From: NACNS <nacns@fernley.com>
To: NACNS <nacns@fernley.com>
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CNS Communiqué

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The CNS Communiqué is an electronic publication of the National Association of Clinical Nurse Specialists. The purpose of this publication is to keep our members updated on the NACNS headquarters news; connect our members with fast-breaking clinical news; and update clinical nurse specialists on state and federal legislative actions.

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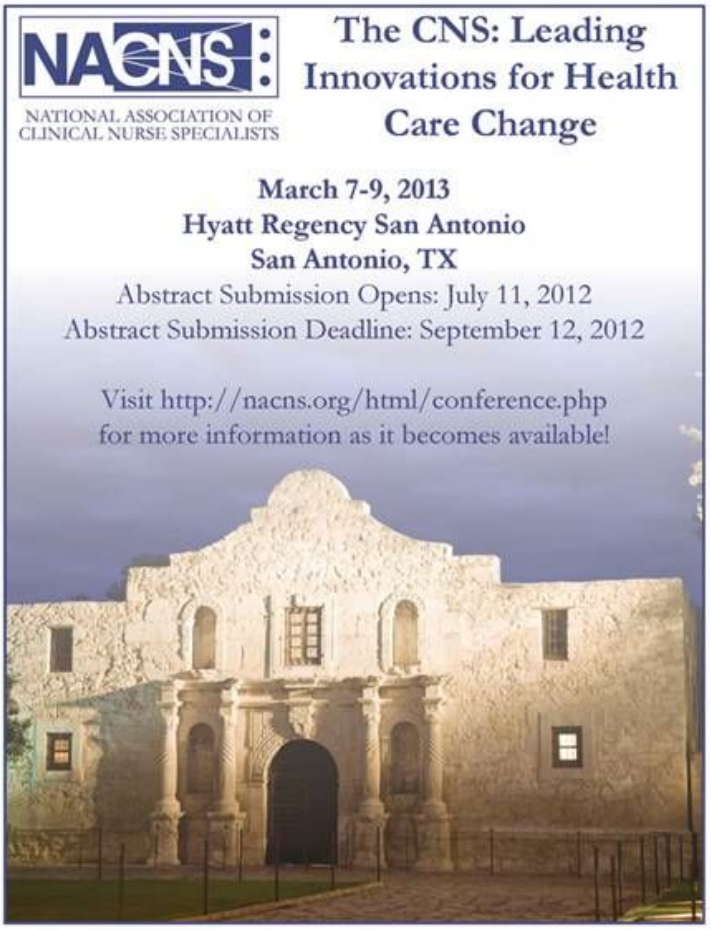

Featured Articles

1. NACNS President Invited to the White House

On Wednesday, June 13, NACNS President and nurse leader Rachel Moody, MS, CNS, RN participated in a White House meeting to discuss how nurses work to improve the delivery of health care. As president of NACNS, Ms. Moody spoke of the many ways the clinical nurse specialist (CNS) works to transform the care of individual patients and patient populations. She also addressed the significant contribution the CNS makes to cost savings for the healthcare system. CNSs are prepared to provide care to patients across the health-illness continuum, including wellness to acute care. CNSs provide expert care to patients with complex conditions. They advance health care through a number of strategies, including designing and implementing innovative evidence-based interventions; and influencing and enhancing the practice of other nurses. It is hopeful that the White House will continue to pursue meetings with nurses in order to engage nurse leaders in health care reform

2. NACNS Board Identifies Three Key Issues to Address with the Implementation of the APRN Consensus Model

The APRN Consensus Model is being implemented in a number of states across the nation. In order to assist CNS members and other CNS leaders, the NACNS Board of Directors has identified three key issues to address when a state considers implementation of the APRN Consensus Model.

- **Grandfathering –** By virtue of the licensing of a state provider, such as the CNS, this individual has a property right to their title and will not lose their license to practice at their current scope of practice when there is a change in legislation that brings in new scope of practice requirements. They will need to adhere to any new requirements if they leave their state and go to another state (or if they wish to practice at the new scope of practice created by the new legislation.) States should grandfather the CNS when they implement the APRN Consensus Model.
- **Lack of Exams for all Populations –** NACNS is currently in the process of developing CNS competencies for Women's Health/Gender Related (with AWHONN) and Family across the Lifespan. These competencies will assist education programs and certifiers. The APRN Consensus Model calls for CNS practice in these population areas. Certification examinations can not be developed in these new population areas until competencies exist. It is hoped that certifiers will step forward and begin test development when these competencies are completed.
- **Inclusion of CNS in the APRN Consensus Model –** There are reports from some states working to implement the APRN Consensus Model that the CNS role is not always included in the discussions of implementation of the APRN Consensus Model. Two contributing factors are thought to be: lack of

certification exams for all populations and/or 2) lack of titling of the CNS in the state.

Headquarter News

3. NACNS Annual Summit a Success

NACNS held its 11th Annual CNS Summit on July, 24, 2012 at the American Public Health Association offices in Washington, DC. This Summit was focused on key issues related to the implementation of the APRN Consensus Model. There were 19 associations represented with a total of 38 people in attendance. The guest speakers included: Maureen Cahill, NCSBN; Winifred Carson, JD, The Carson Companies; Carol Hartigan, AACN; Martha Lavender, NCSBN/Alabama Board of Nursing; Catherine Ruhl, AWHONN; and Diane Thompkins, ANCC. NACNS President Rachel Moody served as the facilitator and the following NACNS members served as speakers: Anne Hysong, Carol Manchester and Patti Zuzelo.

Topics included: an update on NACNS' accomplishments, states efforts to implement the APRN consensus model, grandfathering and property rights, CNS population-based competencies, and advancing the consensus model in education and certification.

The Summit was deemed a success by those in attendance and we appreciate their participation in the lively and informative discussion

4. NACNS to Appoint Two Task Forces – Transitional Care and CNS Cost and Outcomes

NACNS President Rachel Moody has announced the formation of two new task forces established in an effort to move forward NACNS' mission, "to enhance and promote the unique, high value contribution of the clinical nurse specialist…" The Transitional Care Task Force will look at the role of the CNS in transitional care and make recommendation to the NACNS Board of Directors related to transitional care. NACNS president-elect, Carol Manchester will be leading this task force.

"The NACNS Board of Directors is implementing the use of task forces in order to supplement the work of our committee structure. Unlike committees, task forces are formed and appointed by the Board for a time-limited charge with a specific task or tasks. With the many issues the CNS is facing in our ever-changing health care environment, the combination of the established committees and new task forces will allow us to more fully utilize member input to meet the need of today's CNS."

The CNS Cost and Outcomes Task Force will be chaired by Board President Rachel Moody, MS, CNS, RN. This task force will give attention to strategies the CNS can use to document the cost and outcomes of CNS care and interventions. This task force will explore initiatives, products and services that the NACNS Board of Directors might consider in order to promote the CNS as a high quality, cost effective provider in today's healthcare system.

5. NACNS Task Forces Continue Work on CNS Competencies

One challenge in the implementation of the APRN Consensus Model is the availability of certification exams for the full-range of population identified in the Model. While NACNS does not have the infrastructure to develop certification examinations, we are invested in making a significant contribution to the option of developing these examinations. As a result, NACNS is partnering with key specialty organizations to develop CNS Competencies for two of the populations identified in the Model.

NACNS and AWHONN are collaborating on the Women's Health/Gender Related CNS Competencies. The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) is taking a leadership role in this project. The work group, comprised of NACNS and AWHONN members, is making excellent progress. Prior to beginning this work, NACNS and AWHONN included the American College of Nurse-Midwives and the Nurse Practitioners in Women's Health in the planning discussions. Both groups have opted to include a representative on the work group. This combination of experts has been able to have rich discussions about the unique contribution of the CNS in Women's Health. It is hoped that a finalized draft will be available prior to January 2013.

This June, the Family/Individual across the Lifespan CNS Competency work group launched its work. Invitations have been sent to a number of specialty organizations requesting their participation and the appointment of a representative. NACNS' past-president Stephen Patten, MSN, RN, CNS, CNOR will chair this work. More information on the progress of this group will be reported in future issues of the CNS Communiqué.

6. NACNS Annual Meeting

Planning continues for the 2013 NACNS Annual Meeting, March 7 – 9, 2013 at the Hyatt Regency in San Antonio, Texas. We are lining up some exciting speakers and sessions you won't want to miss!

NACNS is looking for abstract reviewers. If you are interested, please submit the form you received via email by August 31. If you need another form, please contact NACNS Headquarters. We appreciate your help with this crucial task.

Don't forget to submit your abstract by the September 12 deadline! Visit www.nacns.org for more information and to submit your abstract.

Clinical Headlines

7. New DNA Test to Help Manage CMV Infection in Organ Transplant Patients

On July 5, 2012, the U.S. Food and Drug Administration announced the approval of the first DNA test to help health care professionals gauge the progress of anti-viral treatment in solid organ transplant patients undergoing cytomegalovirus (CMV) antiviral therapy.

The COBAS AmpliPrep/COBAS TaqMan CMV Test is a viral load test that can help determine the amount of CMV nucleic acid present in a sample of a patient's blood plasma. This product is manufactured by the Roche Molecular Systems in Somerville, N.J.

While a patient is undergoing anti-CMV therapy, a clinician can use the device to perform a series of tests to look for changes in a patient's CMV viral load. A significant decrease in viral load from one test to the next may indicate that a particular therapy is effective, while an increase or no change may indicate the need for a different therapy. When used along with other clinical and laboratory data, this information can aid clinicians to manage and optimize patient care.

CMV is a common virus that can cause severe diseases such as pneumonia or colitis in people with weakened immune systems, including solid organ transplant patients. Solid organ transplants include heart, lung, pancreas, kidney, or small intestine transplants. Transplants of tissue or cells, such as bone marrow, skin, or muscle, are not included in this approval notice.

8. CDC Publishes Updated Recommendations Related to Hepatitis B Virus-Infected Health Care Providers

Published in the July 6, 2012 ***Morbidity and Mortality Weekly Report***, *Updated CDC Recommendations for the Management of Hepatitis B Virus–Infected Health-Care Providers and Students* provides an update to the 1991 CDC recommendations for HBV infection and the health care provider. According to this report, "HBV infection alone should not disqualify infected persons from the practice or study of surgery, dentistry, medicine, or allied health fields." The 1991 recommendations have been updated to include:

- no pre-notification of patients of a health-care provider's or student's HBV status;
- use of HBV DNA serum levels rather than hepatitis B e-antigen status to monitor infectivity; and,
- for those health-care professionals requiring oversight, specific suggestions for composition of expert review panels and threshold value of serum HBV DNA considered "safe" for practice (<1,000 IU/ml).

For most chronically HBV-infected providers and students who conform to current standards for infection control, HBV infection status alone does not require any curtailing of their practices or supervised learning experiences.

It is important for institutions, schools and those involved in management of clinical care be aware of these changes and update policies and procedures to reflect these new recommendations. Nationally, the rate of hepatitis B infection is on the decline. This is due to the implementation of infant vaccination and catch up vaccinations for children and young adults. As a result of the observance of infected health care provider guidelines and the reduction of infected individuals, patient-to-provider and provider-to-patient transmission is on the decline.

9. FDA approves first drug for reducing the risk of sexually acquired HIV infection

On July 16, 2012 the U.S. Food and Drug Administration approved Truvada (emtricitabine/tenofovir disoproxil fumarate). This is the first drug approved to reduce the risk of HIV infection in uninfected individuals who are at high risk of HIV infection and who may engage in sexual activity with HIV-infected partners. Truvada, taken daily, is to be used for pre-exposure prophylaxis (PrEP) in combination with safer sex practices to reduce the risk of sexually-acquired HIV infection in adults at high risk.

The FDA previously approved Truvada to be used in combination with other antiretroviral agents for the treatment of HIV-infected adults and children 12 years or older.

As part of PrEP, HIV-uninfected individuals who are at high risk will take Truvada daily to lower their chances of becoming infected with HIV should they be exposed to the virus. A PrEP indication means Truvada is approved for use as part of a comprehensive HIV prevention strategy that includes other prevention methods, such as safe sex practices, risk reduction counseling, and regular HIV testing.

Every year, about 50,000 U.S. adults and adolescents are diagnosed with HIV infection, despite the availability of prevention methods and strategies to educate, test, and care for people living with the disease. The FDA is requiring Truvada to have a box warning to alert health care professionals and uninfected individuals that Truvada, when used as a preventative measure, must only be used on individuals who are confirmed to be HIV-negative at least three months prior to use. The drug is contraindicated for individual with unknown or positive HIV status.

The prescribing of Truvada as a preventative is approved with a Risk Evaluation and Mitigation Strategy (REMS) that is designed to minimize the risk to uninfected individuals of acquiring HIV infection and to reduce the risk of development of resistant HIV-1 variants. The central component of this REMS is a training and education program to assist prescribers in counseling individuals who are taking or considering Truvada for prevention. The training and education program will not restrict distribution of Truvada but will provide information about the importance of adhering to the recommended dosing regimen and understanding the serious risks of becoming infected with HIV while taking Truvada for the preventative indication.

Truvada's safety and efficacy for prevention were demonstrated in two large, randomized, double-blind, placebo-controlled clinical trials. The iPrEx trial evaluated Truvada in 2,499 HIV-negative men or transgender women who have sex with men and with evidence of high risk behavior for HIV infection, such as inconsistent or no condom use during sex with a partner of positive or unknown HIV status, a high number of sex partners, and exchange of sex for commodities. Results showed Truvada was effective in reducing the risk of HIV infection by 42 percent compared with placebo in this population. Efficacy was strongly correlated with drug adherence in this trial.

The Partners PrEP trial was conducted in 4,758 heterosexual couples where one partner was HIV-infected and the other was not (serodiscordant couples). The trial evaluated the efficacy and safety of Truvada and

tenofovir versus placebo in preventing HIV infection in the uninfected male or female partner. Results showed Truvada reduced the risk of becoming infected by 75 percent compared with placebo.

No new side effects were identified in the clinical trials evaluating Truvada for the preventative indication. The most common side effects reported with Truvada included diarrhea, nausea, abdominal pain, headache, and weight loss. Serious adverse events in general, as well as those specifically related to kidney or bone toxicity, were uncommon.

As a condition of approval, Truvada's manufacturer, Gilead Sciences, Inc., is required to collect viral isolates from individuals who acquire HIV while taking Truvada and to evaluate these isolates for the presence of resistance. Additionally, the company is required to collect data on pregnancy outcomes for women who become pregnant while taking Truvada for prevention and to conduct a trial to evaluate drug adherence and its relationship to adverse events, risk of seroconversion, and resistance development in seroconverters. Gilead Sciences, Inc. is based in Foster City, Calif.

For more information:

- FDA: Consumer Update - FDA Approves First Medication to Reduce HIV Risk
- FDA: HIV and AIDS Activities
- CDC: Pre-Exposure Prophylaxis (PrEP)
- NIH: AIDS Information
- HHS: AIDS News and Resources

10. Caffeine Use in Pregnancy – Does it Impact the Child's Behavior?

A study in the July 9 Online Journal Pediatrics examines the association between maternal caffeine intake during pregnancy and children's problem behavior at age 5 to 6 years. Dietary caffeine intake (coffee, caffeinated tea, and cola) was measured in a community-based, multiethnic birth cohort around the 16th week of gestation. At age 5, children's overall problem behavior, emotional problems, conduct problems, hyperactivity/inattention, peer relationship problems and pro-social behavior were rated by both the children's mother and teacher. Analyses were adjusted for maternal age, ethnicity, cohabitant status, education, smoking and alcohol consumption during pregnancy, child's gender, family size and prenatal maternal anxiety. Caffeine intake during pregnancy was not associated with a higher risk for behavior problems at age 5. The study authors conclude that these results give no indication to advise pregnant women to reduce their caffeine intake to prevent behavior problems in their children.

11. NIH Study Shows Touch is Processed Differently by the Deaf Brain

Research funded by the National Institutes of Health (NIH) has found that people who are born deaf process the sense of touch differently than people who are born with normal hearing. The finding reveals how the early loss of a sense affects brain development. The study was published in the July 11 online issue of The Journal of Neuroscience.
The researchers, Christina M. Karns, Ph.D., a postdoctoral research associate in the Brain Development Lab at the University of Oregon, Eugene, and her colleagues, show that deaf people use the auditory cortex to process touch stimuli and visual stimuli to a much greater degree than occurs in hearing people. The finding suggests that since the developing auditory cortex of profoundly deaf people is not exposed to sound stimuli, it adapts and takes on additional sensory processing tasks.

"This research shows how the brain is capable of rewiring in dramatic ways," said James F. Battey, Jr., M.D., Ph.D., director of the NIDCD. "This will be of great interest to other researchers who are studying multisensory processing in the brain."

Previous research, including studies performed by the lab director, Helen Neville Ph.D., has shown that people who are born deaf are better at processing peripheral vision and motion. Deaf people may process vision using many different brain regions, especially auditory areas, including the primary auditory cortex. However, no one has tackled whether vision and touch together are processed differently in deaf people, primarily because in experimental settings, it is more difficult to produce the kind of precise tactile stimuli needed to answer this question.

Dr. Karns and her colleagues developed a unique apparatus that could be worn like headphones while subjects were in a magnetic resonance imaging (MRI) scanner. Flexible tubing, connected to a compressor in another room, delivered soundless puffs of air above the right eyebrow and to the cheek below the right eye. Visual stimuli — brief pulses of light — were delivered through fiber optic cables mounted directly below the air-puff nozzle. Functional MRI was used to measure reactions to the stimuli in Heschl's gyrus, the site of the primary auditory cortex in the human brain's temporal lobe as well as other brain areas.

The researchers took advantage of an already known perceptual illusion in hearing people known as the auditory induced double flash, in which a single flash of light paired with two or more brief auditory events is perceived as multiple flashes of light. In their experiment, the researchers used a double puff of air as a tactile stimulus to replace the auditory stimulus, but kept the single flash of light. Subjects were also exposed to tactile stimuli and light stimuli separately and time-periods without stimuli to establish a baseline for brain activity.

Hearing people exposed to two puffs of air and one flash of light claimed only to see a single flash. However, when exposed to the same mix of stimuli, the subjects who were deaf saw two flashes. Looking at the brain scans of those who saw the double flash, the scientists observed much greater activity in Heschl's gyrus, although not all deaf brains responded to the same degree. The deaf individuals with the highest levels of activity in the primary auditory cortex in response to touch also had the strongest response to the illusion.

The finding also has the potential to help clinicians improve the quality of hearing after cochlear implants, especially among congenitally deaf children who are implanted after the ages of 3 or 4. These children, who have lacked auditory input since birth, may struggle with comprehension and speech because their auditory cortex has taken on the processing of other senses, such as touch and vision. These changes may make it more challenging for the auditory cortex to recover auditory processing function after cochlear implantation. Being able to measure how much the auditory cortex has been taken over by other sensory processing could offer doctors insights into the kinds of intervention programs that would help the brain retrain and devote more capacity to auditory processing.

Association News

12. Robert Wood Johnson Foundation Young Leader Award

The Robert Wood Johnson Foundation (RWJF) Young Leader Awards will honor up to 10 leaders age 40 and under who offer great promise in improving health and health care for all Americans. The Foundation will make up to 10 awards of $40,000 each to outstanding young leaders who have demonstrated innovative leadership in health and health care. Winners will be publicly announced at a RWJF conference to be held in Princeton, New Jersey, on October 25-26. The deadline for nominations is July 16. For more information, go to http://www.altfutures.org/youngleaderawards.

13. Submissions Being Sought for an Interprofessional Oral Systemic Health Curricular Innovations Award

New York University College of Nursing's Oral Health Nursing Education and Practice (OHNEP) initiative announces a call for proposals for the development of instructional resources to support interprofessional education and collaborative practice in oral-systemic health. The purpose of the OHNEP Interprofessional Oral-Systemic Health Curricular Innovation Award is to develop peer-reviewed instructional resources to prepare health professionals with core competencies in oral-systemic health and interprofessional collaborative practice. This OHNEP program is made possible through the generous support from DentaQuest Foundation, Washington Dental Service Foundation, and Connecticut Health Foundation.

Accepted applicants will receive a $2,000 curricular innovation development award. Curricular innovation awards will be considered either for (a) development of a new oral-systemic health instructional resource for interprofessional education and/or collaborative practice in a clinical setting; or (b) refinement of an existing oral-systemic health instructional resource for interprofessional education and/or collaborative practice in a clinical setting.

To review the full call for proposals and to apply online, please visit http://ohnep.org/call-for-proposals . Deadline for applications is August 15, 2012 by 5:00 p.m. Eastern Time.

14. Nursing Dean's Group Presents Nursing Caucus Hill Briefing

On July 19, 2012, a newly formed groups known as the Dean's Nursing Policy Coalition was held in conjunction with the Nursing Caucus. The title of the briefing was, Nursing's Emerging Role at the Forefront of Health Care Change. Congresswoman Lois Capps (D-CA) and Congressman Steven LaTourette spoke at this briefing. The hearing covered:

- How research findings from nurse scientists promote and improve health outcomes;
- The evolving mission of health care provider teams for disease prevention and treatment; and
- The role of nurses and nurse educators and the importance of federal support.

The Dean's Nursing Policy Coalition was established in 2010 to address issues in health care research and reform on which they could speak with a well-informed and credible voice. Its members are deans of seven leading private schools of nursing education and nursing science. These schools include: Columbia University, Duke University, Yale University, The University of Rochester, Emory University, Vanderbilt University and the University of Pennsylvania.

15. NACNS Board Member and Diabetes Expert to Speak at National Diabetes Meeting

President-elect Carol Manchester, MSN, ACNS, BC-ADM, CDE will be a featured speaker at *A Collaborative Approach to Diabetes Care Conference* on October 10-12, 2012 in Buffalo, New York. The focus of this meeting is meeting the patient demand while reducing costs. Hospitals are looking for better ways to reduce their re-admission rates. Hear how you can effectively manage perioperative glycemic management; meet the "new" endocrine guidelines for inpatient hyperglycemia; improve medication adherence; prepare for population health management and value-based reimbursement, plus more. This is an informational educational closed door event with limited seating.

16. NACNS Celebrates CNS Week!

For the fourth year in the row, NACNS is calling for CNSs around the nation to celebrate the fourth annual CNS Celebration Week, September 1 – 7, 2012. This is an excellent opportunity for you to draw attention to your contribution to patient outcomes and your vital role in the healthcare system. NACNS has posted a package of resources on our website to help you gain the recognition the CNS profession deserves. You can find a list of creative resources: an idea guide, sample press release, flyer, CNS factsheet and sample proclamation. Please email the NACNS office and let us know what creative ideas you used!

Federal and State Policy

17. Supreme Court Decision on ACA Stimulates Action in House and Senate

The June 26, 2012, a 5-4 decision by the U.S. Supreme Court upheld the insurance mandate that is a key aspect of the Patient Protection and Affordable Care Act (ACA). In a surprise move Chief Justice John G. Roberts Jr. cast the deciding vote to uphold the constitutionality of the individual mandate. His rationale was unexpected. In his opinion, he identified the individual mandate as being not a penalty, but a tax. Since Congress has the Constitutional authority to level taxes, he voted to uphold this provision of the ACA. Justice Ruth Bader Ginsburg, with Justices Stephen G. Breyer, Sonia M. Sotomayor, and Elena Kagan, joined Roberts in that part of the opinion. Justices Anthony M. Kennedy, Antonin Scalia, Clarence Thomas, and Samuel A. Alito Jr. dissented.

The Court did act to limit the Medicaid expansion provision in ACA. Specifically, this provision of the legislation would have allowed the Administration to limit current federal funding to the states if they had declined to comply with Medicaid expansion. The Supreme Court justices found that this portion of the law violates the Constitution by threatening states with the loss of existing funding if they decline to comply with the expansion. According to the Court, Congress had the power to make conditions for receipt of new Medicaid

funds based on the states' compliance with the expansion; but they cannot threaten to take away all Medicaid funds.

Congressional support for the ACA has declined since the midterm election and the House GOP leadership is currently working on legislative efforts to repeal the ACA. As the presidential election looms, it is anticipated that the future of provisions of the ACA will hinge on the results of the election. The first efforts were taken the week of July 9th where the House GOP leadership brought up a bill to repeal the ACA. For now, the efforts of the House will likely stand without a companion bill from the Democratic-held Senate.

NACNS has posted resources for its members on this historic Supreme Court decision.

18. President Obama Signs the Food and Drug Administration Safety and Innovation Act

July 9, 2012 President Obama signed into law S. 3187, the "Food and Drug Administration Safety and Innovation Act." This legislation, which passed both the House and Senate with overwhelming bipartisan majorities, is intended to help speed safe and effective medical products to patients and maintain biomedical innovation.

This legislation makes efforts to establish timely review of new innovator drugs and medical devices. This section of the law is the implementation of the program proposed in the 2013 President's Budget to accelerate approval of lower-cost generic drugs, and fund the new approval pathway for biosimilar biologics. S. 3187 also enhances the tools available to the FDA to combat drug shortages by requiring manufacturers of certain drugs to notify the FDA when they experience circumstances that could lead to a potential drug shortage. This is consistent with the administration's request to Congress to complement the actions directed by the 2011 Executive Order to address this key issue.

Provisions in the legislation also will help enhance the safety of the drug supply chain in an increasingly globalized market, increase incentives for the development of new antibiotics, renew mechanisms to ensure that children's medicines are appropriately tested and labeled, and expedite the development and review of certain drugs for the treatment of serious or life-threatening diseases and conditions.

19. IOM Report Calls for Substantial Increase in Mental Health and Substance Abuse Workforce

On July 10, 2012, the Institute of Medicine (IOM) announced their new report, *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* This report is the result of an expert committee's work. They assessed the needs of this population and the workforce that would be needed to support its work.

The report states that at least 5.6 million to 8 million - nearly one in five - older adults in America has one or more mental health and substance use conditions. With the graying of America the number of adults age 65 and older projected to soar from 40.3 million in 2010 to 72.1 million by 2030, the mental health needs of this population must be addressed.

The numbers of elderly that will be represented in the United States in 2030 is compelling. Depressive disorders and dementia-related behavioral and psychiatric symptoms are the most prevalent. Rates of accidental and intentional misuse of prescription medications are increasing. Although the rate of illicit drug use among older individuals is low, studies indicate that it will likely increase as the baby boomers age.

The report highlights that inattention to older adults' mental health conditions and substance misuse is associated with higher costs and poorer health outcomes. Training in geriatric care for these problems is necessary, the committee emphasized. Age alters the way people's bodies metabolize alcohol and medications, increasing the general risk for overdoses; these changes also can worsen or cause alcoholism and addiction. Medicare and Medicaid payment policies deter effective and efficient care for substance abuse and mental health conditions by limiting which personnel can be reimbursed and which types of services are covered, the committee found. Effective care includes helping patients self-manage their conditions and monitoring to prevent relapses, services that can be provided by a range of trained providers and in a variety of care settings. The Centers for Medicare and Medicaid Services should evaluate alternative payment methods that would better reflect and fund effective services and coordinated team-based care for mental health and substance abuse, the report says.

The report emphasizes that most primary care providers will have frequent contact with older patients, yet their training includes little if any education on geriatric mental health and substance use, the report notes. Few opportunities exist to specialize in geriatric care for these conditions, and financial incentives and mentorships are not in place to encourage health professionals to enter or stay in this field. Health professionals' training across all disciplines should include competence in these areas, and they should be expected to be able to respond appropriately to signs of mental health or substance use problems to the full extent of their scope of practice, the committee said. For example, cognitive impairments can affect an older person's ability to comply with medication directions.

The clinical nurse specialist role (CNS) may be one of the key health care providers that can work to meet both the physical and mental health needs of this population. NACNS will be monitoring developments related to this report and look for opportunities to advocate for the role of the CNS.

20. Resources are Available for Child Passenger Safety Week

The National Highway Traffic Safety Administration (NHTSA) has announced the availability of materials designed to support participation in Child Passenger Safety Week 212 (September 16-22) and National Car Seat Check Saturday (September 2). Both events are designed to promote child car seat safety and to increase community awareness on how to properly secure a child in car seats and seatbelts. Materials include copyright-free creative posters and earned media templates are also available, including pre- and post-event press releases, sample proclamations, and talking points. To access Child Passenger Safety Week materials, go to http://www.trafficsafetymarketing.gov/cpsweek2012

21. IOM Report for Post-Incident Recovery Considerations of the Health Care Service Delivery Infrastructure - Workshop Summary

The IOM Forum on Medical and Public Health Preparedness for Catastrophic Events sponsored a town hall session at the 2012 Public Health Preparedness Summit, held February 21-24 in Anaheim, CA. The session focused on sustaining health care delivery beyond the initial response to a disaster and facilitating the full long-term recovery of the local health care delivery systems. While the local communities impacted by a disaster are the first responders and the drivers of long-term recovery, this session also discussed the

important supportive roles played by the federal government, the private sector, NGOs, and state officials. This workshop summary reflects the discussion that was held in Anaheim. Please note workshop summaries reflect the presenters' point of view, not the conclusions of the IOM.

The CNS Communiqué is an electronic publication of the National Association of Clinical Nurse Specialists.
100 North 20th Street, Suite 400, Philadelphia, PA 19103 | Phone: 215-320-3881 | Fax: 215-564-2175
www.nacns.org | info@nacns.org