Report of the 2014 Dialogue Forums
2014 Membership Assembly
June 13-14, 2014

Presented by: Susan Letvak, PhD, RN, FAAN
Chair, ANA Reference Committee

REVISED DIALOGUE FORUM RECOMMENDATIONS

REVISED Recommendations for Dialogue Forum #1

1. Support interprofessional education, practice, and research to promote the full scope of RN practice.
2. Encourage nursing research to compare full practice APRN authority states, transition to APRN practice states, and restricted APRN states.
3. Educate the public, policy makers, and other health professionals about emerging roles and overlapping responsibilities.
4. Support elimination of the requirements for APRNs to have practice agreements with physicians.

REVISED Recommendations for Dialogue Forum #2

1. Promote and support payment models to improve access to palliative and hospice care including nursing care provided by both RNs and APRNs.
2. Advocate for the comprehensive integration of palliative and hospice care education into basic and advanced nursing education and professional development programs.
3. Support the development and expansion of models of nursing care that include advanced care planning for early identification and support of patient preference for palliative and/or hospice services.

REVISED Recommendations for Dialogue Forum #3

1. Educate nurses about the application and impact of evolving patient-centered, team-based care models on patient outcomes.
2. Identify metrics that evaluate the impact of high performing, interdisciplinary health care teams on patient outcomes.

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Madam Chair and ANA Membership Assembly Representatives:

Dialogue Forum #1: Scope of Practice – Full Practice Authority for All RNs

The Dialogue Forum topic, *Scope of Practice – Full Practice Authority for All RNs*, was submitted by the South Carolina Nurses Association.

Issue Summary

As described in ANA's pillar documents, in order for the health care system to be completely optimized, RN's knowledge, skills, and abilities must be fully utilized. Consistent with the first recommendation of the 2010 Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health*, through a model of professional regulation, ANA advocates for and develops strategies that support and advance APRNs' abilities to practice to the full extent of their education, knowledge and professional and specialty nursing scope and standards of practice. Such efforts assume greater importance as ever evolving new categories of health care workers claim overlapping health care delivery responsibilities. ANA supports a flexible, rational health care system that encourages collaboration among health care team members, with an emphasis given to role clarity and accountability, and with appropriate education and training consistent with required competencies. This perspective fosters a patient-centered interprofessional team that communicates and collaborates for the provision of quality care.

Dialogue Forum #1 Participant Comments:

Q1: A number of states have passed APRN legislation mandating a time period of physician supervision before transitioning to full practice authority. What is happening in your state and how do you plan to address?

Current status:

- CT recent legislation is "3 years of written agreement with a physician then no more. The agreement is not supervision or a residency, it is an agreement to talk/review based on identified needs."

Current legislation:

- KS legislation includes a 2000 hours transition to practice requirement.
- MI legislation has 4 year "mentorship agreement" for new graduate CNSs, NPs, & CNMs.
- NJ legislation would remove written protocol requirements.

States planning 2015 legislation without transition period:

- FL is planning to reintroduce the same APRN legislation from 2014 legislative session.
- ID is seeking to expand access to care.
- MD legislation would remove physician attestation requirements.
- CO & NV legislation would remove current requirements for a transition period to full practice authority.
- WI is partnering with the hospital association.

States are planning 2015 legislation that would include a transition period:

- OH is considering 1500 clinical hours before prescriptive authority.
- MA "is considering a waiting period. Compromise is important."
- NE legislation includes 2000 hours supervision by MD or experienced APRN.
- TN is considering a requirement for supervision by experienced APRN.

APRN Transition:

- Concern was expressed that new graduate NPs have virtually no clinical experience.
- Any requirement should allow experienced APRNs to supervise new graduate APRNs.
- No written consensus on whether or not supervision should be required, whether by an APRN or a physician.
- Research is needed to compare full practice authority states, transition to practice states, and restricted states.

Q2: Identify 3-4 practice barriers for RNs, and if asked to rate, which would rank #1?

- Many comments reflected on educational preparation levels
    - ADN versus BSN
    - Inadequate preparation for entry into practice
- Lack of role clarity by RNs, patients and other health professionals.
- Lack of reimbursement for RN services.
- Superior-subordinate dichotomy instead of practice partnership.
- Telemedicine, national licensure, and national scope of practice were mentioned.

- Lack of sufficient staffing as a barrier to RN practice.
- Barriers are more restrictive at hospital/organization level.

Q3: With the evolution of existing health care roles, and the creation of new categories of health care workers, how can we move beyond "turf" battles?

- Nursing should support preparation of a workforce (including non-nurses) to care for an aging population.
- Promote interdisciplinary/interprofessional team-based care.
- Value all members of the health care team.
- Build alliances/coalitions.
- Establish criteria for scope of practice:
  - Clear definition of roles
    - What is it that only RNs can do?
  - Appropriate education
  - Accountability
- Interprofessional/interdisciplinary education and practice should:
  - Include simulation
  - Start early in education program
  - Be incorporated into RN and APRN curriculum
  - Involve multi-professional workgroups to address access to care
- Reframe the conversation:
  - Recognize that there is enough work for all
  - Articulate the full scope of RN practice
  - Shift the conversation to talk about the patient
  - Increase visibility of nurses as leaders of patient care teams
- Equity and parity between all health care professions needs to become the norm

The Reference Committee conducted the dialogue forum and reviewed participant verbal and written comments. Following careful consideration of these inputs, the Reference Committee agreed on the following recommendations for consideration by the Membership Assembly.

The Reference Committee recommends that ANA:

1. Explore issues surrounding transition to APRN practice.
2. Support interprofessional education, practice, and research to promote the full scope of RN practice.
3. Educate the public, policy makers, and other health professionals about emerging roles and overlapping responsibilities.

Background Document: *Scope of Practice – Full Practice Authority for All RNs*

Dialogue Forum #2: Integration of Palliative Care into Health Care Delivery Systems: Removing Barriers–Improving Access

The Dialogue Forum topic, *Integration of Palliative Care into Health Care Delivery Systems: Removing Barriers–Improving Access,* was submitted by the Ohio Nurses Association.

Issue Summary

Reform of Medicare benefits related to hospice coverage was proposed by the Ohio Nurses Association (ONA) Board of Directors to the ANA reference committee to be included in the June 2014 Membership Assembly Dialogue Forum related to an ONA member's personal experiences with lack of access to palliative and hospice care. Medicare coverage for hospice services and payment models have not been changed in over 30 years and do not reflect current recommendations for exemplary palliative and hospice care delivery models. While hospice and palliative care associations do support and lobby for changes that address these concerns, substantive change will require the efforts of many, working in partnership, to reform hospice and palliative care reimbursement mechanisms.

Dialogue Forum #2 Participant Comments:

Q1.A. In your state, what barriers to accessing hospice and/or palliative care are present across settings?

- Lack of education for nurses and health care providers.
- Lack of patient education/community outreach.
- Lack of qualified providers.
- Lack of hospital/health care organization based protocols and standards.
- Stringent requirements for reimbursement limits access.
- Perception by hospital administrators that hospice and palliative care result in increased cost and decreased return on investment for services.
- Cultural differences and attitudes to death and dying.
- Ethical and moral differences in approach to care versus cure.

Q1.B. What nursing led programs/processes have you seen to be or could be effective to alleviate some of the barriers to hospice and/or palliative care-please be specific.

- End of Life Nursing Education Consortium (ELNEC).
- Public service announcements.
- Presence of palliative care teams.
- Embed palliative care education/principles in primary care.
- Promote earlier access to care.
- Access to symptom management protocols.
- Faith-based and community outreach programs.
- Interprofessional team training.
- Engage the legal community to promote as part of advanced directive planning.

Q1.C. What do you believe is the top recommendation that ANA should consider related to this issue?

- Promote and support payment models to improve access to palliative and hospice care.
- Promote/support/sponsor legislative action to improve access for all to palliative and hospice services.
- Advocate for education and training for nurses-including comprehensive integration into academic nursing education programs (and as part of care coordination).
- Address scope of practice issues that prevent nurses from providing palliative care services.
- Identify/create quality nurse-led palliative care models.
- Work closely with Organizational Affiliates (e.g. HPNA), academia and other stakeholders such as AARP to plan and develop initiatives.
- Promote/support the development of standards and protocols.
- Develop educational materials such as webinars.

Q2.A. In your state, how are nurses currently prepared across educational levels to develop competence in providing palliative care to patients and their families?

- Limited formal academic preparation at the undergraduate level.
- Some continuing education.
- ELNEC.

Q2.B. What are your recommendations to promote the development and dissemination of educational programs and resources so that nurses achieve competence in providing palliative care?

- Web-based education.
- Journal articles.

- Increase community awareness.
- Education of faculty.
- Inclusion of palliative and hospice care didactic content for accreditation/certification of education and professional development.
- Hospital based programs for education, debriefing, opportunity for role-playing.
- Availability of ELNEC in all hospitals and healthcare settings.
- Develop competency in acute and long term care settings.

Q2.C. What do you believe is the top recommendation that ANA should consider related to this issue?

- Academic preparation and continuing education for nurses using a variety of methods and venues e.g. student clinical rotations, more defined format for coursework.
- Promote interprofessionl education and team work to achieve best patient care.
- Promote certification.
- Embed in professional practice models so it is not just a separate specialty.
- Include in NCLEX Exam.
- Education for patients/families through community outreach.
- Engage regulatory/accreditation bodies such as the American Nurses Credentialing Center (ANCC), The Joint Commission (TJC), and the Centers for Medicare and Medicaid (CMS) in discussions about adopting standards to include/enhance access for patients to palliative care.
- Monitor and disseminate research and evidence-based practice findings.
- Collaborate with schools of nursing to provide short term courses in palliative care.

The Reference Committee conducted the dialogue forum and reviewed participant verbal and written comments. Following careful consideration of these inputs, the Reference Committee agreed on the following recommendations for consideration by the Membership Assembly.

The Reference Committee recommends that ANA:

1. Promote and support payment models to improve access to palliative and hospice care.
2. Advocate for the comprehensive integration of palliative and hospice care education into basic and advanced nursing education and professional development programs.

Background Document: *Integration of Palliative Care into Health Care Delivery Systems: Removing Barriers–Improving Access*

Dialogue Forum #3: High-Performing Interprofessional Teams

The Dialogue Forum topic, *High-Performing Interprofessional Teams,* was submitted by ANA staff.

Issue Summary

The Institute of Medicine (IOM) identified multiple quality issues inherent in any care delivery model that does not include high performance teamwork. Outcomes include avoidable adverse events (e.g., avoidable hospital acquired conditions [HACs] and readmissions [RAs]) related to inadequate communication and handoffs, and the potential for duplication and waste resulting in higher health care costs (IOM, 2010). In an era of health care reform, organizations are beginning to implement interprofessional team-based care as a strategy to deliver high-quality care more effectively and efficiently. Interprofessional team-based care has been defined as "care delivered by intentionally created, usually relatively small work groups in health care, who are recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient or group of patients."

Dialogue Forum #3 Participant Comments:

Q1. What are the potential challenges associated with successful implementation of high performing interprofessional teams in the practice setting?

- Turf wars, egos, and lack of education on the importance of interprofessional education and care.
- Lack of knowledge of individual roles and responsibilities and lack of understanding of the culture and values of other professions.
- Lack of institutional buy-in and support of leaders. Difficult to change the current culture.
- Lack of integration of other nurse roles, other than APRNs.
- Lack of time (e.g. for rounds) and lack of resources.
- Lack of patient and family member awareness, preparation, and expectations related to interprofessional teams.
- Identifying and cutting down barriers between education and practice.
- Developing longitidual training experiences in order to promote sustained relationships.
- Difficulty incorporating into practice as schedules for different professionals vary.
- Logistical challenges for educational models (such as distance between schools, varying

curriculums).
- Funding and sustainability of programs.

Q2. How can ANA support nurses to further engage and assume roles to advance high performing interprofessional teams across care settings?

- Engage hospice and mental professionals for guidance as they have been using this model for 20-30 years.
- Collaborate with national associations and stakeholders beyond nursing (including AMA and AHA).
- Convene focus groups or group of stakeholders.
- Establish or disseminate an evidence-based model for interprofessional teams and seek ways to incorporate into curriculum in order to support early interprofessional education, include definition of roles. Emphasize patient-centered care and return on investment.
- Support multi-day training for faculty.
- Develop toolkits, training, and web-materials and/or compile and disseminate existing materials, including TEAM STEPPS.
- Develop innovative resources that incorporate interprofessional simulation and social interaction opportunities for acculturation.
- Write articles for ANA publications.
- Develop position statements and white papers.
- American Nurses Foundation grants to support interprofessional community teams.
- Incorporate into the content of the ANA Leadership Institute.
- Effectively advocate for the development and funding of future team-based metrics (ex. shared accountability with attribution).

The Reference Committee conducted the dialogue forum and reviewed participant verbal and written comments. Following careful consideration of these inputs, the Reference Committee agreed on the following recommendations for consideration by the Membership Assembly.

The Reference Committee recommends that ANA:

1. Educate nurses on the application and impact of evolving care models and measurement of high performing interprofessional teams on patient outcomes.

Background Document: *High-Performing Interprofessional Teams*