# The National Quality Forum

## Comments on Draft Report: National Voluntary Consensus Standards for Hospital Care: Outcomes & Efficiency Phase I

## September 2008

| # | Member Council/ Public | Organization Contact | Comment | Response | Topic |
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| 38 | M, Health Professional | Rita Munley Gallagher, PhD, RN, American Nurses Association | NQFâ€™s efforts to identify and endorse measures suitable for both public accountability and quality improvement related to outcomes and efficiency of hospital care are laudable. This project is extremely important and the issues around hospital readmission will, no doubt, increase with the countryâ€™s aging demographics. ANA concurs with the Steering Committee regarding the importance of measurement of readmission rates following hospitalization for both acute myocardial infarction (AMI) and pneumonia. | Support. No response needed. | General |
| 39 | M, Health Plan | Catherine MacLean, WellPoint, Inc | We feel the measures are well specified and reasonable but may present a challenge due to the amount of programming involved in implementing the measures. We would be interested in ascertaining whether or not the measures could be applied to populations outside the Medicare population. | The measures are computed from Medicare claims data and do not require individual hospital programming. Medicare claims data limits applicability to the Medicare population at this time. Discussed expansion of population with CMS who is interested in doing so, but obtaining all-payer longitudinal claims data is the big challenge. Added a research recommendation to explore expansion. Some states (e.g., MA, ME) are trying to construct all payer datasets. | General |
| 45 | M, Provider organization | Brian Clement, OASD, HA/TMA | Concur with the two recommended measures. We look forward to an expansion on the age-group in the future as well. | Support. Medicare claims data limits applicability to the Medicare population at this time.<br>See response to Comment #39. | General |

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| 46 | M, QMRI | Susan Rossi, NIH | Thank you for the opportunity to comment on the National Voluntary Consensus Standards for Hospital Care: Outcomes and Efficiency Phase I â€" Readmission Measures. We have no comments at this time. (Susan Rossi on behalf of Dr. Ruth Kirschstein and NIH) | Support. No response needed. | General |
| 50 | M, Health Professional | Janet Leiker (on behalf of the Commission on Quality), American Academy of Family Physicians | The risk adjustment variables reference "males". Are these variables generalizable to both males and females? | The variable is dichotomous - if not male, then female. | General |
| 51 | M, Health Plan | Rebecca Zimmermann, AHIP | AHIP Comments on the National Quality Forum<br>Hospital Measures: Additional Priorities 2007<br><br>The National Quality Forum has taken an important step in reviewing hospital performance measures that assess readmission rates. These measures are important indicators to assess quality of care, appropriate discharge planning, efficiency, and fill an important gap in the NQF hospital measuresâ€™ set.<br><br>NQF endorsed the CMS/Yale 30-day All-Cause Readmission Rate Following Heart Failure Hospitalization measure earlier this year. The two additional CMS/Yale readmission measures for AMI and pneumonia are also suitable for endorsement. The measures are well specified and clinically appropriate. In addition, these measures are appropriate for populations other than Medicare patients. We suggest that NQF work with CMS to determine if revising the measures to include other populations is possible. It should be noted that hospitals may find these measures challenging to implement as they increase the administrative burden of data programming and collection. | Medicare claims data limits applicability to the Medicare population at this time.<br>See response to Comment #39.<br>The measures are computed from Medicare claims data and do not require individual hospital programming. | General |

| 52 | M, Provider organization | Miriam Marcus-Smith, Harborview Medical Center | Comments submitted on behalf of one of our physician leaders:<br>1. Having reviewed the literature re readmission rates as an indicator of quality a number of years back, my understanding is that readmission is not the most valid marker for quality in and of itself, although it can be used as an indication that there may be quality problems. There may well be new literature on this topic, but my concern is that people can read too much into readmit rates.<br>*Reference: see Lessler DS & Wickizer TM, "The Impact of Utilization Management on Readmissions among Patient with Cardiovascular Disease," HSR: Health Services Research 34:6 (February 2000).<br>2. With respect to both measures, it would be important to adjust readmit rates for severity of illness/co-morbidities. | Readmission can be seen as a proxy for deterioration in health status. As with all outcome measures, patients may have poor outcomes that are not due to quality problems; however variability in risk-adjusted outcome rates that take into account differences in severity of illness/condition at the start of care are considered indicators of quality. Both measures are risk-adjusted. | General |
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| 55 | M, Health Professional | Jill Epstein, Society of Hospital Medicine | Ive reviewed the 2 new NQF proposed measures. These inlcude 30 day readmission following AMI and 30 day readmission following pneumonia.<br>By way of some background, they represent an extension of the current approved readmission measure â€" 30 day readmission following heart failure.<br><br>These measures were developed by Krumholz at el at Yale, under contract by CMS, and are being proposed by CMS<br><br>In case you would like to review the material I have attached the documents to this email - the first is the NQF discussion of the 2 measures, the second is a detailed methods paper.<br><br>Overall I think these are good measures that are suitable for public reporting, but along with the NQF committee would not yet feel comfortable using them for payment . As you well know, most public reporting of hospital quality to date has centered on process measures. This has started to change with the addition of mortality, but because outcomes matter more to patients that processes of care, additional measures are needed. Readmission is a logical next area of focus because it is common, costly, and generally something that patients would like to a | Support. No response needed. | General |

| 56 | M, Health Professional | Jill Epstein, Society of Hospital Medicine | There is one aspect of the readmission measures that SHM would express some concern about. It is the fact that they, intentionally, measure all cause readmission. For the AMI measure the developers do not count readmissions of angioplasty etc. that are likely the natural consequence of care, but in other respects, and for the pneumonia measure, no attempt is made to distinguish potentially preventable readmissions for example, a DVT following an admission for pneumonia) from an elective admission (such as an orthopedic procedure). However, given that the time frame is only 30 days, we doubt that this is likely to have a substantial impact on readmission rates, since elective procedures are probably not likely within such a short time frame following an admission for AMI or CAP. For other kinds of readmissions it quickly becomes difficult to distinguish what might be related to the index hospitalization vs not. For example, one might argue that an admission for a hip fracture shouldnâ €™t be counted because itâ€™s unrelated to pneumonia â€" however one can hypothesize that a patient who was discharged on medications that can lead to falls, or whose fluids were poorly m | In addition to the commenter's statement that it is relatively unlikely for elective readmission within 30 days, if the likelihood of elective readmissions within 30 days is generally the same across providers, it will not adversely affect measure results. | General |
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| 57 | M, Health Professional | Jill Epstein, Society of Hospital Medicine | All that said, SHM agrees that there really isnâ€™t a validated methodology for handling all cause readmission. However, we do believe that additional research and development is warranted to identify more specific readmission measures.<br><br>Thank you for this opportunity. | Additional measures may be submitted in Phase II. | General |
| 58 | Public | Jennifer Eames, Consumer-Purchaser Disclosure Project | The Disclosure Project supports the National Quality Forum efforts to address the need for hospital outcome measures, and is tentatively supportive of both measures that the Steering Committee submitted for comment. Having data on outcomes for AMI and pneumonia will allow consumers and purchasers to make informed decisions about the quality of care provided at their local hospitals, as well as hopefully spurring improvements in care coordination. We understand that there are methodological challenges and limitations involved in calculating readmission rates for AMI and pneumonia, and this is certainly a case where the perfect should not stand in the way of the good. | No response needed. | General |
| 59 | Public | Jennifer Eames, Consumer-Purchaser Disclosure Project | We do have several concerns, however. First, we are very concerned with the fact that both use hierarchical generalized linear modeling for risk-adjustment. Hospitals with a small sample size typically get classified as "average," which is misleading to consumers. Rather, we support not reporting on hospitals that do not have an adequately reliable sample. We would be inclined to not approve these measures if this issue is not addressed by the measure developers. | Hierarchical modeling reduces the misclassification of small providers as outliers (high or low). Suggestion regarding reporting was referred to CMS. CMS is exploring approaches for reporting that provide more distinctions in performance (if they exist). It was also suggested that the website for reporting these measures explain the 1-year data lag. | General |

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| 60 | Public | Jennifer Eames, Consumer-Purchaser Disclosure Project | Second, we are disappointed at the lack of any overall readmission rate for review and comment. We hope that such a measure is included in Phase 2 of the project, along with the measures reflecting a broader definition of outcomes including complication rates, efficiency, and functional status. | There is an NQF-endorsed measure that includes all patients/all conditions (#0329, PacifiCare) and a measure similar to these for CHF Medicare patients. | General |
| 61 | Public | Jennifer Eames, Consumer-Purchaser Disclosure Project | Finally, we note the concern voiced by some members of the Steering Committee, as described in the report, regarding the lack of individual-level SES data elements. As with all measurement efforts, we urge the collection of data on race and ethnicity in order to better understand disparities across all areas of healthcare delivery, including hospital readmissions. | The purpose of risk-adjustment is to account for differences in severity of illness of patients at the start of care that affect the outcome being measured. Including factors such as community resources, SES, and race in risk models adjusts out potential disparities in quality related to those factors. Adjustment makes them less visible to the communities they affect and also implies that lower performance is acceptable for a certain case mix or that we do not need to identify and reduce disparities. The best strategy is to examine results by stratifying on those factors. Referred to CMS regarding the potential for stratification. As in prior committee discussions, some committee members are uncertain about this approach, however it is consistent with NQF evaluation criteria and the majority committee decision on the measures. Add a research recommendation to study the influence of SES on these measures to better inform policy responses. | General |

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| 62 | M, Purchaser | Gaye Fortner, HealthCare 21 Business Coalition | The Disclosure Project supports the National Quality Forum efforts to address the need for hospital outcome measures, and is tentatively supportive of both measures that the Steering Committee submitted for comment. Having data on outcomes for AMI and pneumonia will allow consumers and purchasers to make informed decisions about the quality of care provided at their local hospitals, as well as hopefully spurring improvements in care coordination. We understand that there are methodological challenges and limitations involved in calculating readmission rates for AMI and pneumonia, and this is certainly a case where the perfect should not stand in the way of the good. | See response for Comment #58. | General |
| 63 | M, Purchaser | Gaye Fortner, HealthCare 21 Business Coalition | We do have several concerns, however. First, we are very concerned with the fact that both use hierarchical generalized linear modeling for risk-adjustment. Hospitals with a small sample size typically get classified as "average," which is misleading to consumers. Rather, we support not reporting on hospitals that do not have an adequately reliable sample. We would be inclined to not approve these measures if this issue is not addressed by the measure developers. Second, we are disappointed at the lack of any overall readmission rate for review and comment. We hope that such a measure is included in Phase 2 of the project, along with the measures reflecting a broader definition of outcomes including complication rates, efficiency, and functional status. Finally, we note the concern voiced by some members of the Steering Committee, as described in the report, regarding the lack of individual-level SES data elements. As with all measurement efforts, we urge the collection of data on race and ethnicity in order to better understand disparities across all areas of healthcare delivery, including hospital readmissi | See response for Comment #59, 60, 61. | General |
| 64 | M, Consume r | Debra Ness, National Partnership for Women and Families | The National Partnership for Women & Families supports the effort to increase the measurement portfolio around outcomes and efficiency, and praises the National Quality Forum for taking on this project. That being said, we have a number of concerns related to both of the measures being put forward in Phase 1 of this project. The National Partnership believes that consumers may indeed benefit from having data on outcomes for AMI and pneumonia, as they hopefully will spur improvements in care coordination, transitions of care, medication management, and other systems. We also believe that, if publicly reported, these measures will provide consumers with information about how treatment is delivered at their local hospitals. But at their heart, these are two internal provider quality improvement measures, rather than measures that will be useful to consumers in making choices about their health care.<br><br>Continued... | Measures used for internal quality improvement do not require risk adjustment. Currently there may not be substantial variation in results because of overall lack of attention to the issue of hospital readmission. However, public reporting will bring attention to the issue and strategies to improve, ultimately benefiting consumers. | General |

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| 65 | M, Consumer | Debra Ness, National Partnership for Women and Families | We have several additional concerns. First, both measures use hierarchical generalized linear modeling for risk-adjustment, which may lead to hospitals with a small sample size being classified as "average," which is misleading to consumers. The hierarchical risk adjustment model is the ultimate â€œblack box,â€ and may make the results of the measure difficult for consumers, and possibly even providers, to understand. Rather, we support not reporting on hospitals that do not have an adequate size sample. We are not inclined to approve these measures if this issue is not addressed by the measure developers.<br><br>Second, we are disappointed at the lack of any overall readmission rate. We hope that such a measure is included in Phase 2 of the project, along with measures that reflect a spectrum of outcomes such as complication rates, efficiency, and functional status.<br><br>Third, we would urge NQF to present measures that can be applied to the broad population of consumers, as described on pages 5-6 of the report: â€œadditional priorities for prioritizing measures that pertain to all or large groups of hospitalized patients.â€ These measures, as cur<br>Continued... | See response for Comment #59, 60. | General |
| 66 | M, Consumer | Debra Ness, National Partnership for Women and Families | Finally, we reiterate the concern voiced by some members of the Steering Committee, as described in the report, regarding the lack of individual-level SES data elements in the risk-adjustment model. While we understand the collection of SES data for this purpose is inconsistent, we want to express our support for the collection of data on race and ethnicity in order to better understand disparities across all areas of healthcare delivery, including hospital readmissions.<br><br>Overall, we understand that there are many challenges and limitations involved in calculating readmission rates for AMI and pneumonia, and this is certainly a case where the perfect should not stand in the way of the good. But as reflected in our comments, we have a number of concerns that we would like to see addressed by NQF and the measure developers before further action is taken on Phase 1 of this project. | See response for Comment #61. | General |
| 67 | M, Purchaser | David Hopkins, PBGH | We applaud NQF's efforts to focus measure endorsement more on outcomes and efficiency, and view these Phase I measures as an important first step. However, we are very disappointed that a more expansive set of readmission measures is not being presented for endorsement. These measures address two important conditions; however, together they represent only a limited slice of conditions requiring hospitalization. This seems to contradict the Steering Committee's own goal statement, "additonal priorities for prioritizing measures include measures that pertain to all or large groups of hospitalized patients," with which we would certanly agree. | Broad-based measures were not submitted. There is an NQF-endorsed measure that includes all patients/all conditions (#0329, PacifiCare) and a measure similar to these for CHF Medicare patients. | General |

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| 68 | M, Purchaser | David Hopkins, PBGH | Specific comments:<br>- Add to the list of purposes on page 3: provide information for consumer choice.<br>- Hierarchical risk adjustment tends to remove variation for low volume providers; this is a problem when information is being used for consumer choice and should be dealt with by excluding low volume providers from the reporting.<br>- As presented, the measures are being proposed for a single, specific insured population, i.e., Medicare beneficiaries. They should be more broadly applicable and, therefore, endorsed for broader use. Data availability is a separate issue.<br>- Page 14, Additional Recommendations: recommendations on payment strategies are outside the scope of NQF and should not be included in NQF reports. | Information for consumer choice is a specific example of the purpose of "supplying stakeholders with information to understand quality of care" and can be added to the 4th bullet.<br>Hierarchical modeling reduces the misclassification of small providers as outliers (high or low). Suggestion regarding reporting referred to CMS. See Comment #37.<br>Measures need to be specified for use with a data source. In this case, Medicare claims data limits applicability to the Medicare population at this time. See response to Comment #39.<br>NQF does not endorse implementation strategies, but the committee can make comments and recommendations. Change the language to: "Support the MedPAC recommendation that readmission rates should not be used to adjust payments until after a year or two of public disclosure when there is more experience with the measures and information to support their use for that purpose and when parallel policies for other settings can be implemented." | General |
| 69 | M, Provider organization | Roger Khetan, Baylor Health Care System | Related to the Feasibility of the Measures discussion in the report: I would stress the need for a data source that is hospital record/chart based as the clinical documentation will at times indicate the clinical plans and why they sometimes may have failed. This may only represent a 15-20% discrepancy with claims data, however, this difference is signficant to me. | Medical record based readmission measures were not submitted. | General |

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| 70 | M, Supplier/ Industry | Madeleine Smith, AdvaMed | AdvaMed welcomes this opportunity to provide comments on the draft report on Standards for Hospital Care: Outcomes and Efficiency. We agree with the Committeeâ€™s concerns, as echoed in MedPAC recommendations, that readmission rates should not be used to adjust payments without more experience with these measures. If endorsed by the full NQF, the two readmission measures would be available for both public reporting and quality improvementâ€”two conditions that must be satisfied by proposed measures, according to the NQF Measure Evaluation Criteria. We believe that it is important that the final report note the Committeeâ€™s â€œbiggest concernâ€ and include the additional recommendation found on page 14 of the draft report. Thank you for considering these comments when preparing the final report. | The final report will include the committee's recommendation. | General |
| 71 | M, Health Professional | Mary Andrawis, American Society of Health-System Pharmacists | The American Society of Health-System Pharmacists (ASHP) appreciates the opportunity to comment on NQF's proposed standards for Hospital Care: Outcomes and Efficiency, Phase I. We support the efforts to expand NQF's endorsed readmission measures from the three currently approved measures to include readmission rates for pneumonia and acute MI patients. The measurement of hospital readmission rates addresses the challenges and need for improvement in continuity of care between inpatient and outpatient settings. In addition, these measures specifically target high-risk populations that require multidisciplinary care. | Support. No response needed. | General |
| 72 | M, Health Professional | Nancy Nielsen, AMA | The American Medical Association (AMA) is pleased to provide comments on the draft National Quality Forum (NQF) National Voluntary Consensus Standards for Hospital Care: Outcomes and Efficiency, Phase I â€“ Readmission Measures report. We support the report as written and the two measures put forward for endorsement. We encourage the measure developers to consider expanding the measure to include patients who are not covered under Medicare and broadening the age range beyond those patients over 65 years of age and recommend that this expansion be added as a research recommendation. | Medicare claims data limits applicability to the Medicare population at this time.<br>See response to Comment#39. | General |

| 73 | M, Provider organization | Nancy Foster, AHA | Because the methodology for the proposed measures includes fee-for-service Medicare patients only, the measures could patient an incomplete picture of patient care. By excluding all other patients, there is the potential that the measures could distort the true picture of hospital readmissions.<br><br>The measure methodology takes into account a variety of patient demographic and health status variables; however, it does not capture any information about the community and environmental determinants of health and health care. While some readmissions may be due to poor care delivered in the hospital, in general, preventing readmissions is a complex, system-wide problem that involves hospitals, physicians, and other providers who manage patientsâ€™ care, as well as patients and their families. Many patients are readmitted to the hospital because our health care system is not structured to promote chronic care management. Many patients do not have a medical home outside of the hospital. All of these factors vary among the communities in which hospitals provide care, yet they are not captured in the draft re | Medicare claims data limits applicability to the Medicare population at this time. See response to Comment #39.<br><br>See response for Comment #61. | General |
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| 74 | M, QMRI | Bernard Rosof, MD, MACP, PCPI | The Physician Consortium for Performance Improvement (PCPI) is pleased to provide comments on the draft National Quality Forum (NQF) National Voluntary Consensus Standards for Hospital Care: Outcomes and Efficiency, Phase I â€“ Readmission Measures report. We support the report as written and the two measures put forward for endorsement. We encourage the measure developers to consider expanding the measure to include patients who are not covered under Medicare and broadening the age range beyond those patients over 65 years of age and recommend that this expansion be added as a research recommendation. | See response for Comment #72. | General |

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| 4 | Public | Jennifer Kuhn, St. Luke's Hospital | We are the closest hospital to a nursing home for the specialized care of severely retarded adults. Even though these patients often have G-tubes for feedings they still aspirate as well and are often admitted for a myriad of other acquired or congenital problems and we see them readmitted on a regular basis. It would concern me that since we care for the concentration of these cases in this demographic area that it would adversely affect our numbers. | These measures are for Medicare patients 65 years and older. The codes were reviewed and aspiration pneumonia is not included in the measures. In addition, the pneumonia mortality model adjusts for a number of risk factors relevant to the nursing home population described including neurologic conditions related to impaired swallowing. If the condition is coded in hospital or outpatient claims in the year prior to a pneumonia admission or during the admission the measure will risk adjust for the condition. You may find a specific list of comorbid conditions included in the pneumonia mortality model risk adjustment in your Hospital Specific Report. The specific ICD-9-CM codes that correspond to these variables are listed at at www.qualitynet.org (Hospitals – Inpatient à Readmission Measures à Resources àCondition Category-ICD-9-CM Crosswalk). | HOE-001 |
| 15 | M, QMRI | Barbara Corn, NAHQ | General question on how the measures would be adjusted due to patient volume? Is there a suggested methodology that can be used for reporting- If under xxx number of cases, sample size is not statistically valid? | Hierarchical modeling reduces the misclassification of small providers as outliers (high or low). Suggestion regarding reporting referred to CMS. See response to Comment #59. | HOE-001 |

| 47 | M, Provider organization | Donald Casey, Atlantic Health | This is a comment from our Chief of Cardiology: I read the report and fear that CMS is continuing on the same course that has proven fruitless so far in Heart Failure. That is, they are ignoring the physician role in the hospital readmission metric. The introduction makes you think they understand the issue when the authors mention transition points but in fact never address this in the body of the report. In fact lines 336-350 show that committee members questioned the effect of hospitals and their systems on readmit rates. The authors then go on to counter this argument by citing low performing and high performing hospitals and the 1.82 odds ratio increase between high and low performers. Again this shows a lack of consideration for the effects of the medical staff at these hospitals. The physicians are likely responsible for the majority of these differences but again CMS seems to disregard that component and focus on the low value occurrences in the hospital since they are easier to measure and subsequently control.<br><br>My suggestion would be to intimately weave in the effect of the physician and time to first office | The readmission measures (as with many outcome measures) are integrative reflecting the influence of all disciplines involved in the care of the patient, as well as coordination of care, teamwork, discharge planning, and transitions. | HOE-001 |
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| 48 | M, Provider organization | Donald Casey, Atlantic Health | Another comment from one of our Senior Cardiologists: I haven't read all the detail yet but I must respond to comments offered already by you and Frank. The "re-admission" patterns suffer the same distortion that we experience with chest pain admission. There is a progressive decline in what I refer to as clinical courage in our emergency rooms. The threshold for admission continues to fall. So often my initial response -- and those of my colleagues-- to a call from the ER (most often a resident calls) is "Whatever would make you choose to admit this patient?" But the deed is already done! Until someday when there is a clinical feedback loop where those with such brisk admitting reflex can come to recognize the real discouraging impact upon individual patients admission rates will continue to rise no matter how clever we get with outpatient monitoring and therapeutics. | One purpose of measuring readmission rates is to begin identifying and addressing the reasons for readmissions such as the example provided by the commenter. | HOE-001 |
| 53 | M, Provider organization | Miriam Marcus-Smith, Harborview Medical Center | It is possible that a procedurally-oriented hospital may have a higher readmission rate than a facility that does not perform selected revascularization procedures. As an example, a patient is risk-stratified post-MI and then is readmitted for a procedure, e.g., stent, to the same hospital. How would differences among such facilities be represented? | Admissions for planned revascularization procedures are not counted as readmissions. | HOE-001 |

| 37 | M, Health Professional | Joyce Bruno, American College of Chest Physicians | Disapprove with comments. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. The QIC noted the following: (1) aspiration pneumonia is not included in the denominator of this measure and the QIC feels that hospitals may use this code aggressively so that their sickest patients would be excluded from this measure. (2) The QIC feels that if patient transfers to another acute care setting is an exclusion, there is the opportunity for cost-shifting, and recommends also excluding transfers into a hospital from another acute care setting. (3) The concept of risk adjusted ratio used in the numerator and denominator is convoluted and unclear. The QIC feels that because the results of this measure are not intuitively obvious or self-explanatory it will be extremely challenging for hospitals and clinicians to accept the measure as having validity and thus, use the results to improve care. (4) The QIC questions how this measure would be used in the future and itâ€™s impact on safety net hospitals. | 1) Aspiration pneumonia is different and the committee agreed it should not be included. See response to Comment #4 regarding risk factors. 2) The focus of the measure is on patients discharged to non-acute settings. 3) Risk adjustment is important for outcome measures because outcomes are affected by the patient's severity of illness at the start of care and helps "level the playing field when comparing providers." 4) One purpose of measuring readmission rates is to begin identifying and addressing the reasons for readmissions. | HOE-002 |
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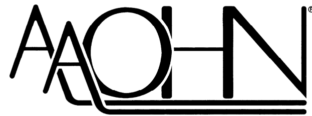
| 49 | M, Health Professional | Janet Leiker (on behalf of the Commission on Quality), American Academy of Family Physicians | Agree with prior comments regarding the exclusion of aspiration pneumonia. Please clarify why it was excluded when the title of the measure only states "pneumonia". | See response for Comment #37. | HOE-002 |
| 54 | M, Provider organization | Miriam Marcus-Smith, Harborview Medical Center | As a large county hospital, many of our mission population (indigent, homeless, and/or mentally ill individuals) live in circumstances beyond the control of our hospital, and those very conditions may have significant impact on their after-care and potential readmission (e.g., their ability to obtain and/or take medications, use oxygen, return for follow-up visits, receive home care, etc. may all be affected by socioeconomic characteristics). | See response for Comment # 61. | HOE-002 |



**AMERICAN ASSOCIATION OF OCCUPATIONAL HEALTH NURSES, INC.**

Richard J. Kowalski, RN, MSA, COHN-S
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August 22, 2008

Rita Munley Gallagher, PhD, RN
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RE: *National Voluntary Consensus Standards for Hospital Care: Outcomes and Efficiency, Phase I – Readmission Measures.*

As a nursing specialty association dedicated to the promotion of health, safety and productivity of workers and worker populations, nationally and internationally, the American Association of Occupational Health Nurses, Inc. (AAOHN) is pleased to provide comments to the American Nurses Association (ANA) on behalf of the Department of Nursing Practice and Policy and the National Quality Forum (NQF) on the proposed standards for hospital readmission measures.

With rising health care costs, increased use of the emergency room for health care services, and early hospital discharges, AAOHN applauds ANA and NQF for taking the initiative to address health care efficiency and outcomes. Since efficiency is related to competency and quality of care, a decrease in the quality of care, i.e., staffing, staff credentials/specialties, surgical outcomes, etc., will impact health care outcomes, therefore, the potential to increase hospital readmissions, possible complication/sequela and health care costs.

A literature review suggest that business and organizational performance outcome measures are influenced by a multiple of factors, i.e., number and location of competitors (hospitals), number of consumers/clients (admissions, discharges and readmissions), consumer/client factors such as health condition and severity, as well as staffing, staff credentials, operational infrastructure and policy. These factors are not independent of each other, but are related or linked to facilitate quality outcomes. According to Donabedian's structure, process and outcome model, "good structure promotes good process and good process promotes good outcomes."

AAOHN agrees with the priority areas and corresponding goals (pages 1 – 8), which incorporates the outcome influencers and the six domains of health care quality: safety, effectiveness, efficiency, timeliness and patient-centered care. The association supports quality health care delivery (hospital facilities, community services, workplace, etc.); a comprehensive discharge plan with consumer/client engagement in the decision making process and with consideration of consumer/client disparities; coordination of care and information sharing with transition provider(s), i.e., home health, public health, nurse case manager, etc., per

confidentiality laws and regulations; consumer/client education on prevention and healthy lifestyles; and safety measures for the prevention of injury, infection control and disease management.

Specific Recommendations

AAOHN would offer the following recommendations:

- Page 7, Lines 216 and 234: Recommend including health literacy to list of disparities.
- Page 7, Line229: Recommend adding, "for example, the severity of illness, condition/state of health at time of discharge (discharge readiness).
- Page 10, Line 285: Agree that discharge readiness as well as hospital care influence consumer/client readmissions. Although limited, research has shown a decrease in hospital readmissions for older consumers/clients who received appropriate, comprehensive discharge planning (discharge readiness). Other studies have shown a relationship between length of stay (medical condition and/or health insurance coverage, i.e., managed care) and readmission. However, any time readmissions occur there is a disruption in the continuum of care and the possibility of unexpected adverse outcomes.

As a national association committed to innovative and business compatible solutions for workplaces and worker health, and whose members are directly and/or indirectly involved with consumer/client transition to ambulatory care post hospital discharge and return to work, the American Association of Occupational Health Nurses, Inc. appreciates the opportunity to state our views and recommendations on the *National Voluntary Consensus Standards for Hospital Care: Outcomes and Efficiency, Phase I – Readmission Measures.*

Sincerely,

Richard Kowalski, RN, MSA, COHN-S
President

CC: AAOHN Board of Directors
Ann Cox, CAE, AAOHN Executive Director