December 22, 2011

Submitted via www.regulations.gov

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-3244-P
P.O. Box 8010
7500 Security Boulevard
Baltimore, MD 21244-8010

RE: CMS-3244-P – Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation; Proposed Rule (76 Fed.Reg. 65891, October 24, 2011)

Dear Ms. Tavenner:

On behalf of the 41 undersigned organizations representing the Nursing Community, we submit the following comments concerning the proposed rule, Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation (76 Fed. Reg. 65891, October 24, 2011). The Nursing Community is a forum for national professional nursing associations to build consensus and advocate on a wide spectrum of health care and nursing issues, including practice, education, and research. The Nursing Community is committed to improving the health and health care of our nation by collaborating to support the education and practice of Registered Nurses (RNs) and Advanced Practice Registered Nurses (APRNs), which include Certified Nurse-Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), Nurse Practitioners (NPs), and Clinical Nurse Specialists (CNSs).

Our organizations are dedicated to reducing regulatory burdens for hospitals and critical access hospitals and applaud the Center for Medicare & Medicaid Services (CMS) for beginning to address these issues in this proposed rule. CMS has shown a commitment to the role RNs and APRNs play in quality and cost-effective healthcare delivery. Additionally, through the proposed rule, the agency has preserved important patient safeguards including the role of nursing in providing direct patient care and supervising allied healthcare providers who perform delegated nursing functions.

The Nursing Community supports such efforts that highlight the role of America's nursing workforce in quality care. For example, we support CMS's proposal to integrate the nursing care plan into the overall interdisciplinary care plan in those hospitals that use an interdisciplinary plan of care; and

CMS's proposal to end the controversial policy requiring that all verbal orders be physically signed or otherwise authenticated within 48 hours, and replace it with the requirement of proposed section 482.24(c)(2) simply requiring that all orders, including verbal orders, must be authenticated "promptly."

Yet, federal policy barriers continue to impede APRN practice and patient choice as well as the advanced role of RNs in quality and safety control. Therefore, our comments specifically address these issues. Individual participating organizations of the Nursing Community have submitted more detailed remarks to this proposed rule. The Nursing Community's comments below reflect the consensus of our organizations.

Enhance the Membership of APRNs on Medical Staff at §482.22

We appreciate the emphasis CMS has placed in its revision of §482.22, to "...provide hospitals the clarity and flexibility they need under federal law to maximize their staffing opportunities for all practitioners, and particularly for non-physician practitioners, under their individual States' laws" (page 65893). This provision directly aligns with a specific recommendation made in the landmark Institute of Medicine (IOM) *Future of Nursing: Leading Change, Advancing Health*, report which calls for CMS to:

> *Amend or clarify the requirements for hospital participation in the Medicare program to ensure that advanced practice registered nurses are eligible for clinical privileges, admitting privileges, and membership on medical staff.*

We believe the changes CMS proposes to §482.22 marks positive progress to existing policies. Specifically, we support the requirement for Medical Staffs to examine credentials of all candidates applying for practice privileges and medical staff membership within the hospital, as well as the credentials of practitioners applying only for hospital practice privileges. We also support the requirement for Medical Staffs to make recommendations to the governing body for the appointment of these candidates and the approval of these privileges in accordance with State law and hospital policies and procedures. These changes will ensure that each applicant is reviewed and considered based upon their experience and expertise with a grounding in state law. Presently, not all applications for clinical privileging submitted by APRNs are reviewed.

Additionally, this rule change will ease confusion and increase the availability of qualified health care providers and remove unnecessary restrictions on legal, safe care of patients by appropriately educated and trained registered nurses. For example, registered nurse first assistants (RNFAs) are perioperative registered nurses who function in an expanded role, working in collaboration with the surgeon and other health care team members to achieve optimal patient outcomes by performing first assistant at surgery services. The RNFA role is recognized as within the nursing scope of practice by the nursing practice acts in all 50 states. Many RNFAs are privileged to perform first assistant at surgery services in Medicare-participating hospitals.

While the changes that CMS proposes is strong progress, we recommend additional steps to improve the likelihood that CMS will achieve its goal of maximizing staffing opportunities. We recommend three additional modifications to §428.22 to maximize the use of APRNs.

- First, we support a requirement that Medical Staffs are representative of the types of health professionals, including APRNs, authorized to provide services under the Medicare and Medicaid programs and authorized to practice under state law. Better representation of health professionals on the Medical Staff will benefit the needs of patients and the community. Each professional on the Medical Staff should maintain full voting privileges and be able to serve on hospital committees addressing care provided in the facility.

- Second, we support uniform procedures for consideration of applications for medical staffing and clinical privileging and believe that they can benefit all health professionals and the patients they serve. To this end we support a requirement to complete review and determination of a complete application for clinical privileges within a sixty-day period.

- Third, the applicant should be notified of the determination in writing and an explanation of the determination should be required. In the case of a decision by a hospital to deny an application from a candidate for appointment to the medical staff or to deny clinical privileges, we support requiring that the hospital include a full statement of the rationale for such decision, including specific information relied upon by the hospital in the decision, and information with respect to rights to a hearing.

These standards would significantly help ensure that APRNs and other appropriately credentialed and licensed health professionals are allowed to practice to the fullest extent possible in accordance with state law, in the interest of expanding patient access to safe, cost-effective healthcare.

Clarify that all Categories of APRNs Are Among the Practitioners Who Can Order Drugs and Biologicals and Document and Sign for them (42 CFR § 482.23(c))

We applaud the agency for proposing to add two new provisions to 42 CFR § 482.23(c). The first one would allow for drugs and biologicals to be prepared and administered on the orders of practitioners other than those specified under §482.12(c). The second would allow for orders for drugs and biologicals to be documented and signed by practitioners other than those specified under §482.12(c). For example, approved standing orders and surgeon preference sheets help eliminate delays in patient care before, during, and after surgery. It has been demonstrated that using standing orders and pre-printed order sets reduces medication errors and improves documentation compliance.[1]

The proposed rule mentions that stakeholders suggested extending the functions of ordering drugs and biological and documenting and signing for them to APRNs. This proposal corresponds with a recommendation from the IOM *Future of Nursing* report, which outlines several paths by which patient access to care may be expanded, quality preserved or improved, and costs controlled through greater use of APRNs.[2] The IOM report specifically recommends that, "advanced practice registered

[1] 2012 Perioperative Standards and Recommended Practices, Recommended Practices for Perioperative Health Care Information Management, page e72 (AORN); Broussard M., Bass PF 3rd. Arnold CL, McLarty JW, Bocchini JA Jr., J Pediatr. 2009; 154(6): 865-868. Doi:10.1016/j.jpeds.2008.12.022.

[2] IOM (Institute of Medicine). *The Future of Nursing: Leading Change, Advancing Health* (Washington, DC: The National Academies Press, 2011), 69.

nurses should be able to practice to the full extent of their education and training."[3] We request that CMS clarify that the new provisions at 42 CFR § 482.23(c) would include all categories of APRNs (CRNAs, CNMs, CNSs, and NPs) who are acting in accordance with state law and hospital policy.

The Nursing Community agrees with CMS' proposal to eliminate the requirement that non-physicians have special training in administering blood transfusions. We support the reference to and reliance upon state law and hospital policy regarding this requirement, provided the applicable laws and policies include adequate safeguards to prevent administration errors, which can be severe and even fatal. Therefore, we believe that the person administering blood transfusions and IV medication should always be a registered nurse, advanced practice registered nurse, physician or physician assistant and recommend that CMS add language to that effect.

Allow APRNs to Authenticate Orders (42 CFR § 482.24(c))

If APRNs are allowed to order drugs and biologicals and to sign and document for them, these practitioners should also be able to authenticate orders where state law and scope of practice allow. In the cases when a practitioner gives an order and then goes "off duty," we request that the final rule allow that a practitioner other than the ordering practitioner to authenticate the order, though the other practitioner may not now be specified under §482.12(c). We, therefore, request that CMS expressly allow APRNs to be granted this function of authenticating orders.

Change the Proposed Definition of Clinical Nurse Specialist (42 CFR § 485.604 (a))

We recommend the following changes to the proposed definition of clinical nurse specialists as stated in the proposed rule (42 CFR § 485.604 (a)) (Relative to the proposed rule, additional language is underlined):

(a) Clinical nurse specialist. A clinical nurse specialist must be a person who—

(1) is a registered nurse with a nursing degree at the master's or doctoral level from an accredited educational institution that is authorized to practice as a CNS based on state nurse licensing laws and regulations.

The definition in the proposed rule does not address the specific educational requirements of a clinical nurse specialist, who is an APRN. CNSs receive education at the graduate level in the specific area of a clinical nurse specialty. This education is specific to the diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities.

On behalf of the Nursing Community and the RNs and APRNs we represent, thank you for the opportunity to comment. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com, AORN's Director of Government Affairs, Amy Hader Ahader@aorn.org, or Suzanne Miyamoto at 202-463-6930 ext. 247, smiyamoto@aacn.nche.edu.

Sincerely,

[3] IOM op. cit. p. 7-8.

Academy of Medical-Surgical Nurses
American Academy of Ambulatory Care Nursing
American Academy of Nurse Practitioners
American Academy of Nursing
American Assembly for Men in Nursing
American Association of Colleges of Nursing
American Association of Critical-Care Nurses
American Association of Nurse Anesthetists
American College of Nurse Practitioners
American College of Nurse-Midwives
American Nephrology Nurses' Association
American Organization of Nurse Executives
American Psychiatric Nurses Association
American Society for Pain Management Nursing
American Society of PeriAnesthesia Nurses
Asian American and Pacific Islander Nurses Association
Association of periOperative Registered Nurses
Association of Rehabilitation Nurses
Association of Women's Health, Obstetric and Neonatal Nurses
Dermatology Nurses' Association
Gerontological Advanced Practice Nurses Association
Hospice and Palliative Nurses Association
Infusion Nurses Society
International Association of Forensic Nurses
International Nurses Society on Addictions
International Society of Psychiatric Nursing
National American Arab Nurses Association
National Association of Clinical Nurse Specialists
National Association of Hispanic Nurses
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Black Nurses Association
National Coalition of Ethnic Minority Nurse Associations
National Gerontological Nursing Association
National Nursing Centers Consortium
National Organization of Nurse Practitioner Faculties
Nurses Organization of Veterans Affairs
Oncology Nursing Society
Preventive Cardiovascular Nurses Association
Public Health Nursing Section, American Public Health Association
Wound, Ostomy and Continence Nurses Society