



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0205

Corresponding Measures:

De.2. Measure Title: Nursing Hours per Patient Day

Co.1.1. Measure Steward: American Nurses Association

De.3. Brief Description of Measure: NSC-13.1 (RN hours per patient day) – The number of productive hours worked by RNs with direct patient care responsibilities per patient day for each in-patient unit in a calendar month.

NSC-13.2 (Total nursing care hours per patient day) – The number of productive hours worked by nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities per patient day for each in-patient unit in a calendar month.

Measure focus is structure of care quality in acute care hospital units.

1b.1. Developer Rationale: Despite the consistent evidence that better nurse staffing contributes significantly to improved patient outcomes, there is considerable variations in nursing care hours across and within different unit types. Nursing care hours has been addressed in the research literature with respect to patient safety and quality of care. A lack of total nursing time and a lack of RN time for patients is thought to constrain the amount and quality of care that can be provided, as well as contribute to stress and fatigue among nursing staff. This creates a hazardous situation for patients and represents a major opportunity for use of the measures quality improvement at the patient care level and accountability (e.g., public reporting, an identified driver of improved patient safety). The Nursing care hours measures allows hospitals, including nurse administrators/managers, to assess and plan their nurse staffing and develop strategies to provide adequate nursing care hours on a unit-by-unit and hospital-level basis allowing comparisons with regional, state, and national staffing data.

S.4. Numerator Statement: Total number of productive hours worked by nursing staff with direct patient care responsibilities for each hospital in-patient unit during the calendar month.

S.6. Denominator Statement: Denominator is the total number of patient days for each in-patient unit during the calendar month. Patient days must be from the same unit in which nursing care hours are reported.

S.8. Denominator Exclusions: Patient days from some non-reporting unit types, such as Emergency Department, peri-operative unit, and obstetrics, are excluded.

De.1. Measure Type: Structure

S.17. Data Source: Management Data, Other

S.20. Level of Analysis: Facility, Other

IF Endorsement Maintenance – Original Endorsement Date: Aug 05, 2009 **Most Recent Endorsement Date:** Oct 23, 2019

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[0205_nqf_evidence_attachment_ver_7.1.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

Yes

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Despite the consistent evidence that better nurse staffing contributes significantly to improved patient outcomes, there is considerable variations in nursing care hours across and within different unit types. Nursing care hours has been addressed in the research literature with respect to patient safety and quality of care. A lack of total nursing time and a lack of RN time for patients is thought to constrain the amount and quality of care that can be provided, as well as contribute to stress and fatigue among nursing staff. This creates a hazardous situation for patients and represents a major opportunity for use of the measures quality improvement at the patient care level and accountability (e.g., public reporting, an identified driver of improved patient safety). The Nursing care hours measures allows hospitals, including nurse administrators/managers, to assess and plan their nurse staffing and develop strategies to provide adequate nursing care hours on a unit-by-unit and hospital-level basis allowing comparisons with regional, state, and national staffing data.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

The following are descriptive statistics of nursing care hours per patient day by unit type across all NDNQI participating hospitals that provided nurse staffing data for 2017.

Descriptives by Unit Type (Unit Level Measure)

TNHPPD Mean	Std Dev	Minimum	25th Pctl	50th Pctl	75th Pctl	Maximum
Adult Critical Care		17.59	4.10	1.70	15.08	17.00 19.23 92.95
Adult Step Down	10.94	2.77	2.20	9.33	10.48	11.96 82.05
Adult Medical	9.35	2.36	1.86	8.08	9.02	10.16 87.14
Adult Surgical	9.58	2.15	2.72	8.38	9.28	10.40 51.88
Adult Medical-Surgical		9.33	2.15	1.03	8.10	9.05 10.23 118.79
Neonatal	12.99	5.39	1.29	10.52	12.15	14.41 108.30
Pediatric Critical Care		20.85	5.52	6.75	17.65	20.30 23.03 78.04
Pediatric Medical/Surgical	13.69	5.94	3.12	10.29	12.32	15.19 79.89
Psychiatric	8.59	3.20	1.02	6.76	8.07	9.73 76.19
Rehabilitation	8.86	2.61	3.16	7.36	8.41	9.78 43.20

RNHPPD Mean	Std Dev	Minimum	25th Pctl	50th Pctl	75th Pctl	Maximum
Adult Critical Care		15.75	3.71	1.23	13.61	15.17 17.16 87.39
Adult Step Down	8.14	2.41	0.27	6.75	7.67	9.02 66.42
Adult Medical	6.45	1.89	0.95	5.38	6.17	7.14 74.56
Adult Surgical	6.72	1.73	1.46	5.68	6.45	7.40 41.23

#0205 Nursing Hours per Patient Day, Last Updated: Oct 23, 2019

Adult Medical-Surgical	6.39	1.72	0.20	5.41	6.19	7.08	82.57		
Neonatal	12.40	5.25	0.91	10.08	11.66	13.72	108.30		
Pediatric Critical Care	19.31	5.31	4.05	16.23	18.73	21.54	85.20		
Pediatric Medical/Surgical	11.38	5.40	0.66	8.35	10.06	12.59	79.28		
Psychiatric	4.75	1.97	0.29	3.59	4.46	5.49	47.86		
Rehabilitation	5.40	1.99	0.49	4.23	5.09	6.14	28.88		
Descriptives By Hospital Characteristics (Hospital Level Measures)									
TNHPPD									
Hospital Type	Mean	Std Dev	Minimum		25th Pctl		50th Pctl	75th Pctl	Maximum
General	-0.06	0.75	-2.54	-0.47	-0.13	0.21	13.64		
Pediatric	0.18	0.89	-1.32	-0.26	-0.03	0.35	8.17		
Rehabilitation	-0.24	0.66	-1.61	-0.59	-0.28	-0.02	4.75		
Psychiatric	-0.11	0.72	-1.60	-0.55	-0.13	0.18	2.91		
Other specialty	0.00	0.80	-1.67	-0.62	-0.27	0.45	3.18		
LTAC	0.39	0.99	-1.12	-0.41	0.22	0.88	2.99		
Critical Access Hospital	1.49	2.04	-1.78	0.22	1.00	2.09	14.30		
Oncology Specialty	0.88	1.01	-0.68	0.40	0.65	0.99	5.68		
Orthopedic Specialty	0.41	1.07	-1.74	-0.24	0.46	1.29	3.17		
Women’s Specialty	0.51	1.10	-0.89	-0.09	0.29	0.68	6.19		
Cardiac Specialty	0.13	1.13	-1.43	-0.57	-0.16	0.43	3.13		
Bed Size	Mean	Std Dev	Minimum		25th Pctl		50th Pctl	75th Pctl	Maximum
<100	0.33	1.22	-2.53	-0.37	0.11	0.72	14.30		
100-199	-0.15	0.55	-2.31	-0.49	-0.18	0.15	3.74		
200-299	-0.17	0.56	-2.54	-0.53	-0.21	0.12	4.27		
300-399	-0.17	0.49	-1.90	-0.50	-0.22	0.04	2.29		
400-499	-0.17	0.57	-2.04	-0.50	-0.18	0.07	2.02		
>=500	-0.07	0.45	-1.46	-0.35	-0.06	0.09	2.14		
Teaching Status	Mean	Std Dev	Minimum		25th Pctl		50th Pctl	75th Pctl	Maximum
Academic Medical Center	0.01	0.55	-2.04	-0.31	-0.02	0.21	2.91		
Teaching Hospital	-0.14	0.67	-2.45	-0.52	-0.21	0.11	8.17		
Non-Teaching Hospital	0.07	0.94	-2.54	-0.45	-0.07	0.36	14.30		
Location	Mean	Std Dev	Minimum		25th Pctl		50th Pctl	75th Pctl	Maximum
Rural	0.91	1.78	-1.66	-0.12	0.37	1.59	12.05		
Metropolitan	-0.06	0.75	-2.54	-0.47	-0.14	0.21	14.30		
Micropolitan	0.17	0.96	-2.46	-0.41	0.04	0.52	7.07		
Magnet Status	Mean	Std Dev	Minimum		25th Pctl		50th Pctl	75th Pctl	Maximum
Not Magnet Designated	0.02	0.93	-2.54	-0.50	-0.12	0.31	13.64		
Magnet Applicant	-0.14	0.61	-1.79	-0.54	-0.21	0.13	6.31		
Magnet Designated	-0.02	0.66	-1.90	-0.36	-0.07	0.21	14.30		
RNHPPD									
Hospital Type	Mean	Std Dev	Minimum		25th Pctl		50th Pctl	75th Pctl	Maximum
General	-0.09	0.71	-2.89	-0.50	-0.17	0.19	12.05		
Pediatric	0.07	0.80	-1.29	-0.36	-0.09	0.21	7.04		
Rehabilitation	-0.51	0.56	-1.34	-0.94	-0.61	-0.15	2.10		
Psychiatric	-0.20	0.86	-1.19	-0.69	-0.47	-0.06	3.41		
Other specialty	0.32	1.03	-1.21	-0.43	0.04	0.70	3.43		
LTAC	0.36	1.20	-1.50	-0.76	0.34	1.16	3.14		
Critical Access Hospital	1.35	1.85	-1.47	0.11	0.95	2.01	11.05		
Oncology Specialty	0.85	0.82	-0.50	0.46	0.71	1.06	4.42		

Orthopedic Specialty	0.12	0.90	-1.76	-0.36	0.00	0.82	2.69
Women's Specialty	0.70	1.37	-0.95	0.03	0.32	0.71	8.13
Cardiac Specialty	0.16	1.19	-1.23	-0.57	-0.21	0.20	3.80

Bed Size	Mean	Std Dev	Minimum	25th Pctl	50th Pctl	75th Pctl	Maximum
<100	0.25	1.13	-2.89	-0.44	0.04	0.64	12.05
100-199	-0.19	0.54	-2.26	-0.51	-0.20	0.09	3.43
200-299	-0.19	0.59	-2.20	-0.57	-0.24	0.09	3.56
300-399	-0.19	0.49	-1.94	-0.50	-0.21	0.07	2.52
400-499	-0.16	0.55	-1.84	-0.51	-0.20	0.10	2.25
>=500	-0.09	0.56	-1.50	-0.43	-0.11	0.16	2.04

Teaching Status	Mean	Std Dev	Minimum	25th Pctl	50th Pctl	75th Pctl	Maximum
Academic Medical Center	0.05	0.63	-2.01	-0.33	-0.01	0.35	3.41
Teaching Hospital	-0.19	0.68	-2.41	-0.58	-0.26	0.08	7.04
Non-Teaching Hospital	0.01	0.87	-2.89	-0.46	-0.12	0.28	12.05

Location	Mean	Std Dev	Minimum	25th Pctl	50th Pctl	75th Pctl	Maximum
Rural	0.66	1.55	-1.67	-0.23	0.22	1.15	12.05
Metropolitan	-0.09	0.73	-2.41	-0.50	-0.17	0.19	11.05
Micropolitan	0.03	0.95	-2.89	-0.53	-0.12	0.36	6.63

Magnet Status	Mean	Std Dev	Minimum	25th Pctl	50th Pctl	75th Pctl	Maximum
Not Magnet Designated	-0.04	0.89	-2.89	-0.56	-0.18	0.27	12.05
Magnet Applicant	-0.17	0.63	-1.94	-0.53	-0.23	0.08	7.74
Magnet Designated	-0.03	0.62	-2.03	-0.38	-0.10	0.20	8.66

Citation for descriptive statistics:

National Database of Nursing Quality Indicators (NDNQI), Q1-Q3 2017 data. The NDNQI is owned by Press Ganey Associates.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

NDNQI has limited patient-level demographic characteristics, however, by linking our staffing data to AHA hospital survey data, we were able to examine nurse staffing by the Hospital-level percentage of Medicaid days. Because Medicaid days are a continuous variable, we categorized the hospitals by quartile for ease of presentation.

Total Nursing Care Hours per Patient Day by Hospital Percentage of Medicaid Days in Quartiles

N=880 Hospitals

	Mean	Standard Deviation	25th Percentile	50th Percentile	75th Percentile
1st Quartile	11.64	5.25	8.75	10.39	13.07
2nd Quartile	10.64	4.26	7.98	9.79	12.52
3rd Quartile	11.12	3.99	8.55	10.58	12.93
4th Quartile	12.05	5.50	8.78	11.37	14.29

RN Hours per Patient Day by Hospital Percentage of Medicaid Days in Quartiles

N=880 Hospitals

	Mean	Standard Deviation		25th Percentile		50th Percentile	75th Percentile
1st Quartile	8.65	5.24	5.75	7.56	10.39		
2nd Quartile	7.73	3.91	5.01	7.05	9.34		
3rd Quartile	8.35	4.19	5.84	7.57	10.33		
4th Quartile	9.16	5.84	5.93	8.39	10.85		

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Non-Condition Specific(check all the areas that apply):

Person-and Family-Centered Care : Workforce

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Children, Populations at Risk

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

None

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: 0205_Codebook.xlsx

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

Yes

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

Additional nursing unit types have been tested at both the unit level, and in the hospital composite measure. Additionally, a new version of the hospital-level measure that includes only medical, surgical, and medical-surgical combined units in the calculation of the composite was tested.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Total number of productive hours worked by nursing staff with direct patient care responsibilities for each hospital in-patient unit during the calendar month.

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Nursing care hours are defined as the number of productive hours worked by nursing staff (registered nurse [RN], licensed vocational/practical nurse [LVN/LPN], and unlicensed assistive personnel [UAP]) assigned to the unit who have direct patient care responsibilities for greater than 50% of their shift.

Productive hours are actual direct patient care hours worked by nursing staff including overtime, not budgeted or scheduled hours. Vacation, sick time, orientation, education leave, or committee time are considered non-productive hours. However, orientation programs vary from hospital to hospital. Once orientees reach the point where they are considered part of the staffing matrix, their work hours are charged to the unit, and they would be replaced if they call in sick, then their hours are counted as productive.

Direct patient care responsibilities: Patient centered nursing activities by unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

- Medication administration
- Nursing treatments
- Nursing rounds
- Admission, transfer, discharge activities
- Patient teaching
- Patient communication
- Coordination of patient care
- Documentation time
- Treatment planning
- Patient screening (e.g. risk) and assessment

Nursing staff included are either staff employed by the facility or temporary staff who are not employed by the facility (contracted/agency staff). Float staff—those are assigned to a unit other than their unit of employment on an as-needed basis—must be counted and reported in the unit's total nursing care hours where they provided direct patient care.

Included nursing staff:

Staff who are counted in the unit's staffing matrix, and
Are replaced if they call in sick, and
Work hours are charged to the unit's cost center.

Excluded nursing staff:

Persons whose primary responsibility is administrative in nature.

Specialty teams, patient educators, or case managers who are not assigned to a specific unit.

Unit secretaries or clerks, monitor technicians, and other with no direct patient care responsibilities (Therapy assistants, student nurses who are fulfilling educational requirements, sitters who either are not employed by the facility or who are employed by the facility, but are not providing typical UAP activities).

Unlicensed Assistive Personnel (UAPs): Individuals trained to function in an assistive role to nurses in the provision of patient care, as delegated by and under the supervision of the registered nurse. Typical activities performed by UAPs may include (but are not limited to): taking vital signs, bathing, feeding, dressing patients, assisting patients with transfers, ambulation, or toileting.

Included UAPs: nursing assistants, orderlies, patient care technicians/assistants, graduate nurses (not yet licensed) who have completed unit orientation.

Mental Health Technicians (MHT): For Psychiatric In-Patient Units ONLY

Individuals functioning in an assistive role, for which your facility requires course work or training that is different from UAP. They may be licensed or unlicensed. MHT hours are included in UAP hours when reporting, but their hours are collected separately from UAP hours if persons in this job position also meet the following criteria:

- They are engaged in direct care activities greater than 50% time, and
- Their position is staffed 24/7 and replaced when they call in sick, and
- Their hours are included in the nursing staff budget

Data Elements:

RN hours (Employee)

RN hours (Contract/Agency)

LPN/LVN hours (Employee)

LPN/LVN hours (Contract/Agency)

UAP hours (Employee)

UAP hours (Contract/Agency)

MHT hours (Employee)

MHT hours (Contract/Agency)

Year

Month

Type of Unit

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

Denominator is the total number of patient days for each in-patient unit during the calendar month. Patient days must be from the same unit in which nursing care hours are reported.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Conceptually, a patient day is 24 hours, beginning the hour of admission. The operational definitions of patient days are described in the section labeled Patient Day Reporting Methods.

The total number of patient days for each in-patient unit is collected by the calendar month using one of patient day reporting methods.

With the growth in the number of short stay in-patient units, included patients are in-patient and short stay patients (i.e., variously called short stay, observation, or same day surgery patients who receive care on a reporting in-patient unit for less than 24 hours).

Four (4) Patient Days reporting methods are as follows:

Method 1-Midnight Census

This is adequate for units that have all in-patient admissions. It is the least accurate method for units that have both in-patient and short stay patients. At the end of the month, sum the daily midnight census counts (the number of patients on the unit at midnight each day).

Method 2-Midnight Census + Patient Days from Actual Hours for Short Stay Patients

This is an accurate method for units that have both in-patients and short stay patients. The short stay “days” should be reported separately from midnight census and will be summed by NDNQI to obtain patient days. The total daily hours for short stay patients should be summed for the month and divided by 24.

Method 3-Patient Days from Actual Hours

This is the most accurate method. An increasing number of facilities have accounting systems that track the actual time spent in the facility by each patient. Sum actual hours for all patients, whether in-patient or short stay, and divide by 24.

Method 4-Patient Days from Multiple Census Reports

Some facilities collect censuses multiple times per day (e.g., every 4 hours or each shift). This method has shown to be as accurate as Method 3. Patient days based on midnight and noon census have shown to be sufficient in adjusting for short stay patients. A sum of the daily average censuses can be calculated to determine patient days for the month on the unit.

For all patient day reporting methods, it is recommended that facilities consistently use the same method for a reporting unit over time. Each unit should report patient days using the method that most accurate for the nursing work load. For some hospitals in which the midnight census may be the only available measure of patient census, units with short stay patients should use either Method 2 or Method 3, if feasible.

Data Elements:

Month

Year

Patient Days Reporting method

Type of Unit

Patient days from Midnight census

Patient days from actual hours (depending on method selected)

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

Patient days from some non-reporting unit types, such as Emergency Department, peri-operative unit, and obstetrics, are excluded.

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

Patient days must be from the same unit as the nursing care hours.

Data regarding nursing care hours in some units (e.g., Emergency Department, peri-operative unit, and obstetrics) have not been collected. Patient days from these types of units are excluded.

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

Stratification variables are patient population and unit type. Units are stratified by patient population first and then unit type based on acuity level, age, or type of service provided.

1. Patient population

- 1) Adult population: limited to units generally caring for patients over 16 years old.
- 2) Pediatric population: limited to units generally caring for patients under 18 years old.
- 3) Neonate population: limited to units caring for newborn infants.
- 4) Psychiatric population: units caring for patients with psychiatric disorders.

5) Rehabilitation population: limited to distinct acute rehabilitation units providing intensive therapy 5 days/week.

2. Unit types by population

1) Adult population

Critical Care

Highest level of care, includes all types of intensive care units. Optional specialty designations include: Burn, Cardiothoracic, Coronary Care, Medical, Neurology, Pulmonary, Surgical and Trauma.

Step-Down

Limited to units that provide care for patients requiring a lower level of care than critical care units and higher level of care than provided on medical/surgical units. Examples include progressive care or intermediate care units. Telemetry alone is not an indicator of acuity level.

Medical

Units that care for patients admitted to medical services, such as internal medicine, family practice, or cardiology. Optional specialty designations include: BMT (Bone Marrow Transplant), Cardiac, GI, Infectious Disease, Neurology, Oncology, Renal or Respiratory.

Surgical

Units that care for patients admitted to surgical services, such as general surgery, neurosurgery, or orthopedics. Optional specialty designations include: Bariatric, Cardiothoracic, Gynecology, Neurosurgery, Orthopedic, Plastic Surgery, Transplant or Trauma.

Medical-Surgical Combined

Units that care for patients admitted to either medical or surgical services. Optional specialty designations include: Cardiac, Neuro/Neurosurgery or Oncology.

Critical Access

A unit located in a Critical Access Hospital that cares for a combination of patients that may include critical care, medical-surgical, skilled nursing (swing bed) and/or obstetrics.

2) Pediatric population

Refer to Adult unit type descriptions for corresponding unit types.

Critical care

Step-Down

Medical

Surgical

Medical-Surgical Combined

3) Neonate population

The three unit types below (Level I, II, and III/IV) are based on the Guidelines for Perinatal Care, 5th Ed., which are used by state certification programs. Level I, II, and III/IV neonatal units are the highest level of infant care provided, and are specified by sequential level of acuity.

Well-baby Nursery

Level I Continuing Care

Level II Intermediate Care

Level III/IV Critical Care

4) Psychiatric population

Adult

Units caring for adult patients with acute psychiatric disorders.

Child/Adolescent

Units caring for children and/or adolescents, predominantly ages 2-18 years old, with acute psychiatric disorders.

Geripsych

Units caring for elderly patients with acute psychiatric disorders.

Other (Behavioral Health, Specialty, Multiple Psychiatric Unit Types)

Behavioral Health

Units caring for individuals of any age with eating disorders or substance abuse (alcohol and drugs) diagnoses.

Specialty

Units caring for patients of any age with dual diagnoses (e.g., mental illness and mental retardation, or substance abuse and an additional mental illness diagnosis).

Multiple Psychiatric Unit Types

Units caring for patients that encompass 3 or more of the above unit types, but for which no one unit type comprises greater than 50% of the entire unit.

5) Rehabilitation population

Adult

Limited to units generally caring for rehab patients over 16 years old. Optional specialty designations include: Brain Injury/SCI, Cardiopulmonary, Neuro/Stroke and Orthopedic/Amputee Rehab units.

Pediatric

Limited to units generally caring for rehab patients under 18 years old.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

Other

If other: Each unit is stratified by unit type (e.g., critical care, step down, medical), which is not identical to risk, but may be related.

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Eligible unit identified and selected; input patient days (including method) for each respective unit by month; input nursing care hours for each eligible staff category by month; then perform calculations to produce each of the quarter patient days and quarter nursing care hours by summing monthly values of the 3 months; then divide the quarterly nursing care hours by the quarterly patients days.

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

N/A

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source (Check *ONLY* the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Management Data, Other

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

Database: National Database of Nursing Quality Indicators(R) [NDNQI(R)]; Hospitals have NDNQI guidelines and Excel spreadsheets to guide data collection; data are provided to NDNQI via web based data entry or XML upload.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check *ONLY* the levels of analysis for which the measure is SPECIFIED AND TESTED)

Facility, Other

S.21. Care Setting (Check *ONLY* the settings for which the measure is SPECIFIED AND TESTED)

Inpatient/Hospital

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2. Validity – See attached Measure Testing Submission Form

0205_Measure_Testing_ver_7.1_v3a.docx

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You **MUST** use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure,

lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Other

If other: [generated from electronic payroll/accounting report or electronic staffing system](#)

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for **maintenance of endorsement.**

[ALL data elements are in defined fields in a combination of electronic sources](#)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement,** if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

[NURSING CARE HOURS DATA COLLECTION PROCESS, SOURCES, AND BURDEN](#)

[According to NDNQI guidelines, all separate nursing care hours data by licensure levels \(RNs, LPNs, and UAPs\), as well as employment status \(hospital employees and agency/contracts\), must reported by the calendar month. Payroll or staffing records should be audited to remove non-direct care hours \(education, sick leave, vacation leave, etc.\) and to ensure that ineligible staff are not included \(i.e., unit secretary, monitor techs\).](#)

[A survey was conducted in October 2018 of site coordinators who have submitted nursing care hours data \(N=324\). Respondents indicated that nursing care hours data are obtained from electronic payroll/accounting systems most frequently \(56.7%\), followed by electronic staffing system reports \(38.7%\). A large majority of respondents \(95.7%\) indicated that generating and submitting nursing care hours takes one day or less each month. The mean total hours required to extract clean, and submit the staffing measures was 6.0 with a range of 1-32 hours each month.](#)

[REPORTING ACCURACY](#)

[more accurate data collection, the NDNQI implemented several strategies, including periodic site coordinator surveys, data cleaning tools, and training for site coordinators. Over 70% of sites verify data before submission. The most common way site coordinators verify the data prior to submission is comparing values to previous quarters \(50.5%\), followed by verification by accounting \(20.6%\). Almost 90% \(88.4%\) of site coordinators indicated that they never or infrequently have to make manual adjustments to the data before submission.](#)

[Since the measure was first endorsed, NDNQI has learned/modified the nursing hours per patient day measure in a variety of ways. First, the definition of nursing care hours has been clarified by providing clear description on float staff \(hospital employees](#)

temporarily assigned to provide direct patient care for all or part of a shift on a unit other than their unit of employment) when reporting their nursing care hours in the NDNQI data collection guidelines. Second, the reporting methods for patient days, a denominator of the nursing care hours per patient day measure, have recently been clarified to better describe in the NDNQI data collection guidelines. In addition, one of options (Midnight census + patient days from average hours for short stay patients), is no longer a reporting option for reporting patient days as starting at the first quarter of 2012. Third, throughout the history of the measure, we have periodically provided teleconferences for site-coordinators to educate, provide updates about data collection guidelines, and address issues about the definition of NDNQI quality indicators (e.g., nursing care hours and patient days) and data collection procedures (changes on the data entry fields and the use of data summary report and data error report to verify data before reporting to NDNQI). Lastly, NDNQI collects nursing care hours data through a secure NDNQI website. We initiated a system to provide data error messages to notify site coordinators that data on nursing care hours or patient days were not entered for all 3 months of a quarter, although it may or may not be an error. Most recently, we have tested the reliability of aggregating at the hospital-level, and have found the measure to be reliable. In addition, we have tested the reliability and validity of aggregating to the hospital-level medical, surgical, and medical-surgical units. These three combined units at the hospital-level have demonstrated reliability and validity.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

None

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
	Public Reporting State of Illinois http://www.healthcarereportcard.illinois.gov/ State of Maine https://mhdo.maine.gov/_pdf/NSI%20Microspec%20Manual%20Nov%202013%20edition%20rev%20B.1.pdf State of Massachusetts https://patientcarelink.org/healthcare-provider-data/hospital-data/staffing-plans-reports/ State of Minnesota http://www.mnhospitalquality.org/#/consumer/ State of New Jersey https://web.doh.state.nj.us/apps2/nursestaffing/quarterly.aspx State of New York https://www.health.ny.gov/regulations/recently_adopted/docs/2015-01-07_disclosure_quality_surveillance.pdf State of Vermont http://legislature.vermont.gov/statutes/section/18/221/09405b State of Illinois http://www.healthcarereportcard.illinois.gov/

	<p>State of Maine https://mhdo.maine.gov/_pdf/NSI%20Microspec%20Manual%20Nov%202013%20edition%20rev%20B.1.pdf State of Massachusetts https://patientcarelink.org/healthcare-provider-data/hospital-data/staffing-plans-reports/ State of Minnesota http://www.mnhospitalquality.org/#/consumer/ State of New Jersey https://web.doh.state.nj.us/apps2/nursestaffing/quarterly.aspx State of New York https://www.health.ny.gov/regulations/recently_adopted/docs/2015-01-07_disclosure_quality_surveillance.pdf State of Vermont http://legislature.vermont.gov/statutes/section/18/221/09405b</p> <p>Professional Certification or Recognition Program The American Nurses Credentialing Center Magnet Recognition Program http://www.nursecredentialing.org/Magnet The American Nurses Credentialing Center Pathways to Excellence Program http://www.nursecredentialing.org/Pathway</p> <p>Quality Improvement (external benchmarking to organizations) National Database for Nursing Quality Indicators http://www.pressganey.com/</p> <p>Quality Improvement (Internal to the specific organization) National Database for Nursing Quality Indicators http://www.pressganey.com/</p>
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4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

Public Reporting

Illinois: "Illinois Hospital Report Card and Consumer Guide to Health Care" through the Illinois Hospital Report Card Act

Sponsor: Illinois General Assembly & Illinois Department of Health

Purpose: Provide consumers with access to information about the quality of health care provided in the state

Geographic Area: All hospitals in Illinois

Information: Total Nursing Hours Per Patient Day, RN Hours Per Patient Day in Medical-Surgical, Critical Care, and Mother-Baby units

Website: <http://www.healthcarereportcard.illinois.gov/>

Maine: "Nursing Sensitive Indicator Quality Data Set"

Sponsor: Maine Health Data Organization

Purpose: To create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens

Geographic Area: All acute care hospitals in Maine

Information: Total Nursing Care Hours Per Patient Day, RN Hours Per Patient Day

Website: https://mhdo.maine.gov/_pdf/NSI%20Microspec%20Manual%20Nov%202013%20edition%20rev%20B.1.pdf

Massachusetts: "Staffing Plans and Reports"

Sponsor: Patient Care Link/Massachusetts Hospital Association

Purpose: Designed to show who is on staff on a unit-by-unit basis

Geographic Area: Voluntary, though according to the Massachusetts Hospital Association, nearly all acute care hospitals in the state participate

Information: (voluntary) Actual Worked Hours Per Patient Day (Total Nursing)

Website: <https://patientcarelink.org/healthcare-provider-data/hospital-data/staffing-plans-reports/>

Minnesota: "Staffing Plan Disclosure Act"

Sponsor: Minnesota Legislature

Purpose: To create transparency and reporting of nurse staffing

Geographic Area: All hospitals in Minnesota

Information: Actual Worked Hours Per Patient Day (Total Nursing)

Website: <http://www.mnhospitalquality.org/#/consumer/>

New Jersey: "Hospital Patient Care Staffing Report"

Sponsor: State of New Jersey Department of Health

Purpose: The New Jersey Hospital Patient Care Staffing Quarterly Reports provide hospital patient care staffing information to hospital patients and their families as required by law. [P.L 1971, c.136(C26:2H-1 et seq.)]. The New Jersey legislature passed this law on public disclosure of staffing levels in recognition of the fact that hospital caregivers contribute to improved patient safety and health care outcomes.

Geographic area: All hospitals in New Jersey

Information: DOH issues quarterly reports for each general hospital that show average staffing levels for a three-month period as follows: Ratios of patients to staff for each type of licensed inpatient unit (i.e., medical-surgical, pediatrics, intensive care, etc.), Daily number of staff and patients in the Emergency Department, and Daily number of Respiratory Care Practitioners.

Website: <https://web.doh.state.nj.us/apps2/nursestaffing/quarterly.aspx>

New York: "Disclosure of Quality and Surveillance Related Information"

Sponsor: New York Public Health and Health Planning Council and the Commissioner of Health

Purpose: Requires hospitals to disclose nursing quality indicator information to any member of the public.

Geographic Area: Hospitals and nursing homes in the state of New York

Information: Total number of nursing hours per patient day, RN hours Per Patient Day, LPN Hours Per Patient Day, UAP Hours Per Patient Day

Website: https://www.health.ny.gov/regulations/recently_adopted/docs/2015-01-07_disclosure_quality_surveillance.pdf

Vermont: "Hospital Community Reports,"

Sponsor: Vermont General Assembly

Purpose: Statute establishing standard formats for hospital community reports

Geographic area: All hospitals in Vermont

Information: Nursing hours per patient day

Website: <http://legislature.vermont.gov/statutes/section/18/221/09405b>

Professional Certification or Recognition Program

The American Nurses Credentialing Center (ANCC) includes nurse staffing as part of their Magnet Recognition Program and Pathways to Excellence Recognition Program (ANCC, 2015).

<http://www.nursecredentialing.org/Magnet>

<http://www.nursecredentialing.org/Pathway>

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

In 2018, we solicited feedback from all NDNQI participating hospitals (approximately 1800), and received feedback from 324.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

Hospitals participating in the National Database of Nursing Quality Indicators receive quarterly reports, which provide unit, unit type, and hospital-level benchmarks across a number of benchmarking categories (e.g. hospital type, bed size, teaching status).

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

In 2018, we survey NDNQI site coordinators using a REDCap survey to obtain feedback about the usability of the measures and reports for quality improvement and feasibility of data collection at their facilities.

4a2.2.2. Summarize the feedback obtained from those being measured.

From a survey of 324 site coordinators, 14.0% report nurse staffing to a state database or regulatory program, 6.2% report to a national regulatory group, 6.7% report to a state quality registry (other than NDNQI), 5.7% report to a national registry (other than NDNQI), and 28.9% report staffing data to a state or national credentialing program.

In a survey of 324 site coordinators, 69.7% reported that the staffing measures are somewhat or very important to their hospital's quality improvement program.

4a2.2.3. Summarize the feedback obtained from other users

N/A

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

In previous years, we have examined the feedback to consider revisions to the measures that will reduce the burden of data collection, including changes to required versus optional data elements, and improved tools for data collection. No changes have been made to the measures based on the most recent feedback.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

A study was conducted evaluating trends in Total Nursing Care Hours per Patient Day and RN Hours Per Patient Day on general care (medical, surgical, and medical-surgical combined) units and critical care units among NDNQI hospitals from 2004-2011. The sample included 2,634 medical units, 1,895 surgical units, 3,561 medical-surgical units, and 2,822 critical care units from 1,499 hospitals. During that time period statistically significant increases occurred for both Total Nursing Care Hours Per Patient Day and RN Hours Per Patient Day increased for both general care and critical care units (Staggs & He, 2013).

Staggs, V. S., & He, J. (2013). Recent trends in hospital nurse staffing in the United States. *The Journal of Nursing Administration*, 43(7-8), 388-393.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

None

4b2.2. Please explain any unexpected benefits from implementation of this measure.

These measures have been used in several studies to demonstrate the positive relationship between nurse staffing and improved patient outcomes. Although this is not an unexpected benefit, it can be used to argue for improved nurse staffing in hospitals.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

0190 : Nurse staffing hours - 4 parts

0204 : Skill mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], unlicensed assistive personnel [UAP], and contract)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

Yes

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Nurse staffing skill mix and nurse staffing hours - 4 parts are related, not competing measures. Nurse staffing skill mix is also a

measure for which the American Nurses Association is the measure steward, and measures a different aspect of nurse staffing. The nurse staffing skill mix is the proportion of nursing hours provided by different types of nursing personnel (RNs, LPNs, and UAPs). There is no additional data collection burden. Therefore, nursing hours per patient day is not considered to be a competing measure with the other two measures (nurse staffing skill mix and nurse staffing hours - 4 parts).

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment **Attachment:** [0205_MeasureLogic_ScientificSupplement.pdf](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): American Nurses Association

Co.2 Point of Contact: Gregory, Craig, gregory.craig@ana.org, 301-628-5395-

Co.3 Measure Developer if different from Measure Steward: University of Kansas Medical Center

Co.4 Point of Contact: Emily, Cramer, ecramer2@kumc.edu, 913-588-1657-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

The American Nurses Association sponsored the development of the nursing hours per patient day and nursing staff skill mix measures. The Lewin Group was hired by ANA to identify measures that likely were nurse-sensitive. An interview guide was developed and various institutions were selected based on their geographical location and organizational characteristics to provide a nation-wide sample that would include an academic medical center, private hospital, public hospital, urban hospitals, rural hospitals and hospital system. JCAHO, Catholic Health Association, AHA and AHCPH were also contacted to provide broader context. The interviews were conducted with nursing executives, quality specialists and other experts identified by each organization between August 1995 and October 1995. ANA's advisory committee was Rhonda Anderson RN, FAAN, Joanne Disch, PhD, RN FAAN, Gwendolyn Johnson, MA, RN, Clair B. Jordan, MSN, RN, Norma Lang, PhD, RN, FAAN, Pamela Mitchell, PhD, CNRN, FAAN, Margaret Sovie PhD, RN, FAAN, and Mary K. Walker, PhD, RN, FAAN.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 1998

Ad.3 Month and Year of most recent revision: 01, 2014

Ad.4 What is your frequency for review/update of this measure? annual updates, with every 3 year reendorsement

Ad.5 When is the next scheduled review/update for this measure? 12, 2013

Ad.6 Copyright statement: Copyright 2011, American Nurses Association. All Rights Reserved.

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: