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February 16, 2021

Dr. Jeffrey M. Zirger
Information Collection Review Office
Centers for Disease Control and Prevention
1600 Clifton Road NE, MS-D74
Atlanta, Georgia 30329

Reference: Non-Substantive Changes to Three Data Collections; Docket No. CDC-2020-0123; OMB Control Nos. 0920-0278, 0920-1015 and 0920-0212

Dear Dr. Zirger:

The Academy of Nutrition and Dietetics (the "Academy") appreciates the opportunity to submit these comments to the Centers for Disease Control and Prevention relative to its December 18, 2020 information request: *Non-Substantive Changes to Three Data Collections*. Representing more than 107,000 registered dietitian nutritionists (RDNs),[1] nutrition and dietetic technicians, registered, and advanced degree nutritionists, the Academy is the world's largest association of food and nutrition professionals and is committed to a vision of a world where all people thrive through the transformative power of food and nutrition. Every day our members provide medical nutrition therapy for patients in clinical settings across the continuum of care, often via telehealth, with the flexibilities necessary throughout the COVID-19 public health emergency.

The Academy supports this revision to the referenced information collections to facilitate understanding of the ability of facilities and providers to provide quality health care during the COVID-19 pandemic. We offer the below suggestions to enhance the utility of each information collection and especially to improve awareness of the importance of RDNs and medical nutrition therapy at all stages of the COVID-19 treatment process.

Specific Suggestions for Survey Questions
A. These suggestions apply to the National Ambulatory Medical Care Survey (NAMCS) traditional physician interview and community health center director interview.
1. During January and February of 2020, was your office's/center's use of or desired ability to use telemedicine or telehealth technologies with out-of-state patients impeded by state-mandated requirements for professional licensing?

2. After February 2020, was your office's/center's use of or desired ability to use telemedicine or telehealth technologies with out-of-state patients impeded to a greater or lesser extent than in the year prior?

[1] The Academy approved the optional use of the credential "registered dietitian nutritionist (RDN)" by "registered dietitians (RDs)" to more accurately convey who they are and what they do as the nation's food and nutrition experts. The RD and RDN credentials have identical meanings and legal trademark definitions.

3. Are your physicians (and other primary providers) aware of the relationship between chronic lifestyle conditions and COVID-19 morbidity?[2] Does your office/center refer patients to a registered dietitian nutritionist to provide medical nutrition therapy to address these chronic lifestyle conditions? Is your office/center more likely to do so given such evidence?

4. The Academy suggests considering the merits of adding the respondent's patient population to join a research cohort for further study and providing an opportunity for staff to assist in identifying data types to collect.

B. These suggestions apply to the National Electronic Health Records Survey (NEHRS)
1. During January and February of 2020, was your practice's use of or desired ability to use telemedicine or telehealth technologies with out-of-state patients impeded by state-mandated requirements for professional licensing?

2. After February 2020, was your practice's use of or desired ability to use telemedicine or telehealth technologies with out-of-state patients impeded to a greater or lesser extent than in the year prior?

3. The Academy suggests considering the merits of adding the respondent's patient population to join a research cohort for further study, and providing an opportunity for staff to assist in identifying data types to collect.

C. These suggestions apply to the National Hospital Care Survey (NHCS).
1. During January and February of 2020, was your office's/center's use of or desired ability to use telemedicine or telehealth technologies with out-of-state patients impeded by state-mandated requirements for professional licensing?

2. After February 2020, was your office's/center's use of or desired ability to use telemedicine or telehealth technologies with out-of-state patients impeded to a greater or lesser extent than in the year prior?

3. Are your physicians (and other primary providers) aware of the relationship between chronic lifestyle conditions and COVID-19 morbidity?[3] Does your office/center refer patients to a registered dietitian nutritionist to provide medical nutrition therapy to address these chronic lifestyle conditions? Is your office/center more likely to do so given such evidence?

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[2] Wang X, Fang X, Cai Z, Wu X, Gao X, Min J, Wang F. Comorbid Chronic Diseases and Acute Organ Injuries Are Strongly Correlated with Disease Severity and Mortality among COVID-19 Patients: A Systemic Review and Meta-Analysis. Research (Wash D C). 2020 Apr 19;2020:2402961. doi: 10.34133/2020/2402961. PMID: 32377638; PMCID: PMC7187729.
[3] Ibid.

4. Was your hospital adequately equipped to meet demand for tubing for enteral nutrition? As previously noted in a prior Academy comment to the CDC, "Tubing for enteral nutrition administration was in short supply even prior to COVID-19, and requires further modification to properly deliver formula and water flushes. These processes can directly impact tolerance of the formula as well as the staff time for administration to the resident. Because enteral feeding supplies and related tubing, pumps and various supplemental formulas directly impact patient care, the Academy recommends the adequacy of supply of these items be surveyed."[4]

5. Is your hospital providing (or referring to another provider for) post-discharge care to address potential long term effects of COVID-19 infection, as well as effects of hospitalization in general on long term nutrition status? This suggestion is based on the work of Krumholz, who details how hospitalization is itself a risk factor for a range of adverse health consequences, including malnutrition.[5] The author notes that the accumulated stress of hospitalization induces a post-hospital syndrome distinct from the original reason for admission and specifically notes that "physiological systems are impaired, physiological reserves are depleted and the body cannot effectively avoid or mitigate health threats."[6] The syndrome emerges during hospitalization due to poor sleep and nourishment, altered circadian rhythms, pain, medications that can alter mental and physical function, and deconditioning due to bed rest, the latter of which can lead to diminished capacity to fulfill post-discharge recommendations and perform ADLs.[7]

The Academy appreciates your consideration of our comment for the *Non-Substantive Changes to Three Data Collections* information collection. Please contact either Jeanne Blankenship at 312-899-1730 or by email at jblankenship@eatright.org or Mark Rifkin at 202-775-8277 ext. 6011 or by email at mrifkin@eatright.org with any questions or requests for additional information.

Sincerely,

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[4] "Academy Provides Feedback on COVID-19 Surveillance in Health Care Facilities." https://www.eatrightpro.org/-/media/eatrightpro-files/news-center/on-the-pulse/regulatorycomments/academy-comments-to-cdc-national-healthcare-safety-network-covid-module.pdf?la=en&hash=6456F234412E0FEDB5F57EEAD0655A50F5C931BD

[5] Krumholz, HM. Post-hospital syndrome--an acquired, transient condition of generalized risk. N Engl J Med. 2013 Jan 10;368(2):100-2.

[6] Ibid.

[7] Ibid.