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HOW THE TAX BILL MIGHT IMPACT HEALTH CARE

Signed into law on December 22, 2017, the tax reconciliation bill, known also as the Tax Cuts and Jobs Act, may be the most consequential health care legislation enacted since the Patient Protection and Affordable Care Act (ACA) in 2010. Here are a number of the more relevant health-related provisions contained in the bill.

Medical Deductions
Patients scored a short-term victory under the new tax law, which maintains and expands deductions for individuals with high medical costs. People whose unreimbursed medical expenses exceed 7.5% of their adjusted gross income can claim a deduction for those expenses in 2017 and 2018. Starting in 2019, it is scheduled to revert to 10%.

Under the current rules, for people 65 or older, the threshold already was set at 7.5%. However, even at the lower threshold, relatively few people can take the deduction because their medical expenses have not been high enough. For many employees with employer-sponsored coverage, health insurance premiums are their greatest health care expense, often paid for with pretax dollars. For most people, that expense cannot be deducted. In 2015, only 8.8 million taxpayers took the medical expense deduction.

Drug Industry
The pharmaceutical industry was highly invested in tax reform. The tax plan’s implications for pharmaceutical manufacturers include these highlights:

- The corporate tax rate is slashed from 35% to 21%.
- The orphan drug tax credit, which encourages firms to research new drugs for diseases that affect fewer than 200,000 people, is partially preserved. Companies can deduct 25% of the costs of clinical trials for rare disease treatments – down from 50% under current law.
- For drug firms that store cash overseas, such as Pfizer with nearly $200 billion of unrepatriated income overseas at the end of 2016, the new tax repatriation rate will be cut dramatically when companies bring cash back to the U.S. from other countries. Under the old law, the rate is 35%. Under the new tax law, the rate will be reduced to 15.5% for cash, and 8% for other items.

ACA Individual Mandate
A main component of the tax plan is the so-called “repeal” of the individual mandate, the ACA requirement that people buy comprehensive health insurance or pay a fine. The mandate still exists in federal law, but the new tax law eliminates the penalty starting in 2019.

The individual mandate is central to the ACA. The mandate is a minimum coverage provision that promotes community-rating reform, a rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors. The logic behind the mandate is that if the pool of insured people were balanced between the healthy and sick, premiums could be lower for everyone. Absent an enforced mandate, some scholars and health care experts predict that large numbers of younger and healthier individuals would opt out of insurance, resulting in spiking premiums.

According to the Congressional Budget Office (CBO) analysis of the effects of the individual mandate repeal, as many as 13 million fewer Americans may have health insurance 10 years from now versus
current law. CBO also projected that premiums would increase an additional 10% in most years compared to what they would have been if the mandate stayed. The expectation is that more healthy people would drop out of the markets without the mandate, leaving the remaining pool sicker and, therefore, more expensive.

**Medicare**

While the tax law does not explicitly address Medicare, the law’s overall impact on the federal deficit could make Medicare a future target. After allowing for predicted economic growth, the CBO projects that the tax law will increase the federal deficit by an estimated $1.45 trillion. Increases in the federal deficit will prompt efforts to reduce federal spending. That is because a 2010 law, known as Pay As You Go (PAYGO), requires cuts to certain federal programs if Congress passes legislation that increases the federal deficit.

Medicare and Medicaid, which account for about 30% of the federal budget, could be the major targets for deficit reduction. If that were to happen, the reductions could take the form of increasing the Medicare eligibility age from 65 to 67 or beyond (resulting in fewer covered elderly), caps on spending per beneficiary (possibly reducing covered benefits), or increases in cost-sharing that would lead to beneficiaries using fewer services.

**HEADQUARTER NEWS**

**NACNS LEGISLATIVE AND REGULATORY TOOLKIT UPDATED**

NACNS’s Leg/Reg Committee has issued an update to the *Starter Kit for Impacting Change at the Government Level: How to Work with Your State Legislators and Regulators*. The toolkit is a series of resources to assist CNSs in advocating for key issues with state and federal policymakers. It provides a better understanding of the legislative and regulatory process, offers suggestions and guidelines on how CNSs can become involved and provides resources for quick reference.

The members of the Leg/Reg Committee are:

- Jennifer Colwill, DNP, APRN, CCNS, PCCN, Chair
- Susan Dresser, MSN, APRN-CNS, CCRN
- Melanie Duffy, MSN, RN, CCRN, CCNS
- Carolyn Horne, PhD, RN, BC
- Jennifer Katlen, MSN, RN, ACNS-BC, CC
- Laura J. McNamara, MSN, RN, CCNS, CCRN-K
- Brenda L. Moffitt, MSN, APRN, CNS-BC
- Paola Richard, MSN, RN, ACCNS-AG, C
- Linda Thurby-Hay, DNP, RN, ACNS-BC, Board Liaison

**CNS CORE COMPETENCIES REVISION IN PROGRESS**

Since its founding in 1995, NACNS has been a leader in articulating CNS practice competencies, educational guidelines and credentialing requirements. In late 2017, the NACNS Task Force for the Revision of the NACNS Statement on Education and Practice opened the comment period on section two of the draft revised CNS Statement. This is the first step in a series of public comment opportunities NACNS members and the general public will have.

The revision takes into consideration the content of the 2004 and 2010 CNS Core Competencies and draws from additional resources to cover more content in accord with the evolution of health care.
When writing the specific competencies, the task force erred on the side of generality in composing a competency because the goal of the competencies is to encompass all of CNS practice. Additionally, this ultimately reduced the number of competencies to 44, down from more than 70.

The final 2017 CNS Core Competences will be published as Section Two of the revised NACNS Statement on Clinical Nurse Specialist Practice and Education. The third edition of the CNS Statement will provide additional guidance on the role of the CNS and the use of the core competencies in education and practice. Revisions to additional sections are expected later this year. NACNS plans to publish the CNS Statement, including the final 2017 CNS Core Competencies, by the fall of 2018.

The task force members are:

Carol Manchester, MSN, APRN, ACNS-BC, BC-ADM, CDE, Chair
Sherri L. Atherton, MS, RN, ACNS-BC, CIC
Kathy A. Baker, PhD, RN, ACNS-BC, FAAN
Niloufar Niakosari Hadidi, PhD, APRN, ACNS-BC, FAHA
Mary Beth Modic, DNP, APRN-CNS, CDE
Mary Fran Tracy, PhD, APRN, CCNS, FAAN
Jane Walker, PhD, RN.

MALNUTRITION TASK FORCE MEMBERS DISSEMINATING THEIR MESSAGE

While the work of the Malnutrition in the Adult Hospitalized Patient Task Force was completed last year, the members formed a close professional bond and have continued to spread awareness about how CNSs can impact addressing malnutrition as a part of their work. This dissemination has been funded by Abbott Nutrition and has allowed the task force members to attend professional health care conferences to discuss the importance of identifying and treating malnutrition.

Highlights include:

- Task force member Melanie Horbal Shuster, PhD, CNS-BC, CNSC, CRNP, presented a poster at the American Association of Medical-Surgical Nurses’ conference in September 2017.
- Task force chair Susan Smith, DNP, APRN, ACNS-BC, presented at the National Association of Student Nurses (NASN) 35th annual mid-year conference in November 2017. In addition to speaking before nursing students, Dr. Smith was also able to present the session on malnutrition and the CNS before NASN faculty attendees.
- Members of the task force will be presenting at the NACNS Annual Conference in Austin, Texas in March 2018.
- The National Teaching Institute, hosted by the American Association of Critical-Care Nurses, accepted an abstract from task force member Melanie Horbal Shuster, PhD, CNS-BC, CNSC, CRNP for a pre-conference meeting session. Dr. Shuster will present in May 2018. NACNS staff is also working with the task force to exhibit at the NTI conference in May in Boston.

The work of the task force was funded with generous support from Abbott Nutrition Health Institute.
NACNS REPORT HIGHLIGHTS IMPLICATIONS FOR POLICY, CNS EDUCATION AND PRACTICE

More patients than ever are living longer and managing chronic health conditions in their day-to-day lives. Health costs associated with chronic conditions are skyrocketing and managing patients with chronic conditions requires an understanding of not only the disease process but also self-care actions. Consequently, NACNS commissioned a task force to consider the impact CNSs can have on managing patients with chronic conditions. The task force’s report, Addressing the Needs of Patients with Chronic Conditions: The Role of the Clinical Nurse Specialist, finds that CNSs are uniquely prepared to manage patients with chronic conditions, lead collaboration within and across health care settings and serve as the bridge between disciplines.

The members of the 2015-2017 NACNS Chronic Conditions Task Force are:

Mary P. Hansen, MN, RN, CNS, CCNS, CCRN, PCCN, Chair
Lori A. Dambaugh, DNP, CNS, RN
Judy K. Dusek, DNP, M.Ed., MSN, APRN-CNS, MSRN, ACNS-BC
Cynthia Kollauf, MS, RN, ACNS-BC
Renee Martin, MN, RN, PHCNS-BC, CGRN
Renada Rochon, MSN, RN, ACNS-BC
Ludmila Maria Santiago-Rotchford, MSN, APRN, ACNS-BC, PCCN
Mitzi M. Saunders, RN, PhD, ACNS-BC
M. Jane Swartz, DNP, RN, ACNS-BC
Julia Senn-Reeves, MSN, APRN, ACNS-BC, CCNS, CCRN

HELP NACNS AFFILIATES AND CLINICAL NURSE SPECIALISTS TAKE ACTION

Last month the American Medical Association fanned the flames of a settled argument with its call for the creation of a national strategy to oppose legislative efforts that grant full practice authority to non-physician practitioners. The Clinical Nurse Specialist Institute is creating a special initiative to help NACNS affiliates and CNSs take action and speak out in defense of the CNS role and full practice authority (FPA).

The contributions the CNS Institute collects from now till January 31, 2018, will serve as the financial base for this work. Please donate and support the work of the CNS Institute and this campaign! The CNS Institute is putting the fight into your hands: Will you fund your colleagues engaged in state battles to ensure the future of the CNS?

After January 31, interested affiliates will be asked to submit proposals and detail how additional funding will help them mobilize activities in support of FPA for CNSs. CNS Institute Trustees will select proposals and promptly release the funding to allow affiliates to initiate outreach efforts early in the 2018 legislative session. With your financial support, the CNS Institute can do even more to focus our efforts on removing barriers to FPA for the almost 70,000 CNSs working in the United States today.

NICE NETWORK UPDATE

NACNS joined the American Nurses Association and the Centers for Disease Control and Prevention in the Nursing Infection Control Education Network (NICE Network) to develop training programs for real time infection prevention and control, improve adherence to best practice and enhance nurses’
confidence when caring for patients with highly contagious diseases. As part of our work in the NICE Network, NACNS will host a special workshop on February 28, 2018, the first day of this year’s annual conference in Austin, Texas. The workshop will focus on the important leadership role CNSs must take in identifying and implementing protections for serious infectious diseases and antibiotic stewardship.

Join us for this event if you have registered for the 2018 NACNS annual meeting. If you live or work near Austin, Texas, this session will be available for you to attend at no fee. To attend other sessions at the 2018 NACNS annual meeting, there will be a charge. Interested? Email 2018annualmeeting@nacns.org.

NURSING STUDENT OUTREACH EFFORTS

In recent years, the NACNS Board of Directors has increased its outreach to nursing students, especially through its work exhibiting and speaking at National Student Nurses Association (NSNA) meetings.

In late 2017, NACNS leadership met with NSNA Executive Director Diane J. Mancino, EdD, RN, CAE, FAAN, and Board President Jennifer Kalenkofski at the Nursing Organizations Alliance meeting and discussed ways to enhance nursing students’ awareness of the clinical nurse specialist role and its impact in health care.

This year, NACNS is pursuing a joint webinar series with NSNA to provide background on the CNS role. NACNS is securing the speakers and driving the webinar content and NSA will advertise the sessions to its members.

NACNS is excited to work with NSNA on this new partnership and encourage more graduating nurses to consider continuing their education to grow the CNS role.

UPCOMING WEBINARS


January 30, 2018, 2–3 pm (ET)
New Treatments in Stroke Care
Susan Fowler, RN, PhD, CNRN, FAHA

February 15, 2018, 2–3 pm (ET)
What’s New in Quality Improvement?
Tracy B. Chamblee, PhD, APRN, PCNS-BC, CPPS
Senior Director, Quality & Patient Safety, Children’s Health Children’s Medical Center, Dallas

March 15, 2018, 2-3 pm ET
Infection Control - Priorities for 2017 and Beyond
Sponsored by the NACNS Infection Control Task Force
April 18, 2018, 2-3 pm ET
System Approaches to Improve Pain Management for Your Institution
Sponsored by the NACNS Opioid/Pain Management Task Force

The webinars in the 2017-2018 NACNS Webinar Series are designed to help clinical nurse specialists address specific gaps in knowledge and provide resources to improve CNS practice. All NACNS webinars are archived. Listen at your leisure and apply for CE certificates. Webinars are competitively priced: member: $25.00; non-member: $60.00; and student: $30.00. For more information regarding contact hours, email info@nacns.org.

Affiliates News

California Association of Clinical Nurse Specialists (CACNS)

CACNS continues to be an active vibrant organization and affiliate to NACNS. Thanks goes out to our President, Paddy Garvin Higgins and our many board members who are dedicated, hardworking volunteers. Paddy has been a great communicator and keeps us all up to date. Our membership is also increasing, and we have around 200 members as of the end of 2017.

CACNS has quarterly and annual programs, which include business meetings. In 2017, meetings were held at Azusa Pacific University in Orange, University of California at Los Angeles in Santa Monica, and Santa Barbara Cottage Hospital. Our members share the responsibility for finding locations and helping to plan each program. Our Program Liaison, Charlene Bugais Tran, helps coordinate the meeting programs or setting up webinars for those not able to attend in person.

Our successful 2017 annual CACNS Conference and 30th anniversary celebration was held in Santa Barbara on October 28, 2017 at Cottage Hospital. Many thanks to Vicki Lekas and Cottage Health for this inspiring program which included Kathleen Vollman as our keynote speaker. About 50 members, students, and other guests attended. There was a special session for students, led by Lianna Ansryan, during which students and experienced CNSs asked and answered questions. Several students found CNS mentors there and requested that this session be part of our future programs. Also, at the conference, an informative and lively discussion of legislative and regulatory issues was led by Garrett Chan, Cheryl Goldfarb Greenwood, and Elissa Brown. Another activity on CACNS’s agenda is a Health Literacy Knowledge and Experience CNS Study. Cheryl Westlake, Azusa Pacific University, one of our CACNS Board members, is facilitating this important study sent to all CNSs. We look forward to the results.

A number of us will be at the 2018 Annual NACNS Conference in Austin, Texas, where we will have the CACNS annual member appreciation dinner. We look forward to being there and seeing everyone and our CNS colleagues from across the country.
Missouri-Kansas CNS Affiliate (MO-KAN)

The MO-KAN CNS Affiliate had a productive and exciting 2017. In an effort to reach CNSs in all of Kansas and Missouri, we launched a new website, changed our name from Greater Kansas City CNS to MO-KAN CNS Affiliate and developed a new logo.

Several of our members also had an eventful 2017.
✓ Kristen Frost, DNP, APRN, AGCNS-BC, CCRN, was awarded the March of Dimes Advanced Practice Nurse of the Year.
✓ Kathryn Barbay, MSN, APRN, ACNS-BC, ONC was a finalist for the March of Dimes Advanced Practice Nurse as well as Shawnee Mission Medical Center Employee of the Year.
✓ Marcie Beck MSN, ACNS-BC, CLT-LANA, Lymphedema Expert, had presentations at the Missouri College of Surgeons, Sigma Theta Tau International, and the Society of Pediatric Nurses.
✓ Three members of our Affiliate will be presenting at the NACNS Conference in Austin 2018!

Our annual CEU event – "Spring Fling" – is scheduled for April 6, 2018 at Shawnee Mission Medical Center. Registration information is on our website.

Oregon Council of Clinical Nurse Specialist (OCCNS)

The OCCNS Stakeholder Group is assisting the Oregon State Board of Nursing (OSBN) in reviewing and revising Chapter 851, Division 54, CLINICAL NURSE SPECIALISTS. Ruby Jason, Executive Director of OSBN, was interested in assembling a diverse group of CNSs from across the state and working in a variety of practice settings to make recommendations for revising and updating Division 54. These recommendations will then be presented to the Oregon State Board of Nursing for consideration.

Meetings began in December and continue into the new year. The CNS stakeholders have been focusing on critical content beginning with purposes and definitions, followed by scope of practice. There is also interest in providing more consistency, when possible, between the CNS and NP regulations. Additional sessions will address clarification between CNSs with prescriptive authority and those without for practice and CE requirements, as well as language regarding the minimum of a DNP for entry to practice. Fourteen CNSs have been working on this project.

OCCNS will hold its winter meeting on February 15, 2018 and review Division 54 with proposed changes to obtain feedback and comments. Our 2018 spring meeting will be a review of lessons and pearls from the upcoming NACNS annual meeting in Austin, Texas.

Washington State Clinical Nurse Specialists

The Washington State Clinical Nurse Specialists affiliate is recruiting members. We are looking for CNSs who wish to contribute their time to increasing our visibility in Washington State health care. There are several of us working on credentialing in our facilities; we need to hear from others. Please contact us at our website and join us on Facebook.
Clinical News

Joint Commission Cracks Down on Hand Hygiene

Effective January 1, 2018, the Joint Commission (TJC) will issue citations to health care organizations if during on-site visits surveyors witness an employee fail to follow correct hand hygiene guidelines. The change is intended to improve health care workers’ compliance with proper hand washing. Poor hand hygiene of health care employees is considered a major contributor to hospital-acquired infections. According to the Centers for Disease Control and Prevention (CDC), about 722,000 hospital-acquired infections occurred in the United States in 2011 and about 75,000 people died with such an infection during their inpatient stay.

TJC has considered hand hygiene a factor for accreditation since 2004. A health care organization can implement guidelines established by either the CDC or the World Health Organization. Given the fact that hospitals and health systems have been required to have a hand hygiene program for well over a decade, TJC leaders felt it was time to extend the requirement to ensuring organizations have properly trained all employees to follow the program in their day-to-day workflow.

Innovations and Opportunities for Improving Medication Adherence

Medication adherence is critical to improving chronic disease outcomes and reducing health care costs. The Centers for Disease Control and Prevention has published a study showing that understanding root causes of medication nonadherence and cost-effective approaches applicable in diverse patient populations is essential to increasing adherence and improving long-term health impact. Among the successful strategies to improve medication adherence are:

▪ Ensuring access to providers across the continuum of care and implementing team-based care;
▪ Educating and empowering patients to understand the treatment regimen and its benefits;
▪ Reducing barriers to obtaining medication, including cost reduction and efforts to retain or re-engage patients in care; and
▪ Using health information technology tools to improve decision-making and communication during and after office visits.

CDC Opioid Prescribing Guideline Clarification

Several weeks ago, the American Society of Addiction Medicine contacted the Centers for Disease Control and Prevention (CDC) to discuss the persistence of misunderstandings surrounding dosage thresholds in the landmark CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 (Guideline). The CDC promptly responded to this concern with a letter confirming that dosage thresholds in the Guideline were not meant to and should not apply to dosing of opioid agonists/partial agonists used for the treatment of opioid use disorder.
The letter describes steps the CDC has taken to clarify this issue. The CDC made several statements clearing up the CDC Guideline thresholds in its translational materials and presentations and on the CDC website.

**OPIOID OVERDOSE MEDICATION MAY BE EFFECTIVE EITHER TAKEN NASALLY OR INJECTED**

A new study, funded by the Agency for Healthcare Research and Quality, found Naloxone might be similarly effective whether inhaled or injected. Naloxone blocks the harmful effects of an overdose when taken immediately after an opioid is ingested. The study, published in *Annals of Internal Medicine*, examined published literature on different doses and methods of administration. It found that a high-concentration dose of naloxone taken through the nose shows effectiveness similar to when it is injected, but that more research is needed to understand different dosages and follow-up care. The study was based on a new AHRQ [comparative effectiveness review](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5323592/) that examined ideal dosages and delivery of naloxone by EMS workers.

**NEW GUIDELINES TO LIMIT THE SPREAD OF ANTIMICROBIAL-RESISTANT INFECTIONS**

The Center for Disease Control and Prevention estimates more than 2 million people in the United States get drug-resistant infections every year, the majority of which are acquired at health care facilities. The cost to treat those patients is about $20 billion a year. Most clinical research has focused on proper protocols at the beginning and throughout the treatment of a patient – but there has been little information on the safest way to end such precautions. This situation has led to varying procedures and potentially, to the spread of infection and overuse of antibiotics.

New guidance published January 11, 2018 in the journal *Infection Control and Hospital Epidemiology* offers hospitals the first standardized recommendations on ending safety protocols when treating patients for multidrug-resistant infections. The guidance suggests clinicians determine how long they should use gowns, gloves and masks when treating patients with antimicrobial-resistant pathogens, as well as deciding how long those patients should remain in isolation.

**STUDY LINKS SEVERE HYPOGLYCEMIA TO CV EVENTS**

Diabetes patients who had at least one severe hypoglycemic episode had a three-year cumulative incidence of mortality at 28.3% and a 10.8% incidence of coronary heart disease, according to a study in *Diabetes Care*. Researchers used a cohort of 1,209 participants and found an association between severe hypoglycemia and all-cause mortality, cancer mortality, cardiovascular mortality and CHD even after adjustments, but found no correlation between hypoglycemia and atrial fibrillation, heart failure, non-CV and noncancerous death, or stroke.
“TEXTING IS NOT PERMITTED” CONFLICTION

The Centers for Medicare & Medicaid Services (CMS) is clearing up recent confusion on what medical providers can text each other. CMS confirmed care team members are allowed to text patient information over a secure messaging app; however, texting a medical order is still not permitted.

Some providers have been using secure messaging platforms as a way to contact providers during emergencies to consult on medical cases or send photos of the patient. The confusion started on December 18, 2017, after an article by the Health Care Compliance Association cited emails CMS had sent to two hospitals saying, “texting is not permitted.” People thought this meant, “texting is never permitted” instead of “texting medical orders isn’t permitted.” In its December 28, 2017 memo to State Survey Agency Directors, CMS explained this was not the case.

BIOTIN (VITAMIN B7) MAY INTERFERE WITH LAB TESTS

FDA has alerted the public, health care providers, lab personnel, and lab test developers that biotin can significantly interfere with certain lab tests and cause incorrect test results that may go undetected. Biotin in blood or other samples taken from patients who are ingesting high levels of biotin in dietary supplements can cause clinically significant incorrect lab test results. The FDA has seen an increase in the number of reported adverse events, including one death, related to biotin interference with lab tests.

FEDERAL/STATE ISSUES

CHIP UPDATE

January 22nd marked three months and 13 days since Congress allowed reauthorization and long-term funding for the Children’s Health Insurance Program (CHIP) to expire. As reported in the November/December 2017 CNS Communiqué, Congressional inaction created a dire situation for children, families, and states relying on this successful, bipartisan, health insurance program that covers nearly nine million children.

The CHIP reauthorization and funding were hung up because the House majority party demanded that CHIP be paid for (i.e., Pay As You Go Act) by cutting federal spending on various preventive-care measures. The disagreement over children’s health funding was resolved with the Congressional Budget Office’s new cost estimate finding the expense of a five-year CHIP extension to be $800 million, down from $8 billion. A Kaiser Family Foundation tracking poll found that 62% of those polled consider funding CHIP a top priority – far above tax reform (28%) or strengthening immigration controls to limit who enters the country (35%).

Rather than pass a stand-alone bill to reauthorize CHIP, the majority party used this popular program as leverage by attaching it to a continuing resolution (CR) in hopes of keeping the federal government open, even though government 2018 fiscal year funding also expired three months and 13 days ago. As the CNS Communiqué goes to press, Congress has passed a 3-week funding extension CR that includes a six-year extension of CHIP.
CONTROVERSIAL MEDICAID WORK REQUIREMENT GUIDELINES

One of NACNS’s mainstay health care policy positions is to advocate for equal access to care and services. During health reform debates, NACNS consistently articulates its values by committing to remove barriers that impede individuals from attaining the necessary quality care to which all persons are entitled.

By contrast, the Centers for Medicare and Medicaid Services recently issued new guidelines allowing states to place a condition on access by establishing work requirements for so-called “able-bodied” adults who receive Medicaid funding. Tying Medicaid benefits to employment has never been permitted since the health care entitlement program for low-income persons was created 52 years ago. Ten states have requested waiver authority to impose a work requirement as a condition of Medicaid eligibility. Kentucky secured the first-ever Medicaid waiver that will require some low-income recipients to work.

In December 2017, the Kaiser Family Foundation published an issue brief to understand the potential implications of work requirement in Medicaid. Key takeaways include:

- Among Medicaid adults, nearly 8 in 10 live in working families, and a majority are working themselves.
- Small firms employ nearly half of working Medicaid enrollees.
- Among the adult Medicaid enrollees who were not working, most report impediments to their ability to work.

FUNDING BARRIERS THREATEN SUCCESSFUL MENTAL HEALTH TREATMENT

The 21st Century Cures Act (Cures), endorsed by NACNS, was signed into law one year ago. The law included key provisions to oversee mental health and substance use disorder treatment services and to ensure compliance with parity and patient safeguards consistent with the Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act of 2008. The Cures Act also mandated funding for mental health block grants.

Republican and Democratic lawmakers have expressed concern that the Cures Act goals have hit major hurdles. For example, a parity report by the National Alliance on Mental Illness found inequities between health insurance coverage of mental health and substance use conditions and that of other medical conditions.

The Cures Act called for Congress to allocate $1 billion over the next two years to support state health care efforts. Yet, only half of the funding has been distributed thus far. Congress has delayed authorizing much of the Cures Act funds, e.g., $30 million for suicide prevention, $5 million to address maternal depression, and $12 million to expand crisis response. As lawmakers look to cut domestic spending, behavioral health and substance use disorder services may be on the chopping block.

GEORGIA PANEL BACKS BROADER POWERS FOR APRNs IN RURAL AREAS
A Georgia Senate study committee has recommended that the state allow APRNs broader practice authority if they work in rural, underserved counties. Under current state law, APRNs in Georgia can prescribe medications only under a collaborative agreement with a physician.

**RESOURCES**

**NEW RESOURCES AT THE SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS**

Some of the best nationwide resources on trauma, suicide prevention, and intimate partner violence are posted on the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) website. Trauma, suicide prevention, and IPV are often interrelated issues, i.e., trauma is highly prevalent and a major risk factor for suicide and IPV.

The CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is funded jointly by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), and run by the National Council for Behavioral Health. It provides training and technical assistance to community behavioral health organizations, community health centers, and other primary care and behavioral health organizations.

**MENSCAPE NURSE CAREER SATISFACTION REPORT 2017**

In 2017, Medscape, an online journal, invited practicing nurses, including APRNs, LPNs and RNs, from the US to participate in an online survey about compensation and career satisfaction. 10,523 nurses, of whom 567 respondents identified as CNSs, responded to the 2017 survey.

The survey issues ranged from best and worst aspects of the profession, to whether respondents would choose nursing again if given the chance to start over. Medscape also focused on some issues specific to early career nurses (how long it took to find their first job, residency program participation) and later-career nurses (when they expect to retire, retirement preparation).

To the issue of the “Most Rewarding Aspect of the Job – APRN” 47% of the CNSs responding identified "helping people/making a difference in peoples' lives" as most rewarding; 15% indicated “working at a job that I like” as most rewarding; and 13% of the CNSs chose “being very good at what I do” as the most rewarding aspect of the job.

**2017 GALLUP POLL RANKS NURSES AS THE MOST ETHICAL PROFESSION**

For the 16th consecutive year, nurses outpace 21 other professions on honesty and ethics rating, according to The Gallup Poll®. Eighty-two percent of Gallup Poll interviewees described nurses' ethics as "very high" or "high", when asked, “How would you rate the honesty and ethical standards of people in these different fields -- very high, high, average, low, or very low?” The next three professions that
followed nursing with combined very high and high ratings were military officers (71%), grade school teachers (66%), and medical doctors (65%).