ATTACHMENT Q

Federal Register Public Comment and NCHS Response

AMERICAN NURSES ASSOCIATION

8515 Georgia Avenue, Suite 400
Silver Spring, Maryland 20910-3492
301 628-5000 • Fax 301 628-5001
www.NursingWorld.org

Rebecca M. Patton, MSN, RN, CNOR
President

Linda J. Stierle, MSN, RN, CNAA,BC
Chief Executive Officer

March 31, 2009

Centers for Disease Control and Prevention
CDC/ATSDR
Assistant Reports Clearing Officer
1600 Clifton Road
MS-D74
Atlanta, GA 30333

Sent via email to: omb@cdc.gov

Re: **Proposed Data Collections Submitted for Public Comments and Recommendations: National Ambulatory Care Survey (NAMCS) (OMB No. 0920-0234)—Revision—National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC)** (74 Fed. Reg. 5660, January 30, 2009)

Dear Sir or Madam:

The American Nurses Association (ANA) welcomes the opportunity to comment on the revised National Ambulatory Medical Care Survey (NAMCS). We urge the National Center for Health Statistics (NCHS) of the Centers for Disease Control and Prevention (CDC) to enhance the quality, utility, and clarity of the data by ensuring that the survey includes both advance practice registered nurses (APRNs), and the full range of ambulatory care facilities currently available to patients.

The ANA is the only full-service professional organization representing the interests of the nation's 2.9 million registered nurses, through its 51 constituent member nurses associations and its 24 specialty nursing and workforce advocacy affiliate organizations. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public. ANA members include advance practice registered nurses such as nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs) and certified registered nurse anesthetists (CRNAs). We support the removal of arbitrary practice restrictions and the reversal of barriers to APRN practice. We oppose any laws, regulations, or policies regarding

APRNs which limit or prohibit prescriptive authority or institutional privileges, require supervision by another health care provider, limit direct reimbursement, or impede liability insurance protection.

The National Ambulatory Medicare Care Survey contains an inherent bias, because it focuses primarily on data collection in physician office practices. "The target universe of NAMCS is visits made in the United States to the offices of nonfederally employed physicians (excluding those in the specialties of anesthesiology, radiology, and pathology) who are classified by the American Medical Association [AMA] and the American Osteopathic Association [AOA] as 'office-based, patient care.'" The NAMCS also includes 104 community health centers, such urban Indian health clinics and Federally Qualified Health Centers.

Unfortunately, the survey fails to include the participation of many non-physician health care providers such as advance practice registered nurses (APRNs). To accurately reflect the provision of ambulatory care, particularly health care visits that focus on primary care and prevention, the survey must include care provided by non-physician health care providers, such as APRNs. The survey also ignores the significant contributions of ambulatory care services provided in other settings – such as retail/minute clinics, student health centers, and student-based clinics, as well as family planning and reproductive health centers. Many healthy women of child-bearing age receive virtually all of their primary care in family planning and reproductive health centers. Working parents often are unable to pursue urgent care until after work or school hours, necessitating seeking health care during evening and weekend hours when very few primary care physicians are available.

As policy makers work to shift the focus of health care toward primary and preventive care, the data collected in community health centers (CHCs) will be increasingly important. We applaud the decision to include CHCs in the NAMCS, particularly the decision to allow nurse practitioners, physician assistants, and nurse midwives who work in CHCs to participate in the NAMCS.

Advance practice registered nurses are licensed independent practitioners with advanced education and training who are legally authorized to practice within standards established or recognized by licensing agencies – including state boards of nursing and national certification bodies.[1] APRNs are educationally prepared to provide a scope of services across the health wellness-illness continuum to at least one population focus as defined by nationally recognized role and population-focused competencies. The emphasis and implementation vary for each type of APRN. The services or care provided by APRNs are not defined or limited by setting, but rather by patient care needs. Minimally, an

[1] Each state independently determines the APRN legal scope of practice, the roles that are recognized, the criteria for entry into advanced practice, and the certification examinations accepted for entry-level competence assessment.

APRN holds a master's degree with advanced didactic and clinical preparation beyond that of an RN. APRNs can be broadly grouped into four categories: nurse practitioners, clinical nurse specialists, certified nurse-midwives, and certified registered nurse anesthetists.

Numerous studies have shown that APRNs provide high-quality health care services. A study published in the January 5, 2000 *Journal of the American Medical Association* compared the outcomes of patients randomly assigned to medical doctors and nurse practitioners within a particular managed care organization and found that patient outcomes and satisfaction were comparable.[2] APRNs often serve in areas where health care coverage is scarce – thus increasing patient access to quality health care. The May/June 2005 issue of *The American Nurse* examined the extensive use of NPs in retail clinics and reported that approximately 50 percent of the patients seen in this setting did not have primary care providers.[3] A 2009 study by the Cochrane collaboration found that "In primary care, it appears that appropriately trained nurses can produce as high quality care and achieve as good health outcomes for patients as doctors."[4]

Nurse Practitioners (NPs) provide care along the wellness-illness continuum in a dynamic process in which direct primary and acute care is provided across settings. The Health Resources and Services Administration estimated there were 141,209 NPs in the United States, in its most recent Sample Survey in 2004.[5] NPs have been providing primary care in this country for almost 40 years.[6] About 66 percent of NPs practice in at least one primary care site, and 20 percent practice in rural or frontier settings.[7]

NPs are members of the health delivery system, practicing autonomously in areas as diverse as family practice, pediatrics, internal medicine, geriatrics, and women's health care. NPs are prepared to diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. Both primary and acute care NPs provide initial, ongoing, and comprehensive care, which includes taking comprehensive histories, providing physical examinations and other health assessment and screening activities. NPs also diagnose, treat,

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[2] Mundinger, M., et al (2000). Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial. *Journal of the American Medical Association, 283, 59-68.*
[3] Trossman, S. (2005). One-stop shopping – and some help for that strep throat: A trend emerges that offers NP-staffed clinics in superstores. *The American Nurse, 5.*
[4] Laurant, M., et al. (2009). Substitution of doctors by nurses in primary care. *The Cochrane Library,* Issue 1 (p. 2). John Wiley & Sons, Ltd.
[5] U.S. Department of Health & Human Services, Health Resources and Services Administration. The Registered Nurse Population: National Sample Survey of Registered Nurses: March 2004: Preliminary Findings.
[6] Frequently Asked Questions About Nurse Practitioners. Website of American College of Nurse Practitioners: www.acnpweb.org/files/public/FAQ_about_NPs_May06.pdf.
[7] Nurse Practitioner Facts. Website of American Association of Nurse Practitioners: www.aanp.org/NR/rdonlyres/51C6BCOF-F1CO-4718-B42F-3DEDC6F5F635/O/AANPNPFacts.pdf.

and manage patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing medication and durable medical equipment; and making appropriate referrals for patients and families. Clinical NP care also includes health promotion, disease prevention, health education, and counseling.

Clinical Nurse Specialists (CNSs) are registered nurses who have graduate level nursing preparation at the master's or doctoral level as a CNS. They are clinical experts in evidence-based nursing practice within a specialty area, treating and managing the health concerns of patients and populations. The CNS specialty may be focused on individuals, populations, settings, type of care, type of problem, or diagnostic systems subspecialty. CNSs practice autonomously and integrate knowledge of disease and medical treatments into the assessment, diagnosis, and treatment of patients' illnesses. These nurses design, implement, and evaluate both patient-specific and population-based programs of care. CNSs provide leadership in advancing the practice of nursing to achieve quality and cost-effective patient outcomes as well as provide leadership of multidisciplinary groups in designing and implementing innovative alternative solutions that address system problems and/or patient care issues. In many jurisdictions, CNSs, as direct care providers, perform comprehensive health assessments, develop differential diagnoses, and may have prescriptive authority. Prescriptive authority allows them to provide pharmacologic and nonpharmacologic treatments and order diagnostic and laboratory tests in addressing and managing specialty health problems of patients and populations. CNSs serve as patient advocates, consultants, and researchers in various settings.[8]

Certified Nurse-Midwives (CNMs) provide a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and care of the newborn. The practice includes treating the male partner of the female client for sexually transmitted diseases and reproductive health. This care is provided in diverse settings, which may include homes, hospitals, birth centers, and a variety of ambulatory care settings including private offices and community and public health clinics.

There are thousands of CNMs in the United States, and their numbers have been increasing in the past 10-15 years. Many list physician practices or hospitals and medical centers as their principal employers. The majority of patient care involves primary, preventive care which includes gynecologic care such as annual exams and reproductive health visits. Currently, 70 percent of the women

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[8] American Nurses Association (2004). *Nursing: Scope and Standards of Practice (15).* Washington, DC: Nurses Books.Org.

seen by nurse-midwives are considered vulnerable by virtue of their age, socioeconomic status, education, ethnicity, or location of residence.[9]

Certified Registered Nurse Anesthetists (CRNAs) are prepared to provide the full spectrum of patients' anesthesia care and anesthesia-related care for individuals across the lifespan. CRNAs must pass a certification exam administered by the Council on Certification of Nurse Anesthetists, after completing an accredited nurse anesthesia educational program. Their patients can range from healthy through all levels of acuity. CRNAs provide care in a number of diverse settings. These include hospital surgical suites, obstetrical delivery rooms, ambulatory surgery centers, endoscopy and other clinics, acute care, pain management centers, and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. Consequently, while anesthesiologists are excluded from the NAMCS, it may be appropriate for CRNAs to participate in the survey.

The Provider Reimbursement Review Board of the Centers for Medicare & Medicaid Services recently ruled that standby or on-call costs for CRNAs at critical access hospitals are allowable costs under Medicare.[10] In a follow-up letter to CMS, the American Hospital Association noted that:

> CRNAs have provided anesthesia care to patients in all parts of the U.S. for more than 125 years. In rural parts of the country, they often are the primary providers of anesthesia, which enables health care facilities in these medically underserved areas to offer surgical services. As a result, CRNAs greatly improve patient access in rural areas where physician shortages are particularly problematic.[11]

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[9] Nurse-Midwifery in 2008: Evidence-Based Practice: A Summary of Research on Midwifery Practice in the United States. Website of American College of Nurse-Midwives, www.midwife.org/siteFiles/news/nurse_midwifery_in_2008.pdf.

[10] St. Luke Community Healthcare v. Blue Cross and Blue Shield Ass'n, PRRB, Dec. No. 09-D9, 2/25/09.

[11] March 18, 2009 Letter of Rick Pollack, American Hospital Association, to Centers for Medicare & Medicaid Services. Website of American Hospital Association, www.aha.org/aha/letter/2009/090319-let-Pollack-Frizzera.pdf.

Conclusion

If the CDC fails to include a broad array of ambulatory care settings, and non-physician health care providers such as APRNs, then the NAMCS will not provide an accurate picture of ambulatory care in this country. The ANA urges the CDC to correct this oversight, and expand the NAMCS to include all types of ambulatory care settings and non-physician health care providers.
The American Nurses Association thanks you for the opportunity to provide its views concerning this proposed rule. Should you have any questions or comments concerning this submission, please feel free to contact Eileen Shannon Carlson, JD, RN, Associate Director of Government Affairs, Eileen.carlson@ana.org, 301-628-5093.

Sincerely,

Linda J. Stierle, MSN, RN, CNAA,BC
Chief Executive Officer
American Nurses Association

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control and Prevention

National Center for Health Statistics
3311 Toledo Road, Room 3323
Hyattsville, Maryland 20782

April 6, 2009

Linda J. Stierle, M.S.N., R.N.
Chief Executive Officer
American Nurses Association
Silver Spring, MD 20910

Dear Ms. Stierle:

This letter is in response to your public comment on the 60-day Federal register notice for the National Ambulatory Medical Care Survey (NAMCS), OMB No. 0920-0234.

When NAMCS and the National Hospital Ambulatory Medical Care Survey (NHAMCS) were initially fielded, the settings of those surveys included a large portion of ambulatory care. In recent years, to accommodate some of the changes in the health care delivery system, both surveys have expanded. In 2006 NAMCS added a separate stratum of community health centers to explore visits to physicians, nurse practitioners, physician assistants, and nurse midwives. In 2009, NHAMCS added visits to hospital-based ambulatory surgery centers (ASCs) to its current data collection. We acknowledge, as your letter states, that NAMCS continues to fall short in documenting (a) ambulatory health care services in settings other than physician offices, and (b) care received by non-physician providers, such as advanced practice registered nurses.

We are continually investigating expanding our surveys to respond to changes in the U.S. ambulatory health care system. For example, recent discussion with both external stakeholders and division staff highlighted the need to expand our sampling frames to cover a broader scope of providers and settings; however, there is currently a lack of funds to support this expansion.

Although NAMCS and NHAMCS do not directly sample nurses, researchers can analyze data for visits where the patient saw an R.N., L.P.N., or nurse practitioner/midwife in physician offices. For example, there is as an item on our survey form that identifies providers seen at a particular visit. Each year in our National Statistics Reports, we publish basic visit statistics on the type of provider seen, including the types of nurses mentioned above (http://www.cdc.gov/nchs/data/nhsr/nhsr003.pdf). Starting in 2009, data from ASCs are being collected on anesthesia provided by Certified Registered Nurse Anesthetists, and in 2010, these data will be collected from freestanding ASCs as well.

The Friends of NCHS is a voluntary coalition of more than 250 organizations that support the National Center for Health Statistics (NCHS). Members of this diverse group - including think-tanks,

professional associations, and universities - rely on the data collected and maintained by NCHS to conduct research, support advocacy efforts, and influence and inform health policy. The ANA is a member of this group and should receive occasional communications from them. In addition, Susan Wilburn of your staff is on our mailing list and receives newsletters from the Director, NCHS.

We are always willing to work with medical associations to enhance the data we produce about health care in the United States. If you would like to further discuss ways we can better represent the important contribution nurses make to ambulatory health care in the United States, please contact either Nancy Sonnenfeld, Associate Director for Science, Division of Health Care Statistics, at nsonnenfeld@cdc.gov, or Jane Sisk, Director, Division of Health Care Statistics, at jsisk@cdc.gov.

Sincerely,

/Paul C. Beatty, Ph.D./

Paul C. Beatty, Ph.D.
Chief, Ambulatory and Hospital Care Statistics Branch
Division of Health Care Statistics
National Center for Health Statistics