Written Statement

of

MaryJean Schumann, MSN, MBA, RN, CPNP

Chief Programs Officer

American Nurses Association
8515 Georgia Avenue, Suite 400
Silver Spring, MD 20903
www.nursingworld.org

for the

Institute of Medicine
Comparative Effectiveness Research Priorities Committee
Public Meeting

March 20, 2009

Thank you for the opportunity to provide ANA's perspective on a national set of priorities for comparative effectiveness research (CER). CER holds great promise *if* done well, and we appreciate your outreach to a broad community of stakeholders.

The ANA is the only full-service professional organization representing the interests of the nation's 2.9 million registered nurses through its constituent member nurses associations, its organizational affiliates, and its workforce advocacy affiliate.

ANA has long advocated for meaningful reform of our health care system, and we are pleased that Congress has made a "down payment" on that reform by investing in comparative effectiveness research.[1]

Nursing has a unique perspective.

Nursing's unique perspective comes from our constant vigilance and engagement in the health care system. Regardless of when, where, or why one intersects the health care system, one is receiving care from a nurse. Whether for a routine health screening in an outpatient setting, an acute illness requiring hospitalization, or rehabilitation in the home or in an institution, nursing is a consistent presence.

Our perspective is through two lenses: 1st) that of the registered nurse providing direct care; and 2nd) that of the advanced practice registered nurse. Advanced practice nurses (APRNs) include certified registered nurse-anesthetists (CRNAs) who provide critical anesthesia services; Clinical Nurse Specialists (CNSs) who provide acute care expertise for complex patients; certified nurse-midwives (CNMs) who provide health care to women across the lifespan, and nurse practitioners (NPs) who deliver a wide range of primary care services.

Nurses are trusted patient advocates.

A CER program must be developed with objectivity, transparency and accountability. Patients are justifiably concerned that decision-making about treatment options not be affected by those who may profit from those decisions. Public opinion polls repeatedly identify nurses as highly trusted professionals. As a result, nurses will play an important role in the acceptance of CER.

The scope of CER must be broad.

The scope of CER should address the full spectrum of health care interventions, extending well beyond pharmaceuticals, devices, and surgical procedures, to include a host of other interventions including prevention, complementary and alternative medicine, and watchful waiting. The use of standardized terminologies is key when looking at problems, interventions, and outcomes, especially when making comparisons.

[1] Our most recent Health System Reform Agenda is available at: www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HSR/ANAsHealthSystemReformAgenda.aspx.

How we keep people healthy has got to become as important as how we treat their diseases, and CER must address the maintenance of health in addition to the treatment of disease.

CER must embrace a wide range of scientific methodology.

In order to evaluate the full spectrum of interventions, there must be a willingness to evaluate evidence that goes beyond randomized controlled trials to include a host of methodologies. The complexity of evaluating therapeutic modalities includes the infinite variables of human behavior. Nurses, educated to see the whole person, within his or her family and community, can bring an important perspective.

The NQF National Priorities & Goals can help frame CER priorities.

ANA has been involved with the work of National Quality Forum from its beginning and an enthusiastic member of the National Priorities Partnership. Nursing will play a critical role in the achievement of each of the six Priority areas. These six priorities and goals can also drive our CER agenda: What are the most effective tools and systems to engage patients in their care? What are the most effective models for care coordination? How do we reduce 30-day readmission rates? How is palliative care best provided?

Patients turn to nurses for information and advice, and physicians and health systems depend on nurses to provide education and counseling and to manage care transitions. Nursing's holistic view – attention to the whole person – makes nurses particularly effective in advancing these priorities. Nurses, with their expertise in health promotion, disease prevention, and health literacy, can contribute to changing the current sickness care system into a true health care system.

ANA's NDNQI can also inform CER priorities.

ANA's priority areas for study are largely informed by decades of work to develop nursing quality and performance measures.[2] In 1998, ANA established the National Database of Nursing Quality Indicators® (NDNQI®), the only national database that provides nursing data and patient outcomes at the unit level where care occurs. Data are collected on structure, process and outcome measures in approximately 1400 hospitals of all sizes, in all 50 states and the District of Columbia. Currently, data is collected on 17 measures, 11 of which have been endorsed by the National Quality Forum.

Patient falls are one example of how our quality work informs a CER priority. As an outcome of interest, falls are of critical importance, highlighted by CMS' decision to include falls on the list of Hospital Acquired Conditions for which they no longer pay. There are many validated fall assessment tools, but there has not, to date, been any

[2] Information about the National Center for Nursing Quality is at: www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/PatientSafetyQuality.aspx

comparative research on the tools to determine which is more effective in determining fall risk assessment and which interventions are most effective for preventing falls.

Pressure ulcers are another important and complex problem, since there are many factors that can impact a patient developing a pressure ulcer. The NDNQI hospitals that have had a sustained improvement in pressure ulcer reduction have employed multiple interventions: frequent turning, pressure relieving devices (particularly on operating room tables), unit-based skin teams, skin rounds and education on skin maintenance, decreasing the amount of bed linen, resource manuals on skin products for treatment and prevention, and others. The NDNQI validity and reliability study identified that we had moderate to near perfect reliability on pressure ulcer assessment based on kappa values, however there was even higher reliability with the wound ostomy certified nurses. The Braden Scale was developed to predict risk for pressure ulcers and many organizations have created algorithms using the Scale to determine treatment. We do not know, however, which scale or algorithm is most predictive, nor which interventions are most effective for a given threshold score – fertile ground for comparative effectiveness research.

Delivering more and better primary care is a priority.

A significant barrier to our ability to increase access to care and shift the focus toward primary and preventive care is the critical shortage of primary care providers. You will certainly hear from other groups today about the small percentage of medical students choosing primary care, and ANA supports efforts to reform our payment system to enhance primary care services.

NPs and CNMs can fill the need for primary care services. Numerous studies have documented the quality of primary care delivered by NPs and CNMs. A Cochrane review concluded that "appropriately trained nurses can produce as high quality care as primary care doctors and achieve as good health outcomes for patients." It was noted that the research available is limited and some may call for further comparative studies.

There are, however, no other professionals who have been subjected to the depth of study that NPs and CNMs have, and we question the need to expend limited resources on additional studies comparing professional groups, though we stand ready to play a role in the design and conduct of such studies should they be deemed necessary.

We suggest that there is sufficient evidence for the quality and safety of nurse-led care, reflected in payment policies that support those roles. APRNs have prescriptive authority, are eligible for direct Medicare reimbursement and are employed by federal agencies from the VA to the US Public Health Service. There are a host of frequent health care needs - routine pediatric care, prenatal care, management of certain uncomplicated chronic diseases - that can be provided in a safe, cost-effective manner by APRNs.

There are, however, questions remaining about the specific processes of care and how they vary among providers. We know much too little about what makes the most effective interprofessional teams. What is the best provider mix? What makes an effective collaboration among clinicians? These questions are worthy of prioritizing for CER dollars.

Nursing has a unique perspective to offer in the development of CER priorities. The scope of CER must be broad and embrace a wide range of methodologies. ANA urges looking to the NQF National Priorities & Goals and existing work on quality improvement to frame CER priorities and we look forward to playing a role in this important initiative.