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June 19, 2015

Senator Johnny Isakson
Senator Mark R. Warner
Chronic Care Working Group
Committee on Finance
United States Senate
Washington, DC 20510-6200

Submitted electronically to chronic_care@finance.senate.gov

Re: Request for comments on committee plans to consider chronic care reform efforts

Dear Senators Isakson and Warner:

The American Nurses Association (ANA) welcomes the opportunity to provide comments in response to your letter to stakeholders, dated May 22, 2015, seeking comments to the Finance Committee work group concerning chronic care reform efforts.

As the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses (RNs), ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate and engage patients, their families and other caregivers as well as the public about various health conditions, wellness, and prevention, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.[1]

Below I discuss a number of the specific policy categories identified in your May 22nd letter to stakeholders.

Strategies for Increasing chronic care coordination in rural and frontier areas

A growing number of APRNs are enrolled as Medicare and Medicaid providers. For calendar year 2013, The Center for Medicare and Medicaid Services (CMS) reported that no less than 107,355 nurse practitioners, clinical nurse specialists and certified-nurse midwives directly billed Medicare Part B carriers. Many of these APRNs serve as primary care providers, particularly for underserved populations and in rural areas, and are charged with ensuring their patients receive appropriate, well-coordinated care.

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

However, the ability to APRNs to fully engage in providing patient care, including chronic care coordination in rural areas, is impeded by scope-of-practice restrictions. The 2010 IOM report, *The Future of Nursing: Leading Change, Advancing Health*,[2] sponsored by the Robert Wood Johnson Foundation (RWJF), found that scope-of-practice restrictions "have undermined the nursing profession's ability to provide and improve both general and advanced care." The IOM report also stated that APRNs' scope of practice varies widely "for reasons that are related not to their ability, education or training, or safety concerns, but to the political decisions of the state in which they work." The report includes recommendations for stakeholders,[3] including Congress, to ensure that APRNs are able to function to the full extent of their education and training. ANA urges the Senate Committee on Finance work group, when evaluating efforts and initiatives to advance chronic care coordination, to consider steps they can take to remove barriers to APRN practice to ensure that all members of the health care team fully function consistent with their education and training.

In addition, it is also important to appropriately reward APRNs when they provide complex chronic care management services for their sickest and most complex patients. Nurse-run clinics can manage patients with complex chronic conditions effectively and efficiently, ensuring that patients obtain the general and specialty care necessary.[4] ANA urges the work group to ensure that any chronic care reform efforts recognize and appropriately compensate APRNs who are providing complex chronic care management services to patients, including those in rural and frontier areas.

Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions

Care coordination and transition care are essential and fundamental to improving patient outcomes. RNs and APRNs play a pivotal role in providing this care, as chronic care and case management are integral parts of nursing practice. Many RNs and APRNs provide complex chronic care management as a key component of their nursing practice, in various nursing roles and across all health care settings. For example, ANA's Nursing Scope and Standards of

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[2] See http://books.nap.edu/openbook.php?record_id=12956.

[3] See http://www.iom.edu/~/media/Files/Report%20Files/2010/The-Future-of-Nursing/Nursing%20Scope%20of%20Practice%202010%20Brief.pdf.

[4] According to the National Nursing Centers Consortium (NNCC), recent estimates indicate that there are approximately 250 nurse-led delivering primary and preventive care to vulnerable medically underserved patients around the nation. More than half of the patients using these clinics have complex chronic conditions requiring regular care. APRNs working in nurse-led clinics have consistently shown they can manage patients with complex chronic conditions effectively and efficiently, ensuring that patients obtain the general and specialty care necessary. For example, NNCC's independent analysis of 2010 data collected as part of Pennsylvania's Chronic Care Initiative, a patient-centered medical home demonstration project, found that the nurse-led clinics participating in the initiative performed equal to or better than other participating providers on quality indicators related to chronic care. In fact, six of the eight participating nurse-led clinics consistently reported outcomes that were above average when compared to other providers. Two nurse-led clinics even won Best in Region honors for care connected to diabetes, tobacco cessation, and asthma.

Practice[5] lists RN and APRN competencies integral to complex chronic care management. Standard 5A of the Nursing Scope and Standards of Practice states that "the registered nurse coordinates care delivery" and details six related competencies. The registered nurse:

- organizes the components of the plan;
- manages a healthcare consumer's care in order to maximize independence and quality of life;
- assists the healthcare consumer in identifying options for alternative care;
- communicates with the healthcare consumer, family, and system during transitions in care;
- advocates for the delivery of dignified and humane care by the interprofessional team; and
- documents the coordination of care.

The APRN has additional competencies which include providing "leadership in the coordination of interprofessional health care for integrated delivery of healthcare consumer care services."

RNs and APRNs are skilled in developing plans of care and identifying outcomes. RNs and APRNs are experts in health teaching and health promotion using information technologies (including electronic health records) – all essential elements of chronic care coordination. In addition, APRNs are skilled in assessment and evaluation. APRNs use prescriptive authority, procedures, referrals, treatments, and therapies in complex chronic care management. ANA urges the work group to ensure that the key role of RNs and APRNs in coordinating care are recognized and appropriately utilized in any chronic care reform efforts.

ANA also wants to bring to the attention of this work group the significant research has been done to identify effective care coordination models that utilize care coordination to improve chronic care delivery. This research has been described in detail in the book *Care Coordination: The Game Changer – How Nursing is Revolutionizing Quality Care*.[6] In addition, this book provides key information about the essential role of nurses in care coordination[7] and the role of nurse leaders in advancing care coordination.[8]

With regard to reimbursement, ANA believes that the specific chronic care codes included in the CMS Physician Fee Schedule should be better targeted to more seriously ill Medicare patients for whom improved care coordination would be more likely to improve quality and reduce costs. Current CMS policy applies the chronic care management code to patients with two or more chronic conditions. As expressed in letters to CMS in August, 2014[9] and September, 2013[10], ANA has recommended that CMS target chronic care management to more seriously ill Medicare patients by increasing the number of chronic conditions from two to four in order to

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[5] American Nurses Association. (2010). Nursing: Scope and Standards of Practice, 2nd edition, Standard 5A. Silver Spring, MD: Nursesbooks.org, 32-46.
[6] Lamb, G. (Ed.). (2014). Care Coordination: The Game Changer – How Nursing is Revolutionizing Quality Care. Silver Spring, MD: Nursesbooks.org, 57-74.
[7] *Id.* at 81-94.
[8] *Id.* at 97-109.
[9] See http://www.nursingworld.org/ANA-MFS-response.
[10] See http://www.nursingworld.org/MFS-NPRM-Letter.

better target Medicare resources to beneficiaries with the greatest need for chronic care management.

Options for empowering Medicare Patients to play a greater role in managing their health and meaningfully engaging with their health care providers

Patient engagement has been described by the Center for Advancing Health as the actions that are taken to benefit from available health care,[11] and the concept of patient engagement is showing promise as a way to improve health outcomes.[12] The National Quality Forum (NQF), a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in health care, recently published a report entitled *Person- and Family-Centered Care Final Report - Phase 1,*[13] which "sought to review measures that captured the essence of person- and family-centered care including patient and family engagement in care, care based on patient needs and preferences, shared decision-making, and activation for self-care management." This important document will provide critical information to the work group regarding experience-of-care measures relevant to engagement.

ANA also urges the work group to remain cognizant of the important role of nursing in patient engagement. Much of what constitutes patient engagement falls squarely within the domain of nursing.[14] Descriptions of the essential role that nurses play in advancing the engagement of patients and families are set forth in a paper from the Nursing Alliance for Quality Care (NAQC), a group consisting of consumer advocacy groups and nursing organizations. The paper, entitled *Fostering successful patient and family engagement: Nursing's critical role,*[15] emphasizes NAQC's position that "the active engagement of patients, families and others is essential to improving quality and reducing medical errors and harm to patients," and that "nurses at all levels of education and across all health care settings must play a central role in fostering successful patient and family engagement."

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[11] Center for Advancing Health (2010). Engagement. Retrieved from: www.cfah.org/engagement.

[12] Hibbard, J., & Greene, J. (2013). What evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. Health Affairs, 32(2), 207–214; Hibbard, J., Greene, J., & Overton, V. (2013). Patients with lower activation associated with higher costs; delivery systems should know their patients' scores. Health Affairs, 32(2), 216–222; Katon, W., Von Korff, M., Lin, E., Walker, E., Simon, G. E., et al. (1995). Collaborative management to achieve treatment guidelines: Impact on depression in primary care. Journal of the American Medical Association, 273(13), 1026–1031; Robinson, J. H., Callister, L. C., Berry, J. A., & Dearing, K. A. (2008). Patient-centered care and adherence: Definitions and applications to improve outcomes. Journal of the American Academy of Nurse Practitioners, 20(12), 600–607.

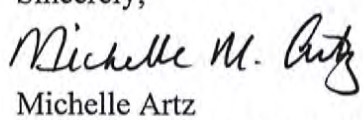
[13] National Quality Forum (2015). Person- and Family-Centered Care Final Report - Phase 1. Retrieved from: http://www.qualityforum.org/Publications/2015/03/Person-_and_Family-Centered_Care_Final_Report_-_Phase_1.aspx.

[14] Mason, D., Gardner, D., Hopkins Outlaw, and O'Grady, E. (Eds.). (2015). Policy & Politics in Nursing and Health Care. St. Louis, MO: Elsevier, 208.

[15] Sofaer, S., & Schumann, M. (2013). Fostering successful patient and family engagement: Nursing's critical role. Washington, DC: Nursing Alliance for Quality Care. Retrieved from: http://www.naqc.org/Main/Resources/Publications/March2013-FosteringSuccessfulPatientFamilyEngagement.pdf.

ANA appreciates the opportunity to share our views on this matter and welcomes the opportunity to discuss these issues in greater detail. Should you have any questions, please do not hesitate to contact me at 301-628-5098 or Jane Clare Joyner, Senior Policy Fellow (301.628.5083 or janeclare.joyner@ana.org).

Sincerely,



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