November 27, 2019

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The Honorable Danny Davis
Member of Congress

The Honorable Brad Wenstrup
Member of Congress

The Honorable Terri Sewell
Member of Congress

The Honorable Jodey Arrington
Member of Congress

Re: Request for Suggestions or Recommendations to Improve Health Care Outcomes Within Underserved Communities

Submitted electronically to Rural_Urban@mail.house.gov

Dear Members,
The American Nurses Association (ANA) appreciates the opportunity to provide comment to the Rural and Underserved Communities Health Task Force (Task Force) in response to its "Request for suggestions or recommendations to improve health care outcomes within underserved communities."

In our comments below, ANA shares its perspectives on promising strategies to address rural access and quality by optimizing and leveraging nurse capacity. Please see our brief responses to the Task Force's questions below:

1. ***What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?***

Simply put, patients in these areas lack access to quality care. At the same time, Federal and State restrictions on APRN scope of practice exacerbate health care workforce shortages and undermine systemic reforms in rural, underserved, and appointment shortage areas. Innovative models, including but not limited to telehealth technologies, are sorely needed to expand provider capacity, and ensure access, quality and value. We urge the Task Force to support efforts to remove unnecessary and burdensome restrictions on scope of practice, including the following:

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Full Practice Authority for APRNs

It is estimated that shortages in primary care providers, including in rural areas, affect one in five Americans. There are many instances across states in which APRNs are not permitted to practice to the full extent of their education and training, including instances of prescribing buprenorphine in order to help curb the opioid epidemic; prescribing pre-exposure prophylaxis (PrEP) to prevent HIV infection; ordering home health care and hospice services; or delivering anesthesia and other health care services to Veterans, who wait dangerously long times for care across the country. Given the shortage of physicians in primary care, we urge the Task Force to consider ways of harnessing the skills and training of APRNs and other non-physician providers to give patients more options and more timely access to services. In addition to directly reducing patient access, restrictions on practice authority can create serious challenges for public and private health care purchasers striving to build out and support adequate provider networks. Addressing these systematic impacts should be prioritized.
There is strong support for policies that better leverage the role and skills of APRNs, including from the American Enterprise Institute, Americans for Prosperity, the Brookings Institute, MedPAC, the Institute of Medicine, the National Governors Association, the Federal Trade Commission, the Veteran's Health Administration, the Bipartisan Policy Center, the current administration, among others, to remove all barriers to full practice authority. We urge the Task Force to consider workable federal approaches to incentivize effective state reforms.

2. ***What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?***

- The Center for Medicare and Medicaid Innovation (CMMI) has used its waiver authority to allow nurse practitioners (NPs) to certify the necessity of Medicare home health services in Maryland. Removing this barrier across the Medicare program would ensure that patients, under the care of Nurse Practitioners, could commence home health services without delay.

- The Oncology Care Model (OCM) allows for $160 per beneficiary per month that can be used to support care coordination activities that are not subject to Medicare's supervision rules. This model should serve as an example and be incorporated into future models that continue to remove unnecessary and burdensome supervision requirements. We believe that doing so would expedite access to care, while also creating new opportunities to include and evaluate APRNs in emerging Medicare and all-payer care models.

- The American Academy of Nursing's (AAN) Edge Runner program focuses on patient-centered care coordination, emphasizing core professional standards and competencies for all RN practice. The program recognizes a wide range of nurse-designed models of care and interventions

- designed to manage costs, improve health care quality and enhance consumer satisfaction. These models provide templates to strengthen and incentivize care coordination and recognize the important role that RNs play in primary care and care coordination. Many of Edge Runner's innovative concepts are applicable in rural communities. We recommend Congress draw upon the promising approaches identified by the Edge Runner program of the AAN.

- Transitional Care Nursing (TCN) program, an initiative of the Southwestern Vermont Medical Center, works in partnership with a range of health care and community service providers to care for high-risk patients with chronic disease. The goal of the care model is to reduce hospitalization and emergency room visits. The program documented a 56 percent reduction in hospital admissions and observation visits among high risk patients participating in the TCN program over 180 days, with a sustained decrease of 46.8 percent over a one-year period.

ANA urges the Task Force to examine these models of care coordination and others that have successfully leveraged the role of RNs and APRNs in improving health care consumers' care quality and outcomes across patient populations and health care settings.
In addition, telehealth innovations hold promise for improved care delivery in rural and underserved areas. Nurses work in a variety of settings including rural, urban, and underserved areas and, as mentioned above, nurses work in a variety of specialties. For many, they are the sole and trusted provider in a community. Nurses are well trained and educated to effectively use telehealth technologies to supervise remote patient monitoring activities and provide quality care. Remote patient monitoring in alignment with care coordination is especially important for patients with multiple chronic conditions and for those that multiple appointments could prove challenging from a transportation, provider, or geographic barrier.

7. ***Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?***

Nurses play a critical role in providing front line care and treatment for individuals living with substance use disorders (SUDs). A succession of bipartisan measures passed into law in recent years (Section 303 of the Comprehensive Addiction and Recovery Act (CARA) and Section 3201 of the SUPPORT Act), has helped expand treatment to individuals with SUD. We encourage the Taskforce to continue building on this critical progress by supporting the *Mainstreaming Addiction Treatment Act of 2019* (S.2704/H.R. 2482). The bill would eliminate the requirement for providers to obtain a waiver from the Drug Enforcement Administration (DEA) to treat opioid use disorder with buprenorphine or any other Schedule III, IV or V drug, in accordance with their prescribing authorities under state law.

Providers can already prescribe buprenorphine for pain, but not to treat opioid addiction. This waiver requirement is unnecessarily limiting access points for patients to get treatment for SUDs

and co-occurring conditions such as HIV and viral hepatitis. An additional reason to remove the waiver requirement is that not enough providers are participating. Because of stigma, there are concerns that if they are the only waived provider in an area, they will then be the only one to see these patients, and it will dramatically alter their practice and patient population.

10. ***Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?***

ANA is actively working to strengthen patient safety by seeking greater transparency of nurse staffing levels in Medicare-participating hospitals. Federal regulation requires that hospitals certified to participate in Medicare "have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed" (42 Code of Federal Regulations 42CFR 482.23(b). The requirement was adopted to ensure that an important element of patient care and safety standards was met by hospitals. Over the years, however, CMS has not defined or measured the adequacy of nurse staffing levels in the hospital setting. ANA is working with Members of Congress to gain a better understanding of CMS's oversight in this regard.

ANA is also advocating for CMS adoption of two nurse staffing measures – Skill Mix and Nursing Hours per Patient Day – in the Hospital Inpatient Quality Reporting Program. Requiring hospitals to publicly report these two measures would help ensure appropriate nurse staffing levels and the provision of the highest quality of care to patients. Understanding the experience and expertise of the nursing staff, as well as patient acuity mix on a given unit, is crucial in determining appropriate nurse staffing levels and in working towards better patient outcomes.

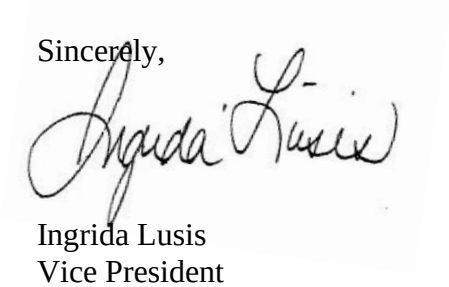
Conclusion

As the Task Force continues to lead improvements in rural health, ANA encourages you to bring nurse leaders to the table to truly understand the quality care and trust that APRNs and RNs bring to underserved areas. Without the expert care of APRNs and RNs, many communities would be left without any health care provider.

ANA is the premier organization representing the interests of the nation's 4 million registered nurses (RNs) through its constituent and state nurses 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 patients and the public about various health conditions, and provide advice and emotional support to patients and their family members. ANA members also include those practicing in the four advanced practice registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives, and certified registered nurse anesthetists. ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

We would be pleased to assist the Task Force to develop policy recommendations, including options to ensure that all nurses can practice to the full extent of their education and training. If you have questions, please contact Kristina Weger, Senior Associate Director of Policy and Government Affairs, at (301) 628-5119 or Kristina.Weger@ana.org.

Sincerely,



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