Report of the 2021 ANA Professional Policy Committee

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Chair, ANA Professional Policy Committee

President Grant and ANA Membership Assembly Representatives:

The ANA Professional Policy Committee convened four virtual Dialogue Forums. Dialogue Forum #1, Health Care Delivery Systems that Fully Incorporate Nursing Services, and #2, Precision Health and Genomics, were held on Tuesday, June 1, 2021. Dialogue Forum #3, APRN Full Practice in Nursing Homes, and #4, Lessons Learned: COVID-19 Pandemic Crisis Standards of Care, were held on Thursday, June 3, 2021.

One proposal was received for consideration as an emergent proposal prior to the deadline at 5:00 pm ET on Monday, June 7, 2021. The proposal, Recognizing Mary Eliza Mahoney during National Nurses Week/Month, was determined to not meet the criteria to be considered by the 2021 Membership Assembly. Specifically, per Section 4 of the Membership Assembly Policy Development Guide, the information contained in the submission was known prior to the submission deadline for 2021 Call for Proposals. The ANA Professional Policy Committee has communicated with the submitters and forwarded the proposal to the ANA Board of Directors for consideration prior to the board’s May 2022 meeting.

An online comment period focused on reviewing the recommendations following the Dialogue Forums was held from Wednesday, June 9, 2021, to 12:00pm ET, Monday, June 14, 2021. Nine (9) individuals submitted comments during this period.

Dialogue Forum #1 Health Care Delivery Systems that Fully Incorporate Nursing Services

This Dialogue Forum topic was submitted by ANA Board of Directors in 2020.

Issue Overview:
The ANA Board of Directors requests that the ANA Membership Assembly endorse universal health care coverage that assures access to comprehensive nursing services, incorporating appropriate reimbursement of all needed services and full practice authority for all nurses in the health care delivery system; therefore, rescinding its 1999 House of Delegates (HOD) approved policy endorsing single-payer as the most desirable option for financing a reformed health care system.

Regardless of how the health care system is financed (private payer, public option, single payer, payment based on quality, etc.), ANA needs flexibility to advocate for
equitable payment for nursing services and to allow nurses to practice at the top of their training, while also advocating for patient access to needed, quality care.

Summary of Dialogue Forum Discussion

- Overall, there was support for this recommendation.
- One commenter applauded ANA’s consideration of moving to this position, increased political awareness, and savvy. Single payer unlikely in the U.S.
- One commenter noted that we all want to have basic health costs covered by either single payer or universal care. How do we ensure that with universal care, competing insurance companies do not raise prices and cost limiting access? How will we avoid a multi-tiered system where the rich get better coverage?
- Another commenter noted that this is important so that we can be at the table regardless of who pays, to define “basic health rights for all.”
- One commenter reflected that ANA is challenged when restricted to speak to only one system. Removing restrictions allows access to discussion to the variety of systems.
- Another commenter referenced that the Future of Nursing 2030 report speaks to this issue regarding payment/reimbursement for nursing services and ensuring access, quality, and equity. This direction is in line with the National Academy of Medicine report.
- One commenter noted that “universal healthcare” is a term that is misunderstood given history. We are advocating for any system of health care coverage that is equitable and assures access to nursing services. Nomenclature that incorporates reimbursement for nurses etc. is important.
  - The submitters noted that the definition of universal healthcare included in the background document was the World Health Organizations definition: universal health coverage ensures that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship. The submitters noted that this was included for context and may change should this recommendation move forward.

Comment Period

- One commenter noted that while a single payer system was their preferred approach, they recognized that there is not wide-spread support for this financial approach; therefore, the commenter endorses the proposed recommendation. The commenter agreed with the recommendation of defining “universal healthcare.”
- Another commenter noted that “incorporating appropriate reimbursement of all needed services” should ensure that APRNs are reimbursed at 100% of the fee pay schedule.

- A commenter concurred with the recommendation noting that it provided ANA with more flexibility, supports ANA being at policy making tables, and was more in keeping with the political climate.

- Another commenter agreed with the recommendation but felt the use of the term “rescinding” is harsh. Would recommend a gentler term, such as “revision.”

- One commenter noted that it seems awkward trying to fit comprehensive nursing services into a position that is really trying to move from single payer to universal coverage. Nursing is in the draft position, but what universal coverage means is not. I do not support the recommendation without the WHO definition of "universal coverage" (universal health care coverage ensures that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship). ANA needs to stand strong for a reformed health care system that fulfills the WHO definition. To do less during this time of focus on equity and racism seems especially inappropriate.

Several people in the dialogue forum suggested a second position for the full incorporation of nursing services, which I agreed with. Perhaps, instead, a second paragraph about nursing services (I'm not all that fond of the term "nursing services". Isn't there another way of describing access to appropriate nursing care at every level, in every setting where healthcare is provided?)

- The Wisconsin Nurses Association support the recommendation as presented.

The Professional Policy Committee reflected on the comments made regarding the need to define the term universal health care coverage. The board included the World Health Organizations’ definition of universal coverage in the background document as context but noted an ongoing need for flexibility as this recommendation hopefully moves forward into implementation. The Committee is very sympathetic to both the attendees’ desire for a definition and the board’s desire for flexibility. The Professional Policy Committee chose not to include the WHO definition in the recommendation; however, it strongly urges the ANA Board of Directors to quickly establish a definition of “universal health care coverage.”

**RECOMMENDATION:**

1. ANA adopts the position to:
   
   Endorse universal health care coverage that assures equitable access to comprehensive nursing services, incorporating appropriate reimbursement of all needed services and full practice authority for all nurses in the health care delivery system; therefore,
rescinding its 1999 House of Delegates approved policy endorsing single-payer as the most desirable option for financing a reformed health care system.

Background Document: Health Care Delivery Systems that Fully Incorporate Nursing Services

Dialogue Forum #2: Precision Health and Genomics
This Dialogue Forum topic was submitted by Kathleen Calzone, PhD, RN, AGN-BC, FAAN, Maryland Nurses Association; Laurie Badzek, LLM, JD, MS, RN, FAAN, Pennsylvania State Nurses Association; and Mary Anne Schultz, PhD, MBA, MSN, RN and Evangeline Fagonil-Gagalang, PhD, MSN, RN, ANA\California. This proposal was submitted in 2020.

Issue Overview
Genomics is the entire set of genetic instructions found in a cell, including their interactions with each other, the environment, and the influence of other psychosocial and cultural factors. Precision Health is an approach to wellness which is underpinned by genomics and is respectful of individual lifestyle, behaviors and environmental contexts of our uniqueness. Precision Health and Genomics (PH&G) can increase therapeutic efficacy, safety, quality, and reduce healthcare costs. As these are clinically relevant throughout the entire healthcare continuum from before birth to after death has implications for the entire nursing profession regardless of level of academic training, role, or clinical specialty. There exists confusion amongst providers and their organizations as to implications of PH&G and as a result there is no consensus or direction from national provider organizations including nursing societies. Nursing, as the most trusted healthcare provider has both a clinical, moral, and ethical obligation to establish a multi-faceted initiative to overcome organizational and nursing practice deficits in PH&G. Therefore, these phenomena are deserving of the time, attention, and resources of our nation’s largest, and arguably, most influential, provider organization--the American Nurses Association.

Summary of Dialogue Forum Discussion
- Attendees voiced support for this report and recommendations.
- Several attendees acknowledged a lack of awareness of this science and the potential impact on healthcare.
- One commenter noted that this is an essential topic, and it is imperative we are proactive as opposed to being reactive to genomics and impact on healthcare.
- One concern raised was the potential for racial and social inequities as it pertains to precision health services. Often these services are for insured individuals. As we look to
advance this incredible practice, we must continue the conversation and efforts to include vulnerable populations and reflect on the social determinants of health.

- The submitters noted that the underserved and vulnerable populations are a focus for large National Institutes of Health study, All of Us Research Program.

- Several attendees spoke to personal and professional experiences where Precision Health/Genomics are informing treatment and ongoing therapeutic interventions.

- It was also noted that targeted testing and therapies resulting from Precision Health/Genomics can reduce the cost of health care.

- When developing basic level competencies, it was recommended to include education to guide patients about differences in testing and limits of testing including privacy issues. Commenters recounted their professional experience “When I run metabolic genetic testing, I often have patients asking if this test will tell them if they will get cancer or dementia in the future or whether “the government” will have their DNA information on file after running the test. I think it’s important to educate nurses about testing available and differences in what we test for so that the information can be shared with patients.”

- Several commenters referenced the need to make sure that we consider ethics and privacy issues.

- Will need guidance for integrating this content into curriculum.

**Comment Period**

- One commenter agreed with the proposed recommendations but would suggest that any competencies and/or teaching materials consider this healthcare technology through a cost/benefit lens. My prior perspective was that this type of technology was extremely costly and therefore would be limited to individuals with very comprehensive health insurance coverage. If you factor in improved quality of care by delivering the right doses of medications initially, then perhaps this becomes less of an impediment to broader acceptance.

- Another commenter agreed with the five recommendations, noting that the first three will be easier to implement and #4 and #5 are longer term and challenging to execute.

- Another commenter noted that ethics and data security are important to consider in these recommendations. This topic would also work well for research projects and expand nursing knowledge, skills and attitudes.

- One commenter noted that inter-professional education about PH & G that does not make it into the report. It seems this could lead to a 6th bullet to explore avenues for inter-professional education. This is a practical suggestion since other professions may
be further ahead of nursing in this issue and the practice of PH&G would certainly be an
inter-professional practice.

- ANA’s Individual Member Division supports the recommendations.
- The Wisconsin Nurses Association support the revised recommendations are presented.
- Thank you for the opportunity to comment on the Precision Health and Genomics
  (PH&G) dialogue forum. It is understood from the background documents that ethics is
  an essential and foundational element of PH&G work. Additionally, ethics and privacy
  issues were mentioned in the live discussion on June 1st. Since the proposed
  recommendations are not exhaustive, it may be helpful to consider a statement that is
  explicit to message a firm grounding of this work in an ethics, privacy, and security
  framework. Thank you, again, for this work to elevate the practice of nursing and
  improve the health of individuals.

RECOMMENDATIONS:

1. ANA launch a strategic initiative to integrate Precision Health and Genomics (PH&G) into
   basic and advanced nursing practice. This would include but not be limited to:
   a. Recognizing a framework grounded in ethics, privacy, security, and cost-
      effectiveness.
   b. Establishing entry level and advanced nursing competencies for Precision Health
      that will inform policy and practice recommendations.
   c. Updating the Genomic Nursing Competencies for Nurses with Graduate Degrees
      (the basic Genetic and Genomic Nursing Competencies [2006] are in the final
      phases of updating).
   d. Integrating the PH&G competencies into all nursing scopes and standards of
      practice inclusive of practice specialties.
   e. Assessing the state of PH&G Nursing capacity in the existing nursing workforce to
      inform an education initiative and provide the basis by which to measure
      outcomes.
   f. Addressing deficits in nursing knowledge, skills, and attitudes (KSAs) uncovered
      in the PH&G nursing capacity assessment. This should include demonstration
      projects leading to evidence-based best practices underpinned by policy.
   g. Promoting intra-professional education and collaboration for the advancement
      of this knowledge and practice.

Background Document: Precision Health and Genomics
Dialogue Forum #3: APRN Full Practice in Nursing Homes

This Dialogue Forum topic was submitted by Marilyn Rantz, RN, PhD, FAAN and Lori Popejoy, RN, PhD, FAAN, both members of the Missouri Nurses Association.

Issue Overview

Nursing homes are in desperate need of transformation. APRNs working in nursing homes can tip the scales to transform critical systems of care in nursing homes so residents can get timely early illness recognition and management. There are current restrictions on APRN practice in nursing homes that need to be removed so they can be hired directly by nursing homes and also bill Medicare for care services that are billable under Medicare. Currently, physicians CAN be hired directly by nursing homes AND also bill Medicare for the care services they provide to the nursing home residents. However, APRNs are RESTRICTED from doing the same. This is an old, overlooked restriction that must be removed so that nursing home residents have unrestricted access to APRN care.

Summary of Dialogue Forum Discussions

- Attendees expressed significant support for this report and the proposed recommendation.
- There were several comments reflecting on the need to continue to advocate for full practice authority for APRNs to increase access to care and promote quality.
- There was some discussion related to the use of unlicensed personnel to provide medications in long term care facilities. The Professional Policy Committee considered this issue to be outside the purview of the initial policy submission.
- Several attendees raised questions and concerns about the proposed language included in Appendix 1. *Recommended Changes in Social Security Act 42 U.S.C. and Related Federal Regulations in CFR x483.40 for Access to Advanced Practice Registered Nurses (APRNs) for Nursing Facility Residents* (pg. 8 – 1396r (b)(6)(A)-(B)). This language speaks to requirements for collaboration or supervision with physicians and runs counter to existing requirements in states where APRNs have full practice authority.
- An attendee also suggested another approach could be a state-level opt out, like the opt out of physician anesthesia care. It was noted that in 2001, CMS changed the federal physician supervision rule for nurse anesthetists to allow state governors to opt out of the facility reimbursement requirements.
- It was noted that this change could have a significant, positive impact on access to care for critical access rural communities.
- It was also suggested that consideration be given to addressing the requirement that the medical director must be a physician.
As a result of comments noted on lines 163-172, the Professional Policy Committee revised the original recommendation to address the policy change being sought as opposed to the specific proposed language included in Appendix 1.

Initial recommendation proposed by submitters:

Advocate for the inclusion of the language “including those employed by the facility” when referring to an APRN working within a nursing home within CFR x483.40.

Appendix 1 outlines the recommended changes developed by faculty of the University of Missouri School of Law and is provided to assist in locating the language needing to be changed. Suggested wording is provided.

Comment Period:

- ANA’s Individual Member Division (IMD) submits a comment noting that in order for the IMD to support the PPC Recommendation for Dialogue Forum #3: APRN Full Practice in Nursing Homes, the IMD respectfully requests that the recommendation be revised so that it reads: "The American Nurses Association advocates for change(s) in the Social Security Act and related Federal Regulations that would authorize the compensation of Advanced Practice Registered Nurses (APRNs) employed directly by skilled nursing facilities for Medicare-billable services they provide to nursing home residents."

- The Wisconsin Nurses Association support the revised recommendations as presented.

- Should consider allowing APRNs to serve as the medical directors of adult care homes. This would require ANA to continue to advocate for removal of barriers to care that APRNs face, such as removing the permission slip/collaborative practice agreement requirement.

  It should be stated that APRN’s should be allowed to receive the same reimbursement rate that a physician receives.

- I am fully in support of this initiative but wanted to suggest the following: If ANA is going to advocate for changes to CFR x483.40, perhaps we can also address a long standing problem with CFR x483.152, which relates to "Requirements for approval of a nurse aide training and competency evaluation program." This section requires that RN’s seeking to be instructors for nursing assistant training programs must have one-year clinical experience in the long-term care setting. Section 5 (i) reads: "at least 1 year of which must be in the provision of long-term care facility services." This is an antiquated provision and severely limits the number of RNs who can qualify to teach in nurse aid training programs. NHNA tried to address this issue in 2019/2020 but efforts were sidelined due to the COVID-19 pandemic and limited resources of a small C/SNA. Lack of clinical instructors has limited the pipeline for new certified and/or licensed nursing assistants to support RNs and impact instruction programs all around the country.
• I concur with the revised recommendation from the ANA PPC. Our country and our nursing home residents desperately need this legislation NOW!

• ANA’s Department of Policy and Government Affairs noted that the proposed change regarding employment of APRNs and the ability to bill may be more appropriate for Medicaid regulation, as opposed to Medicare. Applying the language of the proposed resolution for Medicare SNF’s may require a statutory change in addition to the proposed regulatory changes. Policy/GOVA’s recommendation is to advance a resolution that states the general goal of removing barriers to practice in Medicare and Medicaid long-term services and support (including home and community-based care). Implementation of the current resolution or alternative could include development of a position statement that clarifies policy options.

**REVISED RECOMMENDATION proposed by the Professional Policy Committee:**

1. The American Nurses Association advocate for changes that would authorize APRNs to directly bill for services provided for skilled nursing care, long-term care, and home and community-based care, including those services provided as an employee.

**Background Document:** [APRN Full Practice in Nursing Homes](#)

**Dialogue Forum #4: Lessons Learned: COVID-19 Pandemic Crisis Standards of Care**

This Dialogue Forum topic was prepared by the Professional Policy Committee.

No recommendations were proposed by the Professional Policy Committee in advance of the Dialogue Forum. In this report, the Professional Policy Committee proposes two recommendations for consideration during the online comment period.

**Issue Overview**

One of the greatest challenges encountered during the COVID-19 pandemic was initiating a uniform, well-understood crisis standard of care when there were not sufficient resources, either human or material, to meet patient care needs. While this is likely inevitable in future events, particularly during a large-scale event of long duration, there are strategies that can and should be implemented to mitigate the overall impact. The focus of this Dialogue Forum is to receive feedback to inform ANA moving forward.

**Summary of the Dialogue Forum Discussion:**

• There were multiple references to the need for education, for both students and as professional development, based on identified competencies to support future response
to disasters and pandemics. The profession needs all nurses to understand basic emergency response principles.

- Consider using FEMA coursework and the American Red Cross education modules.
- It would be helpful to have a uniform protocol/policy allowing upper-level student nurses or new nurse graduates before licensure to do some limited pandemic response tasks such as vaccination without faculty supervision.
- Would have been good to have “virtual touch bases” to share learnings in real time when there was little to no guidance.
- All nurses need to engage in personal and professional preparation for responding to a disaster.

- Several attendees spoke to the negative impact that the lack of trust on government and health care institutions had on the overall response and support for public health mitigation measures.

- Work environment issues raised:
  - Lack of staffing and in states with staffing committees the ability of facilities to put on hold staffing committee recommendations due to “emergency conditions.”
    - Hospitals have hired many high paid travel nurses to fix staffing holes. There are pros and cons to this. It is helping staffing, but some travel nurses are not motivated to learn hospital policies or get to know staff members which is harmful to patient care and unit cohesion.
  - Cross-training and the challenges of using non-ICU nurses in the ICU setting. Despite training and education, the staff were not confident on how to provide care.
  - Need more training about the movement into team-based models to delivering care during resource constraints.
  - Community plan to share staff from one hospital to another.
  - How to move staff from one state to another – we benefitted from outside nurses coming into our state in the beginning.

- Sufficient supplies of equipment:
  - Significant challenges with personal protective equipment (PPE), including re-use and decontamination.
  - There was PPE shortages in pandemic designated- and non-designated units; these challenges extended to supply chain issues contributing to access issues and increase purchasing costs. Highlighted was the need for entities outside of
the hospital system (primary care, remote, ACS) to have a connection to needed resources (PPE, vaccines, etc.).

- Need to look at policies related to national stockpile.
- There were facilities "with resources" and those "without", challenges with regard to equitably access – in the beginning there was some hording, then there was sharing, and then there was hoarding again.
- Facility policies associated with how and when PPE could be accessed by employees.
- Nurses were to speak up on PPE access. There was a disconnect to what leaders said was available versus what nurses reported.

- Multiple commenters spoke to ongoing concerns about the mental health issues that nurses are currently experiencing and likely to experience into the future as a result of dealing with the pandemic.
  - Nurse-to-nurse sharing was critical.
  - Nurses are exhausted.
  - We have wonderful resources for self-care, but we cannot keep up the needed pace to continue with long-term disaster situations.

- One commenter noted that “crisis” standards of care seem to be for relatively short-term/emergencies, not weeks or months long emergent circumstances. There are significant qualitative and quantitative differences between the aftermath of a hurricane or tornado and the constant assault of a pandemic.
- It was also noted that state-level committees found that health systems that are generally in competition had a hard time working collaboratively to the detriment of decision-making. Nurses felt that sometimes the conversations were “too politically correct” and that they, as nurses, needed to become more forthright.
- One commenter noted that findings from a survey on crisis standards of care found that 45% of the participants responded that they did not know if their crisis standards of care were up to date. Another interesting point was that 32% indicated that healthcare facilities did not actively communicate crisis standards of care guidance within their communities. Clear guidance on how to inform the staff and community about crisis standards of care needs to be part of developing future policy.
  - Did not know where to find the crisis standard of care plan.
- Consider a policy of presumption that nurses working clinically that acquire COVID were infected because of their work and also address financial compensation.
- Need to advocate for all nurses and caregivers across all areas. Hospice and other specialty areas were excluded from PPE allocations and were not included in waivers from CMS until much later in the year.
• It is important for everyone to also know and understand when it is time to return to the “normal standard.”

• Need to leverage the Code of Ethics for Nurses to underscore our obligation to protect ourselves and each other, our family members, and our patients from spread of infectious disease.

• Consideration needs to be given to how we will reintegrate patients back into the healthcare system. Our EDs are full and hospital census is at capacity and capability as we see those who did not receive care during the pandemic – these are sick patients. “Getting back to normal” does not look “normal” at all.

• Liability protections when there are changes in the standard of care.

Comment Period:

• During the pandemic, many Crisis Standards of Care (CSC) were activated, in whole or in part, in states around the country. To ensure that a comprehensive understanding of the impact these CSCs had on care delivery, ANA should reach out to states which activated their CSC during the pandemic to explore some of their lessons learned. I recently attended a Project Echo for Emergency Care Providers to discuss their perspectives on CSC and how they were implemented within their organizations. As part of this Project Echo, a brief survey was conducted to see how CSC were perceived and how they impacted patient care. The results of this real-time survey were interesting. ANA could consider a similar approach for nurses, particularly those working in the ICU caring for COVID patients. Some of the questions that could be asked are: Did your organization implement CSC? In what areas were they implemented (vents, O2, medications, etc.)? Do you know the ethical underpinnings of your organization’s CSC? Do you know how these underpinning relate to the Code of Ethics for Nurses?

• Concur with the recommendations from the ANA PPC.

• The discussion of this topic was very broad - not sure how the ANA Board would prioritize. Would suggest looking at the proposed National Coronavirus Commission Act of 2021 to help with focus, with emphasis on these areas: 1. the preparedness and response of specific types of institutions that experienced high rates of COVID-19, including hospitals, SNFs, assisted living and LTC; prisons, jails and immigration detention centers; elementary and secondary schools 2. management, allocation, and distribution of relevant resources including PPE, testing supplies and other medical equipment. And, of course, advocacy for nurses at all levels in all practice settings, including mental health care and COVID long haulers.

• The Wisconsin Nurses Association support the recommendations as presented.
Proposed recommendations from the Professional Policy Committee:

1. ANA report back to the 2022 Membership Assembly on actions taken to further address crisis standards of care and advance the preparation of nurses and the profession to respond to future disasters and pandemics.

2. C/SNAs consider the information contained in the Committee’s report and encourage the LCEC to coordinate the sharing of innovations, best practices and lessons learned and request that the LCEC report back to the 2022 Membership Assembly on efforts at the state level to advance preparation for responding to disasters and pandemics.

Background Document: Lessons Learned: COVID-19 Pandemic Crisis Standards of Care