

## ***Written Testimony for Panel 4: Finding Solutions; Creating Outcomes to Meet MU3***

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Bio: Maureen Dailey DNSc, RN, CWOCN is the Senior Policy Fellow at the National Center for Nursing Quality at the American Nurses Association (ANA). She has thirty years of nursing experience in leadership and direct care roles across healthcare settings. In multiple roles, she has focused on patient safety enhancement and other quality improvement initiatives to reduce avoidable readmissions, healthcare associated conditions, and excessive cost across settings. These programs included population-based (disease and condition-based) risk stratification and patient-centered care coordination, targeted transitional care for patients with complex care needs, and electronic health record innovations such as electronic clinical decision support, and integrated advanced practice nurse telehealth consultation.

### **Panel 4: Finding Solutions; Creating Outcomes**

**Question 1** What are the key data challenges to improving America's health system from the perspective you represent (e.g., quality measure development, certification of healthcare professionals, consumer use of comparison data, coordination of care, payer)?

*Thank you for the opportunity to present on behalf of the American Nurses Association (ANA) to the Meaningful Use Workgroup. Dr. Marla Weston, the ANA Chief Executive Officer, who is presenting at the ANA Magnet™ conference, sends her greetings.*

*Collection of quality data elements important to patient-centric outcomes is key to improved quality outcomes. Currently, there are gaps in quality data collected to effectively evaluate the quality of patient-centered care. The current portfolio of National Quality Forum (NQF) endorsed quality measures are predominantly medical diagnosis and body part focused. Key gap areas include care coordination and patient/caregiver engagement, including patient (caregiver) activation for effective self-care. The NQF has noted the portfolio of measures is limited largely due to the types of measures delivered in the endorsement pipeline; the subset of electronically retooled measures is even more limited. Thus, there is an urgent need for measure development support to fill those gaps, and specifically, measures that are interprofessional in focus as well as cross cutting in nature (i.e., across settings, transitions of care, and across care episodes).*

*Essential data elements must be efficiently captured across care settings utilizing comprehensive data models for transfer to data libraries or warehouses. The data should serve multiple purposes. Data should enable efficient calculation of quality measures as well as capture the essential processes in team-based care coordination across settings, within the context of care. To that end, the ANA has promoted collaborative development of a prototype*

*data model. The pressure ulcer measure has been chosen as the first measure to prototype using the new model. Pressure ulcers were chosen since they have been identified as preventable healthcare acquired conditions across settings. The human and financial resources expended and its impact is costly. Moreover, the NQF has identified full thickness pressure ulcers as a serious, costly adverse event.*

*This ANA-supported pressure ulcer model was developed by the Veteran’s Administration (VA) and Kaiser Permanente to meet the Office of the National Coordinator (ONC) Meaningful Use (MU) standards. The pressure ulcer model captures data for existing pressure ulcer assessment, pressure ulcer risk assessment, and pressure ulcer risk interventions for identified risk across interprofessional team members and settings. In the ANA hosted Health Information Technology (HIT) Summit (Tipping Point 2) held recently in mid-September, strategic goals for the model completion were identified. The model includes key structural, process, and outcomes measures. Structural measures will inform decisions about the best skill mix and staffing for interprofessional teams providing complex care coordination within settings, in transitional care, and across settings and episodes of care. Processes of care, comprehensive care coordination and communication, can be analyzed for best practices. In addition, research can be done to determine predictive risk modeling for specified populations and identification of best practices to reduce pressure ulcer incidence.*

*An area where there are data gaps in quality measurement is transitional care. Specifically, there are limitations in the current transitional care measures. The ANA supports the National Transition of Care Coalition (NTOCC) criteria for improved transitional care measures. For example, transitional care measures should include requirements for two-way communication of data as specified by the NTOCC. Quality measures that use a “check-off” process for sending discharge summaries are not necessarily adequate to ensure data is used timely and integrated effectively in patient care coordination, including timely care planning to ensure patient safety. Furthermore, a 30 day window for clinician accountability in medication reconciliation upon hospital discharge is not adequate for vulnerable populations needing complex care coordination and support (e.g., frail elderly, chronically ill, particularly those with multiple chronic illnesses and comorbid mental health illness). The timely meaningful use of data in care transitions is essential to improve care coordination for the chronically ill, elderly, and other populations to prevent harm and readmissions.*

*It is important to identify common core data elements that all health systems and settings should collect for quality measurement and evaluation as well as research, as exemplified in the Tipping Point pressure ulcer measure prototype. The overarching goal is to be able to achieve predictive modeling and identification of best practices that improve patient outcomes and reduce excessive avoidable cost. The best way to achieve this is through the use of timely, clinically-enriched, harmonized data that promotes patient-centered systems of care.*

*As the most trusted professional for a decade (Gallop Survey), nurses can engage consumers in utilizing and understanding publicly reported quality data. The ANA has signed onto the ONC pledge to advance the integration of healthcare information technology (HIT) across stakeholders, including the public, to improve quality outcomes. The ANA strongly supports key structural, process, and outcome quality measures that are understandable and meaningful (important) to consumers and all stakeholders in healthcare. Harmonization of quality measures across Federal programs, public and private payers, and settings, is key to reducing consumer, provider, and clinician confusion to achieve a parsimonious set of quality measures that is meaningful to all stakeholders.*

**Question 2** *What approaches or solution alternatives (e.g., standards, architectural approaches, workflow changes, policy changes) would you recommend to make the acquisition, analysis, and use of health data more effective and efficient from the perspective you represent?*

*Although quality reporting occurs at the provider and clinician level in the current public reporting and pay for quality programs, interprofessional team-based reporting and shared accountability is the envisioned future. Multiple stakeholders will better understand public reporting of quality data on comparable hospital units and community-based teams, e.g., accountability care organizations (ACO). Thus, inclusion of structural measures of quality (data registries with both patient level data and team-based data) would best serve multiple stakeholders. The ANA strongly supports the inclusion of clinically enriched data at the patient and unit level in both public reporting and pay for quality. Structural, process, and outcome quality measures should be reported at the provider, clinician, and population levels.*

*The data platform used should capitalize on current successes in transforming data into quality outcomes in hospitals and efficiently pull data elements from existing data sets across post-acute care/long term care settings to improve care coordination within settings and across settings:*

- *Acute Care - National Database of Nursing Quality Indicators® (NDNQI®)*
- *Nursing Home – Minimum Data Set (MDS) 3.0*
- *Home Care - Outcomes Assessment Instrument Set (OASIS)*

*A harmonized set of data elements (a data library) that is employed efficiently and effectively across settings will promote the Institute of Medicine (IOM) six aims for care: safe, effective, equitable, patient-centered, timely, and efficient.*

*The National Quality Strategy has focused healthcare performance improvement on the Triple Aim - the priority areas to achieve these aim. Workflow revisions should be prioritized for MU that addresses the needs of the interprofessional team in key priority areas to improve quality, such as transitional care and patient safety (e.g., hospital acquired conditions (HACs).*

*The ANA supports policy changes that require vendors to include data models/elements that support the work of interprofessional teams. The focus of vendors has been meeting the needs of hospital providers and physicians. There has been little consideration of supporting the work and quality measurement of other disciplines. It is important to capture data elements from the lens of nursing, and other interprofessional team members, within the context of where care coordination is provided. In order to achieve MU, vendors should be required and incentivized to incorporate necessary patient-centric data elements that speak to the work of nursing and other healthcare professionals, while providing the necessary tools to efficiently report and analyze the data to improve patient care and outcomes.*