June 22, 2015

The Honorable Orrin Hatch
Chairman
Committee on Finance
Unites States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
Unites States Senate
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

The National Association of Clinical Nurse Specialists (NACNS), representing more than 72,000 clinical nurse specialists (CNS), applauds the Finance Committee's chronic care reform efforts and appreciates the opportunity to comment on the impact of chronic disease on the Medicare program.

As you may know, CNSs are licensed registered nurses who have graduate preparation (master's or doctorate) in nursing as clinical nurse specialists. 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 readmissions.

In 2014, the NACNS Board of Directors appointed a Chronic Care Taskforce comprised of CNS experts from around the country. Through intensive literature review and expert deliberation, they are identifying best practices and clinical practice innovations that CNSs use to improve the care provided to patients with chronic conditions. CNSs are advanced practice registered nurses who are directly reimbursed by the Centers for Medicare and Medicaid Services and other insurances for their services. They can prescribe medications and durable medical equipment in a majority of states. Consequently, CNSs as vital members of the health care team, are poised to manage the care of patients that experience chronic care conditions.

As such, we believe that we can provide a qualified and unique perspective to your deliberations. Our comments regarding specific issues outlined in the committee's call for information follow.

3. Reforms to Medicare's current fee-for-service program that incentivizes providers to coordinate care for patients living with chronic conditions.

The NACNS supports the measurement of chronic care outcomes and processes accompanied by incentives to coordinate better care for patients living with these conditions. The incentives will support the

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practitioners in providing the needed care. CNSs have documented their ability to improve outcomes by preventing readmissions and emergency department utilization.

- In a community-based care program, CNSs who provided care to those with complex and chronic care conditions had an impact on clinical quality, costs, and client satisfaction. Financial measures showed reductions in all key indicators: cost (decreased 24 percent), emergency department utilization (decreased 38 percent), inpatient admissions (decreased 23 percent), and inpatient days (decreased 49 percent), when compared with the year prior to the program.

  (Schmidt M, Ulch P. Innovative CNS practice in a community-based case management program. Clin Nurse Spec. 2012;26(2):E-27. Abstract retrieved from Conference Abstracts database.)

- Clinical nurse specialists identify early those at risk for costly chronic diseases, such as diabetes and heart failure, while providing wellness and preventive care. For example, a wellness company, owned and managed by CNSs, provides ongoing care to employees to maintain a healthy status and to lower the risk for the development of disease. An employer, who has engaged the services of these CNSs, saw a decrease in health care costs and an annual increase in health insurance premiums into the single digits, as opposed to previous double-digit increases.

  (Dayhoff D. Clinical Solutions, LLC http://www.aannet.org/edgerunners-wise-health-decisions. Accessed June 11, 2014.)

4. The effective use, coordination and cost of prescription drugs.

CNSs have prescriptive privileges in 36 states – in 16 states they can prescribe independently and in 20 they can prescribe with physician supervision. Their ability to prescribe drugs allows them to better care for those with chronic conditions. The effective use of medications is encouraged through education on how to take the medications and why it is important at the time the prescription is provided. Follow-up on medication compliance is an additional safety component. In addition, CNSs' ability to change prescription at the time of need avoids any delays or safety issues instead of waiting for a physician's order. Unfortunately, 34 states do not extend independent prescriptive privileges to CNSs; thus contributing to an ineffective use and coordination of prescription drugs.

(Dayhoff D. Clinical Solutions, LLC http://www.aannet.org/edgerunners-wise-health-decisions. Accessed June 11, 2014.)
(Schmidt M, Ulch P. Innovative CNS practice in a community based case management program. Clin Nurse Spec. 2012;26(2):E-27. Abstract retrieved from Conference Abstracts database.)

5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology.

The ***Medicare Telehealth Parity Act*** introduced in the last Congress presented a phased-in expansion of telehealth coverage under Medicare as well as promoted maximum utilization of health providers – it allowed eligible practitioners, including clinical nurse specialists, to provide care across state lines. NACNS endorses this concept and urges the Finance Committee to do the same.

Telehealth offers patients the opportunity to receive care from a provider through the support of electronic information and telecommunications technologies. This innovative solution ensures access to

care for patients across the country and is critical given the growing national demand for health providers and services. It is especially important in rural and underserved areas. Unfortunately, current federal statute limits the type of services and the eligible settings for patients to receive care through telehealth services. CNSs have distinguished themselves as effective coaches of those with chronic illness by promoting self-care and reducing the costs of illness. Several studies document CNS efforts in care of the chronically ill, including those with heart failure, asthma, chronic pulmonary disease and epilepsy.

6. Strategies to increase chronic care coordination in rural and frontier areas.

NACNS recommends that CNS services be covered by Medicare in rural health clinics and federally qualified health clinics, in parity with the services of other nonphysicians (nurse practitioners, certified nurse midwives and physician assistants). Providing CNSs with this authority would increase the availability of primary and chronic care services in those areas.

The CNS is a health care provider who has a scope of practice that ranges from wellness to illness and acute to chronic care. An individual CNS will have a depth of expertise in a specific patient population's clinical care. For example, one CNS may specialize in diabetes care another in cardiopulmonary care. Unlike other primary care providers who have expertise in a wide-range of primary care conditions, the CNS will have in-depth knowledge in a specific clinical condition. This expertise provides cost-effective, high-quality services to patients in these clinics. If a clinic has a high number of diabetic patients, then it could employ a CNS with a specialty focus of endocrine diseases. If the clinic has a high number of patients with hypertension, asthma, and cardiac disease, the CNS could provide expert management of their primary care needs along with ongoing management of their chronic disease status. The studies mentioned above that demonstrate the effectiveness of CNSs in improving outcomes for those with chronic care conditions support this change.

7. ***Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers.***
8. ***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.***

A heart failure program in one health care system is a concrete example of how to effectively utilize primary care providers and care coordination teams to maximize health care outcomes. This program is staffed by an integrated interdisciplinary team coordinated by a CNS. The goals of the team are to eliminate barriers to care, develop individualized strategies for patients to participate in self-care, and consult with other nurses (bedside nurses, case managers, community navigators, nurses at physician offices/extended care facilities/homecare, advanced practice nurses, cardiac rehabilitation nurses) at each transition point to assure adherence to the plan of care. Primary care providers and cardiologists are engaged throughout the process to optimize heart failure therapy.

Key patient outcomes to measure program success are readmission rates and heart failure mortality. The monthly readmission rate for the CNS-coordinated program thus far in fiscal year 2015 averaged 20 percent for all causes, all ages, and all patients with and without Medicare. The monthly readmission rate for heart failure patients that participated in the Heart Failure Center Program was 3.9 percent. The model for self-care management educates the heart failure patients to recognize symptoms earlier,

manage the symptoms, and thus decrease readmissions. The CMS benchmark for all-cause mortality for the heart failure population is 11.9 percent. All-cause heart failure mortality that occurs within 30 days of discharge from this specific health care facility is 10.8 percent. In addition, mortality for the heart failure population in the CNS-coordinated program during hospitalization is 2.8 percent.

Since the cardiologists and other providers work in collaboration with the CNS to determine medical care, the heart failure program is an excellent example of expert advanced nursing practice and nursing's role to coordinate safe transitions. Recent initiatives implemented by the team include screening for palliative care, development of laboratory protocols for outpatients, men's heart failure support group, text alerts for the team if patients are readmitted within 30 days of discharge from the health care facility, education materials printed in languages other than English and for patients with low literacy skills.

The clinical nurse specialist manages a team of nurse navigators who comprise the core of the program. The nurses provide concurrent surveillance to assure patient adherence to the American College of Cardiology/American Heart Association Guidelines for the Management of Heart Failure. Processes that are monitored include discharge on evidence-based medications, 5 to 7 day follow-up appointments, 72-hour phone calls, and conversations related to advanced directives and patient goals of care. Promotion of education materials to teach recognition of heart failure symptoms and an action plan for "good" and "bad" days is a hallmark of the program.

The relationship of nurses with patients and families is at the heart of the program. Heart failure success is not just measured in data, but in the experience of providing knowledge to a new heart failure patient who feels helpless, supporting a family to make difficult end of life decisions, offering food from the low-sodium pantry, and coaching a patient to make significant lifestyle changes to manage heart failure. This is an excellent example of exceptional advanced nursing practice as provided by the CNS.

Thank you for the opportunity to provide these comments and for your careful consideration of them. NACNS would be pleased to provide the findings and recommendations of our Chronic Care Task Force when the groups work is complete. If you have any questions or require additional information, please feel free to contact Melinda Mercer Ray, NACNS Executive Director, at 703-929-8995.

Sincerely yours,

Peggy Barksdale, MSN, RN, OCNS-C, CNS-BC
President