



June 13, 2017

Ms. Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244

ATTN: CMS-1677-P

Dear Ms. Verma:

As the voice of more than 72,000 clinical nurse specialists (CNS), the National Association of Clinical Nurse Specialists (NACNS) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) ***FY 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule and Request for Information***. NACNS specifically supports the proposal to adopt the Malnutrition Measures and Safe Use of Opioids electronic clinical quality measures (eCQMs) for inclusion in the Hospital Inpatient Quality Reporting (IQR) and Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

CNSs are licensed advanced practice registered nurses (APRN) who have graduate preparation (master's or doctorate) in nursing as a clinical nurse specialist. They have unique and advanced level competencies that meet the increased needs of improving quality and reducing costs in today's health care system. CNSs provide direct patient care, including assessment, diagnosis, and management of patient health care issues. They are leaders of change in health organizations, developers of scientific evidence-based programs to prevent avoidable complications, and coaches of those with chronic diseases to prevent hospital readmissions. CNSs are facilitators of multidisciplinary teams in acute and chronic care facilities to improve the quality and safety of care, including preventing hospital-acquired infections, reducing length of stays, and preventing hospital readmissions.

MALNUTRITION MEASURES

NACNS backs CMS's recognition of the impact of malnutrition on older adult health and outcomes, as well as the proposition that clinically-relevant malnutrition eCQMs should be considered for adoption into the Hospital Inpatient Quality Reporting (IQR) Program. In February 2017, NACNS issued the report, [*Malnutrition in Hospitalized Adult Patients: The Role of the Clinical Nurse Specialist*](#), produced by the NACNS Malnutrition Task Force and sponsored by a grant from the Abbott Nutrition Health Institute.

Our report found that an estimated 20% to 50% of hospitalized adult patients are malnourished and that treatment costs associated with malnutrition are estimated to be greater than \$11 billion annually. The costs are related not only to the treatment of malnutrition and its underlying cause, but also to the sequelae of malnutrition, including muscle wasting, loss of functional ability, and hospital-acquired conditions (e.g., falls, pressure injuries, and infections). These sequelae also can lead to increased morbidity and mortality, longer lengths of stay, and higher readmission rates.

NACNS recognizes that hospitals and providers are concerned with measure reporting burden, yet we also contend that these malnutrition eQMs ultimately will reduce the economic burden incurred by them. Adopting the patient-centered measures comprising the malnutrition measure set and encouraging the use of interprofessional approaches to achieving these goals is imperative to improve patient outcomes and care coordination, and to decrease costs to the system. We agree with CMS that “addressing malnutrition among beneficiaries is an important clinical issue.” Consequently, NACNS **urges immediate adoption of malnutrition eQMs into the Hospital IQR Program in FY 2018 and the adoption of a malnutrition composite eQm as soon as feasible.** Concurring with CMS’s nutrition measures, the NACNS malnutrition report includes these recommendations as a call to action:

- CNSs should use their full scope of practice, including prescriptive authority, to identify and treat hospitalized adult patients at risk for and experiencing malnutrition. The clinical nurse specialist is a unique advanced practiced registered nurse who can integrate treatment across the care continuum and through three spheres of influence: patient, nurse and system. The three spheres overlap and interrelate, but each possesses a distinctive focus. The CNS is well positioned to impact the nutritional status of a patient, potentially decreasing complications and cost, optimizing healing and improving overall outcomes.
- CNSs should advocate for and support the implementation of systems-level malnutrition identification, prevention, and treatment interventions with a hospital or health system’s executive leadership. Once implemented, CNSs should quantify the cost-savings associated with the strategies implemented. NACNS further encourages its members who have expertise in malnutrition to partner with economists and others who can identify exemplars of system innovations that enhance the nutritional status of hospitalized adults and assist in developing models for capturing cost savings with an emphasis on nutritional interventions.

On the frontline of monitoring and management, nursing plays a critical role addressing adult malnutrition in collaboration with dietitians and other health care professionals. In order to coordinate a team-based, interprofessional approach, NACNS advocates for needed resources and required skill sets among team members to positively affect the nutrition care paradigm for hospitalized adult patients. Development of a bundled approach to nutritional care may be an optimal model.

As is demonstrated through the substantive body of evidence supporting the impact of optimal malnutrition care on patient outcomes and benefits to the overall health care system, now is the time to address malnutrition in hospitalized older adults. The four malnutrition eQMs are valid and reliable measures; their use will incentivize the adoption of evidence-based malnutrition care best practices to reduce costs and improve patient outcomes.

SAFE USE OF OPIOIDS

NACNS also supports CMS’s proposal to consider the possible future inclusion of prescribed opioids and/or benzodiazepines eQMs in the Hospital IQR Program. Measures are needed that assess opioid follow-up, prescription and appropriate prescribing, even as there are times when concurrent prescriptions of opioids and benzodiazepines are appropriate. In a growing number of healthcare systems, the CNS leads efforts to modify the use of opioids for pain relief, implements system-level protocols that call for alternate pain relief measures and provides individualized patient consultation to improve the appropriate use and prescribing of these medications. NACNS supports the use of opioids and/or benzodiazepines in certain clinical situations and is exploring the optimal ways the CNS can contribute to reducing the opioid crisis. In 2016 NACNS appointed an Opioid/Pain Management Task Force that is currently developing tools and resources to assist the CNS to improve the management of pain and enhance the correct use of opioids and other pain management options.

Furthermore, NACNS endorses CMS’s proposal to revise the current Pain Management questions in the Hospital Consumer Assessment of Healthcare Providers and Systems Survey by adopting the proposed “Communication about Pain” composite measure. NACNS maintains that our nation is facing two inter-related public health epidemics – chronic pain and opioid misuse and overdose. Owing to the importance of these epidemics, NACNS established its Opioid/Pain Management Task Force to research and identify the resources CNSs need to address appropriate opioid use and pain management in their practices. NACNS believes that a long-term solution to the opioid epidemic will not be achieved without addressing the challenge of chronic pain and investing in research on effective pain relief alternatives. Better acute and chronic pain treatment will improve the lives of millions of Americans, save billions of dollars and reduce opioid misuse.

Inadequate treatment of pain, either under-treatment or over-treatment, can lead to negative health effects, a decreased quality of life, or adverse events for the patient (e.g., opioid misuse). Chronic pain management services are provided by CNSs in a variety of practice models based on patient, provider, and facility needs. CNSs may be members of an interprofessional pain management team, or serve as the sole providers of chronic pain management services. CNSs’ holistic practice works toward the common goal of decreasing patients’ pain and improving their quality of life and functionality.

CNSs are uniquely skilled to deliver patient-centered, chronic pain treatments. By virtue of education and individual clinical experience and competency, a CNS may practice chronic pain management using a variety of therapeutic, physiological, pharmacological, interventional and psychological modalities in the management and treatment of pain. As part of their educational preparation, CNSs are required to learn and demonstrate competence in the management of pain, a critical component in the delivery of quality care.

Regarding CMS’s Request for Information as it applies to the full range of relevant professionals to “provide screening, assessment and evidence-based treatment for individuals with opioid use disorder and other substance use disorders, including reimbursement methodologies, care coordination, systems and services integration”, please note that since the passage of the **Balanced Budget Act of 1997** (P.L. 105–33), CNSs have been allowed to directly bill their services, under Part B participation in Medicare, including the services of prescribing and of managing medication-assisted treatment to beneficiaries. Prescriptive authority, with lawful prescriptive authority for controlled substances, is within the scope of

practice of CNSs. Currently CNSs have the state-level authority to prescribe pharmacotherapeutics in 39 states.

Since there is a devastating lack of capacity to treat those seeking help, NACNS agrees with CMS that as many qualified prescribers as possible are necessary to treat patients who are struggling in our nationwide opioid epidemic. Many CNSs work in pain management clinics – a primary point of contact to at-risk beneficiaries for prescription drug abuse – and have taken extensive training in addiction treatment. CNSs’ ability to prescribe allows them to better care for those with chronic conditions. The effective use of medications is encouraged through education provided to patients on how to take the medications and why it is important at the time the prescription is given. Follow-up on medication compliance is an additional safety component. Furthermore, CNSs’ ability to change prescription at the time of need avoids any delays or safety issues. ***NACNS urges CMS to prioritize allowing at-risk beneficiaries, for prescription drug abuse, access to clinical nurse specialists who are lawful prescribers of medication-assisted treatments.***

NURSE STAFFING MEASURES

NACNS endorses the CMS proposal to consider including two nurse staffing measures in the Hospital IQR Program. These two measures are fully endorsed as a priority for ***Hospital Compare*** by the National Quality Forum (NQF): 1) Skill Mix (Registered Nurse, Licensed Vocational/Practical Nurse, Unlicensed Assistive Personnel, and Contract) (Nursing Skill Mix) Measure (NQF #0204); and 2) Nursing Hours per Patient Day Measure (NQF #0205).

The CMS proposal affirms the growing body of research demonstrating the link between nurse staffing and skill mix on patient safety and outcomes. Studies continue to find that inadequate registered nurse staffing is associated with increased mortality and multiple types of avoidable adverse events causing patient harm, reinforcing the need to match staffing and skill mix to patients’ need for nursing care. Thus, these two staffing measures are the hallmarks of all measures of nursing performance and impact on care. Moreover, as these staffing measures represent key indicators of patient safety in a hospital, collecting and reporting the data present hospitals with the opportunity to improve quality and the value of care.

Collecting and reporting these two nurse staffing measures promote transparency, quality patient care and safer, more effective interdisciplinary teams across the hospital setting. They provide the clearest guidance to patients on the quality of the nursing service at hospitals. ***NACNS supports the inclusion of both NQF-endorsed measures in the final hospital payment rule.***

Note that in the skill mix of a care setting, clinical nurse specialists can provide diagnosis, treatment, and ongoing management of patients. CNSs also provide expertise and support to nurses caring for patients at the bedside, help drive practice changes throughout the organization, and ensure the use of best practices and evidence-based care to achieve the best possible patient outcomes.

CNSs have the skills and expertise to identify where the gaps are in health care delivery. They can help design and implement interventions, and assess and evaluate those to improve overall health care delivery. Research into CNS practice demonstrates outcomes such as:

- reduced hospital costs and length of stay;
- reduced frequency of emergency department visits;
- improved pain management practices;
- increased patient satisfaction with nursing care; and
- reduced medical complications in hospitalized patients.

CARE COORDINATION

In proposal Section XIII.C. ***Request for Information on CMS Flexibilities and Efficiencies***, CMS asks for ideas on regulatory, sub-regulatory, policy, practice, and procedural changes which might improve the health care delivery system. ***NACNS encourages the continued implementation and expansion of care coordination models.*** Care coordination has a critical contribution to a patient's well-being, and it is one area where change is achievable in the near term. Care Coordination payment should be available for consistency across all qualified health professionals delivering high-value care coordination activities. All qualified providers should be able to perform a common set of tasks with supporting documentation. All members of the health care team should be accountable and transparent. All nurses have the education and training to make a significant difference in care coordination.

The CNS plays an essential role in care coordination and transitions of care that result in reduced hospital length of stay, fewer hospital readmissions and hospital-acquired conditions (HACs). The CNS role is particularly significant in care coordination for patients with complex chronic conditions. The [NACNS Chronic Care Task Force](#) report demonstrates that CNSs have distinguished themselves as effective coaches of those with chronic illness by promoting self-care and reducing the costs of the illness and readmissions. Several studies document their efforts in the care of the chronically ill, including those with heart failure, asthma and epilepsy. In addition, CNSs have developed and demonstrated the effectiveness of their community programs that identify those with COPD early, slowing down the progression of their disease.

The CNS is in the ideal position to lead collaboration within and across health care settings. With overlapping spheres of influence that affect the patient, nursing practice and system components of care, CNSs are versatile in their approach to managing patients with chronic conditions and to serve as the bridge between disciplines. Effective management of this patient population presents opportunities for the CNS to contribute to reducing costs for the patient and the system.

A review of the CNS core competencies supports the centrality of the function of care coordination within the CNS role. The CNS is educated and prepared to be, not only a participant in care coordination, but also to partner with other providers in the leadership role for care coordination. With the expansion of the nation's aging population, a population that has been identified to have higher risk for chronic conditions and multiple chronic conditions, it is imperative that all health care providers, including the CNS, be able to practice at the full scope of their practice in order to meet the impending gap in health care needs

FALLS WITH INJURY MEASURE

Section V.K.4. ***Request for Comments on Additional Measures for Potential Future Adoption*** asks for public comment on additional measures which might reduce the incidence of three specific HACs. ***NACNS strongly supports the adoption of a Falls with Injury measure to be included in CMS' IQR Program to support the Hospital Acquired Condition Reduction Program.*** The central goal in health care must be to provide high-value care for patients, with value defined as generally a function of outcomes relative to costs.

As previously mentioned, CNSs are leaders in preventing HACs. Multiple studies have proven the CNS role as expert clinician, consultant, and change-agent in the prevention of HACs, including pressure ulcers, infections, and falls. Preventing HACs is critical for improving the quality of care and reducing overall health care costs. The CNS is well-placed within the health care system to implement effective programs to reduce falls with injury.

ELECTRONIC HEALTH RECORDS

NACNS advocates for interoperability and inclusion of recognized terminologies supporting nursing practice and person-centered care within electronic health records (EHR) to achieve shareable and comparable data and improve outcomes. To attain the goal, ***NACNS urges CMS to establish EHR provisions that collect data specific to the interventions for all providers including APRNs and, specifically, CNSs.***

At present, the EHR measurement is limited to one group of eligible providers using a subset of a core set of measures. It is important that an evaluation of the capability to exchange data in an interoperable manner include all clinicians on the interprofessional care team, particularly as it relates to care coordination, including transitional care. NACNS agrees with inclusion of organizations in long-term care and behavioral health settings with the capability to exchange. This is essential to improve patient safety and reduce excessive cost due to avoidable HACs and 30-day readmissions. The exchange of data between providers and all health care settings is essential. The need to escalate steps to achieve interoperable, interprofessional, patient-driven care plans that are longitudinal in nature reflecting the lifespan of the patient and family will be achieved when recognized terminologies supporting person-centered care and nursing practice are integrated into information technology solutions.

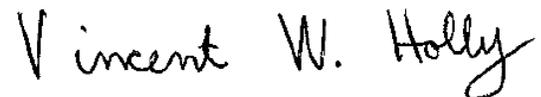
AOs, PROVIDER AND SUPPLIER CONDITIONS, AND POSTING OF SURVEY REPORTS AND ACCEPTABLE PoCs

NACNS supports the CMS proposal under Section XI.A. ***Proposed Revisions to the Application and Re-Application Procedures for National Accrediting Organizations (AOs), Provider and Supplier Conditions, and Posting of Survey Reports and Acceptable Plans of Corrections (PoCs)***, to require AOs with CMS-approved accreditation programs to post final accreditation survey reports and acceptable PoCs on a public web site. NACNS supports all types of public reporting of information that stands to increase patient safety and value of care. NACNS concurs with CMS that adding a standard for posting both accredited and non-accredited provider and supplier survey reports, as well as acceptable PoCs, would expand transparency for consumers and provide information for patients and decision makers in choosing a health care facility. NACNS also supports CMS's proposed change to allow CMS regional offices

and providers and suppliers more media platforms in which to publish termination notices, both voluntary and involuntary, with the intent of making these notices more visible and effective.

NACNS is committed to work with CMS to develop a health care system that addresses the most pressing issues facing quality patient care today – issues that clinical nurse specialists tackle every day. If you have any questions or require additional information, please feel free to contact Melinda Mercer Ray, NACNS Executive Director, at 703-929-8995 or via email at mray@nacns.org.

Sincerely yours,

A handwritten signature in black ink that reads "Vincent W. Holly". The signature is written in a cursive style with a large initial "V".

Vincent W. Holly, MSN, RN, CCRN, CCNS, ACNS-BC
President