CMS noted in 2015, public reporting is one of nine effective levers identified in the National Quality Strategy. Therefore, timely public reporting of these measures in CMS's IQR program is an essential lever in reducing the current staffing and skill mix variation and will improve patient safety and reduce avoidable death, harm and cost. ANA stands ready to assist CMS to develop a plan to expedite national standardized public reporting of nurse staffing and skill mix in CMS's IQR program.

    II.   **ANA requests timely inclusion of critical safety clinical measures (falls and falls with injury) for public reporting in the CMS Inpatient Quality Reporting (IQR) Program , or, timely CMS support for electronic clinical measures (eCQM) development**

In a timely manner, CMS must include a robust set of falls metrics in IQR. The current gap is apparent in the proposed rule published Table, Proposed Hospital IQR Program Measure Set for FY 2019 Payment Determination and Subsequent Years (p. 25193-25194). This persistent robust falls measure gap has been identified by multiple stakeholders including ANA, consumers, purchasers, and clinical team members. Specifically, the falls injury post-surgical metric is narrow in the AHRQ PSI-90 and seriously

under-reports injuries related to falls as described below. Multiple stakeholders have asked CMS to consider ANA's falls metrics.

In previous proposed rules, CMS signaled that eCQMs are preferred for additions to the IQR. ANA was pleased that CMS recognized the importance of these measures and the falls measures gap and supported ANA's NQF-endorsed falls and falls with injuries measures on the MAP Measures Under Consideration list for the 2015 MAP evaluation. The MAP Hospital Workgroup conditionally supported the ANA falls measures for inclusion in CMS's IQR upon the condition of NQF-endorsement at the hospital-level reporting. This vote was finalized by the MAP's Coordinating Committee in 2015. These ANA's falls measures are now endorsed by NQF at the hospital level reporting, reported in the NQF's Safety Measures SC report (NQF, 2016).

Data exists for immediate development of robust falls measures

Given that most hospitals already collect falls and injuries from falls in electronic data bases, data reporting via a similar system CDC uses for infection reporting is feasible (e.g., requirements common standards and data dictionary) using hybrid electronic data. CMS prefers to report clinical process and outcome measures as de novo eMeasures pulled only via EHRs, however, recent discussions acknowledge limitations in EHR data. It is currently feasible to use hybrid electronic data to develop high impact measures. ANA respectfully requests CMS to prioritize development of clinically meaningful, clinically enriched eCQMs using hybrid data for falls metrics that capture nursing data. Nursing data is critical for robust performance improvement. Specifically, nursing assessment, interventions (including prevention, and response to treatment date) are critical to improving patient outcomes and informing a Learning Health System. National reporting can be expedited through funding support for development of eMeasures informed by the current ANA's NQF-endorsed falls measures. Robust falls measures that are clinically enriched with nursing data better evaluate the quality of care and can be employed as a public reporting policy lever via CMS's IQR. ANA is committed to working collaboratively with CMS to develop an eCQM set of falls metrics that includes nursing data.

Established weaknesses with current metrics

There are multiple persistent weaknesses with modified AHRQ PSI-90 safety composite and the falls metric. Additionally, in 2014 both CMS and AHRQ have identified a lack of harmonization between the AHRQ falls metric and ANA's falls measures. ANA urges CMS to fund timely development of robust falls eCQMs for reporting in IQR that include clinical data from nursing.

Because only physician data is collected from discharge data, The AHRQ PSI-90 undercounts multiple nursing-sensitive HACs, such as pressure ulcers and falls due to coding errors. Another weakness in the data collection process is lack of timely data collected to calculate timely measures for consumer, purchaser, provider, clinician team, and other stakeholder decision making. For example, the 2013 results from this measure were published in December, 2014 (ARHQ, 2014). The AHRQ PSI-90 also lacks robust clinical data provided by nurses, the largest group of health care professionals in acute care and the proximal caregiver. These weaknesses limit the clinical meaning of the data which clinicians could use to improve performance improvement activities and increase the robustness of the quality evaluation in the transparent public reporting via CMS's IQR.

Furthermore, the AHRQ PSI-90 measure has persistent problems in NQF Safety Measures SC endorsement review. The measure did not pass the NQF maintenance re-endorsement review in the 2014 NQF Safety Measures SC and was subsequently pulled for revision by AHRQ. Subsequently, AHRQ submitted the composite measure for review as a surgical safety composite measure limiting it to the

surgical population. The narrower population was intended to improve the scientific acceptability of the measure. However, during review in 2015, the NQF Safety Measures SC members expressed reliability and validity concerns. Ultimately, the AHRQ PSI-90 measure was approved by the SC with adjustments, including three new metrics and new weighting. NQF endorsed the measure earlier this year.

Current research (Winters et al., 2016) continues to highlight problems with the composite measure. The researcher stated:

> Only 5 measures, Iatrogenic Pneumothorax (PSI 6/HAC 17), Central Line-associated Bloodstream Infections (PSI 7), Postoperative hemorrhage/hematoma (PSI 9), Postoperative deep vein thrombosis/pulmonary embolus (PSI 12), and Accidental Puncture/Laceration (PSI 15), had sufficient data for pooled meta-analysis. Only PSI 15 (Accidental Puncture and Laceration) met our proposed threshold for validity (positive predictive value only) but this result was weakened by considerable heterogeneity. Coding errors were the most common reasons for discrepancies between medical record review and administrative databases.

The researchers reported:

> [The] systematic review finds that there is limited validity for the PSI and HAC measures when measured against the reference standard of a medical chart review. Their use, as they currently exist, for public reporting and pay-for-performance, should be publicly reevaluated in light of these findings.

In an earlier study, researchers:

> [F]ound that the adverse event detection methods commonly used to track patient safety in the United States today—voluntary reporting and the Agency for Healthcare Research and Quality's Patient Safety Indicators—fared very poorly compared to other methods and missed 90 percent of the adverse events (Classen et al., 2011, p 581).

Delay in safety reporting using the AHRQ "Safety Scorecard," which includes data from random chart reviews through redacted data, is not timely enough for critical work in safety performance improvement. We urge CMS to fund robust safety clinical eMeasures, particularly for falls, a prevalent source of harm for patients in hospitals.

Given the identified problems in the current metric and proposed narrowed surgical population focus of the PSI 90, there is no reliable, valid and timely safety measure of the quality of large proportion of acute care patients in CMS's IQR program. The gaps include prevalent, vulnerable populations that do not undergo surgical procedures. This is important since the MAP Dual Eligible Workgroup has identified the vulnerable, dual eligible populations that have a higher risk for harm. Thus, the MAP Dual Eligible Workgroup identified safe nurse staffing as important to dual eligible population.

National data collected with ANA's NQF-endorsed falls metric (NQF measure # 0202, falls with injury), was used as a lever to inform performance improvement and for evaluation in CMS's Partnership for Patients (PfP) 1.0 initiative. National evaluations have demonstrated reduction in falls related injuries. It is important that national robust falls metrics, falls and falls with injury, be included in IQR to achieve alignment with robust safety metrics that are currently employed in effective performance improvement programs and initiatives. Specifically, clinically meaningful and robust metrics should be transparently available for consumers and other stakeholders to further inform decision making. National data collection via the falls eCQMs can be the future pathway for robust, standardized clinical

measures with low burden that are essential to inform a Learning Health System. ANA's falls measures were also identified by CMMI for use by hospitals engagement networks in the PfP "2.0" contract. It is important for CMS to employ the effective public reporting lever through the use of robust safety outcome metrics that are high impact, clinically relevant, and understood by consumers and other stakeholders.

III.   **ANA requests that CMS retain IQR public reporting for participation in a systematic clinical database registry for nursing**

For FY 2019, CMS proposes removing the structural measure asking hospitals if they participate in a clinical data registry for nursing sensitive care. CMS's reasoning for this proposal is that performance on the measure does not result in improved outcomes, and that the burden to meet the measure outweighs the benefit. While an affirmative response to this structural measure is not a direct measure of quality, it does serve as an indication of a hospital's commitment to measuring and improving nursing care quality. Registry participation is valuable in that it provides national comparison data, enabling hospitals to compare their performance to peer facilities on a standardized set of structure, process and outcome measures. With respect to this measures' inclusion in CMS's IQR program and transparent reporting on CMS's Hospital Compare website, ANA believes the public understands that a hospital's emphasis on nursing signals high quality of care. Specifically, participation in a systematic clinical database registry informs the public of a hospital's commitment to nursing care quality by investing in the use of robust data for performance improvement. Moreover, public reporting of this measure is a lever to promote continued hospital participation in a nursing-sensitive data registry. Hospitals can choose to participate in a number of nursing-sensitive data registries. Clinical nursing data such as nursing assessments, interventions, and patient response, as well as structural measures of safety, are critical for hospitals to fully evaluate the quality of care and improve patient outcomes. There is a paucity of nursing-sensitive measures in CMS's accountability measure portfolio, and specifically, in the CMS IQR program. If this measure is not continued in IQR, the invisibility of nursing will be worsened in CMS's IQR program. Furthermore, this measure is low burden to report. Until nursing sensitive process and outcome measures are developed as eCQMs and reported in CMS's IQR program, we urge CMS to retain this structural quality measure.

Research has been conducted to evaluate the benefit of participating in nursing-sensitive benchmarking programs. For example, a study (Hickey, Gauvreau, Curley, & Connor, 2013) of 38 children's hospitals found lower odds of in-hospital mortality for cardiac surgery patients in hospitals participating in national quality metric benchmarking programs such as the National Database of Nursing Quality Indicators NDNQI[®]

With unit-level data and high participation rates (> 2,000 US hospitals), NDNQI® is the largest nursing-sensitive data registry. It is also international in scope. NDNQI's benchmarking program is invaluable for expanding the research evidence (see Addendum B, Research Conducted with NDNQI Data) on factors influencing patient, nurse, and organizational outcomes. For example:

- One study (Walters et al., 2015) of adult nursing units in 1381 hospitals that investigated the effect of Medicare's nonpayment on four hospital-acquired conditions found that the initiative was associated with improvements central line-associated bloodstream infections (CLABSIs) and catheter-associated urinary tract infections (CAUTIs) but not associated with significant changes in hospital-acquired pressure ulcers (HAPUs) or injurious falls.
- Many studies (See Appendix A) have used NDNQI data to examine relationships between various nursing and organizational factors (processes of care, nurse education and experience, certification, staffing characteristics such as skill mix or hours per patient day, job satisfaction,

turnover, practice environment, and Magnet recognition) and outcomes such as falls, pressure ulcers, CLABSI, and CAUTI as well as nurse staff turnover.

- NDNQI data has frequently been used to conduct prevalence studies (e.g.., Baldin et al., 2013; He, Staggs, Bergquist-Beringer, & Dunton, 2013) and to evaluate measurement options. (e.g., Staggs, Davidson, Dunton, & Crosser, 2015).

IV. ANA supports the proposed update to the MORT-30-STK measure to include the NIH Stroke Scale as a measure of stroke severity in the risk-adjustment in future rulemaking

ANA supports the measure as recommended by ANA's organizational affiliate, the American Association of Neuroscience Nurses.

We appreciate the opportunity to share our views and current evidence related to the IPPS FY 2017 proposed rule-making and welcome the opportunity to discuss these issues in greater detail. If you have questions, please contact Maureen Dailey, PhD, RN, CWOCN, Senior Policy Advisor, ANA Health Policy, at 301.628.5062 or maureen.dailey@ana.org.

Sincerely,

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
     Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer

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Appendix A

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