Meetings of the 2021 ANA Membership Assembly were held virtually, during the first three weeks of June. Intrepid MNORN Representatives Heidi Orstad, Sara McCumber, and Kelli Greder, along with alternate Molly Maxwell and ED, Kathi Koehn, rearranged their schedules to attend Dialogue Forums; Candidate Forums; Hill Briefings and Visits; ANA-PAC events; an update on the National Commission to Study Racism in Nursing; an ANA Open Board Meeting and the actual (virtual) Membership Assembly. It was a month packed full of information, deliberation and decisions. This newsletter is intended to give you a sample of what was discussed and decided by this year's Membership Assembly, the governing and official voting body of the American Nurses Association.

A reminder of the role of Membership Assembly. It functions to identify and discusses issues of concern to members and provide direction to the ANA Board of Directors. It is also the body that elects the ANA Board and the members of the Nominations and Elections Committee.

One of the key responsibilities of the ANA Membership Assembly is to determine policy and positions for the Association. The meeting of the ANA Membership Assembly provides a forum for discussion of critical nursing practice and policy issues and input from a broad cross section of nursing leaders.

The ANA Membership Assembly is comprised of ANA members who are representatives from ANA's constituent member organizations (C/SNAs), Individual Member Division(IMD), affiliated organizations, or members of the ANA Board of Directors.

While the meetings were robust and meaningful this year, we have every hope that next year will find us in Washington DC, meeting in-person, during one week in June, rather than several weeks as we did it this year!

A special shout-out to MNORN member Mary Tanner, who ran for the Nominations and Elections Committee. While her campaign was not successful, she did MNORN proud with her candidacy!

Included in this report are the following:

- Minnesota nurses remembered in the 2021 Nightingale Tribute
- 2021 Hill Briefing and Day on the Hill
- Report of the National Commission to Address Racism in Nursing
- Report on the 2021 Dialogue Forums
- Results of the 2021 ANA Elections

Nightingale Tribute: Nurses in Memoriam

On the Saturday morning of June 23, 2005, a meeting of the 2005 House of Delegates sanctioned the Nightingale Tribute as a way of honoring nurses at the end of their life's journey. With the consent of the house, ANA adopted this tribute as its official ceremony for honoring nurses who are no longer with us.

ANA has thus instituted a "Nurses in Memoriam" book, which is displayed at ANA Headquarters.

At every ANA Membership Assembly there is a white rose and white candle placed before the dais. It is the custom, approved by the 2005 house that anytime the Membership Assembly is in session, the white candle will be lit and will remain lit until the house adjourns.

She/He Was There

When a calming, quiet presence was all that was needed,
She/he was there.
In the excitement and miracle of birth or in the mystery and loss of life, She was there.
When a silent glance could uplift a patient, family member or friend, She was there.
At those times when the unexplainable needed to be explained,
She was there.
When the situation demanded a swift foot and sharp mind,
She was there.
When a gentle touch, a firm push, or an encouraging word was needed, She was there.
In choosing the best one from a family's "Thank You" box of chocolates,
She was there.
To witness humanity–its beauty, in good times and bad, without judgment,
She was there.
To embrace the woes of the world, willingly, and offer hope,
She was there
And now, that it is time to be at the Greater One's side,
She is there.
Our colleagues, we honor you this day and present this white rose and light this candle to symbolize our honor and appreciation for being our nurse colleagues.

By Duane Jaeger MSN, RN

Nurses remembered from Minnesota are:

Betty Ann Honermann, Colin Jame Mulcahy, Corin Helgeson-Selman, Dana Beckenbaugh, Donna M. Hanson, Dorothy M. Berg, Elizabeth Truitt, Hazel R. Scheitel, Irene Weis, Janet Ford, Jean Mary Rauk, Joan (Judy) Podolske, Joanne Evelyn Larsen, John B. Mestad, Judith Giababazi, Judith K. Kramer, Judith Kulas, Judith Maire Priniski, Karen Ann Spaulding, Karen Fryer, Kathleen Louise Brandenburg, Kathryn T. Mewhorter, Leona Klassen, Linda Marie Squires, Lois Wendorf, Lucy Schwartz Sontag, Lynn Nomann, Margaret J. Lawler, Martha Kamin, Marty Plombon, Mary Nielsen Smith, Monica Rene Lindgren, Pat McAllister Oja, Rose Maire Bayuk, Sister Charlotte Dusbabek, Veronica L. "Bonnie" Mudge, and Vicki Schroeder

These nurses were colleagues, mentors, and friends. Some had finished long careers in nursing, Unfortunately, others had just begun their careers in our profession. Their obituaries are filled with joy and creativity and sadness. Here are exerts from a few of the nurses' obituaries.

- *Monica Rene Lindgren was a devoted nurse for 44 years, working at Mayo, then Fairview Ridges Hospitals. "Our mother was enchanting and wise. She loved music, dancing, singing, cooking, gardening, shopping, and spending time with her grandchildren…. our mother was a healer, a lover of truth, justice and words."*

- *Sister Charlotte Dusbabek was instrumental in contributing toward the advancement of health care during the forty years she was on staff at Saint Marys Hospital. She became the trainer of cardiopulmonary resuscitation technique, organized the first classes in cardiac defibrillation, developed Saint Marys first critical care nurse training program and was head nurse in the first Medical Intensive Care Unit. She also served as a staff nurse, head nurse, psychiatry and cardiovascular in-service instructor. Sister Charlotte also served as an administrative assistant, responsible for coordinating a Nurse Productivity and Quality program for Nursing Service. She retired from nursing at Saint Marys in 1995 and immediately began visiting patients at the Hospital as well as working to donate left over food to nonprofit shelters in Rochester. In 2011, she was the recipient of the Mayo Excellence Award for Community Caring. She believed in giving compassionately in everything she did.*

- *Linda Marie Squires spent her life caring for people professionally and personally. She started her career as a surgical nurse at the Mayo Clinic, moving on to director of nurses at the Plainview nursing home, and finished her career working for the state of Minnesota Health Department in the survey and compliance division.*

- *Rose Marie Bayuk graduated as an RN in 1938, ranking second in her class. Both the Mayo Brothers (William and Charles) signed her diploma. Rose then returned home to Buhl and a position at the new Virginia Hospital. Two years later, she took a friend's advice and traveled by car to California and took a position at the Glendale Research Hospital, where she stayed until returning to Buhl after the Pearl Harbor bombing. On Nov. 3, 1942, Rose and her sister, Patricia, enlisted together in the Army Nurse Corps. Her first duty station was the converted British liner Queen Elizabeth; followed by serving primarily as a Ward Charge Nurse (in a complement of 35 nurses) aboard the USAHS Thistle, a 455-bed converted cargo and passenger ship, Army controlled, but Merchant Marine commanded and operated. During Rose's tour of duty, the Thistle made 11 transatlantic round trips. After the European War ended, the ship deployed via the Panama Canal to the Philippines, where it provided hospital services until returning to the United States long after V-J Day. 1st Lt. Rose Bayuk's wartime awards and decorations include: American Campaign Medal; European-African-Middle East Campaign Medal with 3 stars (Southern France, Rhineland, and Rome-Arno Campaigns); Asia-Pacific Campaign Medal with 4 Overseas Bars; World War II Victory Medal. (Most recently in 2020, the National World War II Museum in New Orleans selected Rose to receive its Silver Service Medallion, the first nurse to receive this award.*

- *Colin James Mulcahy, 27, died unexpectedly on February 25, 2021 in Saint Paul. From the beginning, Colin lived life to the rhythm of his own skateboard wheels. Born August 28, 1993 in Eau Claire Wisconsin, he grew up in a large, loving, rambunctious family with five human siblings and many furry ones. Colin attended St. Jude of the Lake Elementary School, Mahtomedi High School, Century College, and the College of St. Scholastica; he became a registered nurse in 2017 and worked in a trauma unit at Regions Hospital. His ability to work with patients, particularly the elderly, was not a learned skill; it was a gift. If you'd like to honor Colin and his life: hug your loved ones and tell them how you feel about them. Be proud of yourself and your accomplishments. Spread laughter, fun, and sometimes good-natured confusion and wackiness. Be brave, dream big, and do scary things - like trying out parasailing the day before your brother's wedding, or like having the courage and grit to go back to school and start again. Spend time with friends and hobbies that bring you joy. Live big and tend to your mental health. Don't let the darkness take you. Live your life like a skateboarding raccoon with a jetpack.*

2021 Hill Briefing and Day on the Hill (Virtual)

Unfortunately, this year our Hill Day visits were done virtually, through the "magic" of Zoom. Not quite the same as searching/and finding the offices of our members of Congress, but actually, as far as advocacy goes, was quite effective.

Our intrepid Hill Day participants were Heidi Orstad, Sara McCumber, Kelli Greder and Kathi Koehn. We made visits to the offices of Senators Amy Klobuchar and Tina Smith and Representatives Angie Craig and Tom Emmer.

Prior to our day of advocacy, we attended the ANA Hill Day Briefing. There were over 500 registrants for this meeting. We heard remarks from Rep. Rodney Davis (R-IL), who is vice co-chair of the Congressional Nurse Caucus. He also has the distinction of having a wife who is a nurse!

The following are the Bills we discussed with our Members of Congress.

PPE In America Act (S. 308/H.R. 1436)

The Protecting Providers Everywhere in America (PPE in America) Act is bipartisan, bicameral legislation that will boost domestic personal protection equipment (PPE) production and promote a more sustainable supply chain by ensuring more predictable, dedicated funding from the Strategic National Stockpile (SNS) to American manufacturers of applicable medical supplies.

Lack of PPE and the extended reuse of PPE has been the most common complaint from nurses and other frontline health care providers since the beginning of the pandemic. ANA has conducted several surveys since the beginning of the pandemic. One conducted in February 2021, with more than 22,000 nurses responding, 81 percent of nurses reported still having to reuse N95 respirators in their facilities.

Even before the COVID-19 pandemic, China already dominated the global market in manufacturing of PPE by exporting more respirators, surgical masks, medical goggles, and protective garments than the rest of the world combined and has only increased since. Bringing manufacturing of PPE back to the United States will help ensure our frontline health care providers will not be put in the same deadly situation for the next pandemic.

Specifically, the PPE in America Act would authorize a pilot project at the Department of Health and Human Services that would:
Boost domestic PPE and production by requiring at least 40 percent, and up to 100 percent, of applicable supplies procured by the SNS to be from domestic manufacturers;
Support predictability for the domestic manufacturing base by establishing a replenishable mechanism for the SNS by routinely transferring supplies to federal agencies or selling to the commercial health care market. This arrangement would streamline management of supplies and use the SNS as an engine for domestic manufacturing capabilities, while mitigating the current risk of product expiration.

HHS must report on its efforts to maintain the stockpile's inventory of testing supplies and personal protective equipment.

The following organizations have endorsed the legislation: American Hospital Association, International Safety Equipment Association, Illinois Nurses Association, Illinois Health and Hospital Association.

CONNECT for Health Act (S. 1512/H.R. 2903) (Senators Klobuchar/Smith co-sponsors)

The Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act is bipartisan, bicameral legislation that would continue the expanded use of telehealth services to deliver cost effective and efficient care to patients.

Nurses work in a variety of health care settings in rural, urban, underserved, and appointment shortage areas. Nurses are highly trained and well-educated to effectively use telehealth technologies, supervise remote patient monitoring activities, and provide quality care using tools that promote access to timely care without the barriers often existing in remote geographic locations or appointment shortage areas. The opportunities that telehealth technologies can provide are limitless and witnessing the expanded access to care has been inspiring and imperative to patients, caregivers, and providers alike during the COVID-19 pandemic. The diversity of geographic regions, social determinants of health, and challenges to accessing quality care can create unnecessary barriers to individual and population health; however, technology can bridge the gap between these divides if implemented equitably across communities. The urban and rural divide is just one area that we can close using telehealth through access to diverse providers across the country that meet the needs of patients and their families.

Provisions of the CONNECT for Health Act that ANA supports for immediate passage:
Waive restrictions during national emergencies;
Remove the Medicare originating site and rural area restrictions;

Allow telehealth to be used to re-certify patients as eligible for hospice benefits;
Work to prevent telehealth fraud and abuse;
Permanently allows Federally Qualified Health Centers and Rural Health Clinics to furnish telehealth services as distant site providers;
Requires a study on telehealth utilization during the COVID-19 pandemic; and
Requires an analysis of the impact of telehealth waivers in CMS Innovation Center models.
The future of care delivery involves a hybrid approach of in-person and virtual methods to meet the patients needs. Building on the foundation already set through the Medicare and Medicaid programs will allow a glide path forward for public and private payers alike. The CONNECT for Health Act is endorsed by over 150 organizations. Please ask your Member of Congress and Senators to cosponsor this important legislation so we can expand access to telehealth services on a permanent basis.
This legislation is sponsored by Senators Brian Schatz (D-HI) and Roger Wicker (R-MS) and Representatives Mike Thompson (D-CA-5th) and David Schweikert (R-AZ-6th).

The Workplace Violence Prevention for Health Care and Social Services Workers Act (S. xxx / H.R. 1195) (Representatives Craig, McCollum, Omar, Stauber)

The Workplace Violence Prevention for Health Care and Social Service Workers Act requires the U.S. Department of Labor to establish needed protections from workplace violence in the health care and social services sectors. The legislation directs the Occupational Safety and Health Administration (OSHA) to issue a standard requiring health care and social service employers to develop and implement a comprehensive violence prevention plan tailored to the facility and services with the intention to protect employees from risks of violent incidents in the workplace.

Employers must:
Identify potential risks and hazards to mitigate future incidents;
Provide training and education to employees on potential risks, workplace control measures, and reporting;
Investigate incidents as soon as practicable;
Meet record-keeping requirements; and
Protect employees from acts of discrimination or retaliation for reporting incidents of violence, threats, or safety concerns.

The Workplace Violence Prevention for Health Care and Social Service Workers Act protects nurses. The rate of violence against health care workers has reached epidemic proportions. The Government Accountability Office (GAO) estimates that rates of workplace violence in health care and social assistance settings are 5-12 times higher than the estimated rates for workers overall. As many as one in four nurses may experience some form of violence on the job. However, nurse abuse is under-reported. Therefore, reliable data about incidence are

not readily available to describe the magnitude of the risks and threats. Nonetheless, many policymakers are health care stakeholders and recognize the need to prioritize violence prevention in settings where care is provided.

Thank you to the members in the House of Representatives who voted in support of this critical legislation earlier this year. Please urge your Senators to cosponsor this legislation when it is introduced. This legislation is one step closer to being signed into law because of you. Safe work environments and quality care are not mutually exclusive; both must be considered in order to promote positive health outcomes for patients and communities.

FACTS AT A GLANCE
Violence in health care settings can result in personal injury and lost time at work.
Further, multiple studies have shown that workplace violence can adversely affect the quality of patient care and care outcomes, contribute to the development of psychological conditions, and reduce the nurse's level of job satisfaction and organizational commitment.

OSHA currently has no specific standard to address risks of workplace violence that nurses face every day on the job. H.R. 1195 will engage stakeholders and lead to stronger enforcement. OSHA currently lacks meaningful authority that can hold health care employers accountable for mitigating risks of violence in the workplace.

Dr. Lorna Breen Health Care Provider Protection Act (S 610, HR 1667) (Senators Klobuchar, Smith co-sponsors; Representatives McCullum, Omar, Emmer, Craig co-sponsors)

To address behavioral health and well-being among health care professionals.
This bill establishes grants and requires other activities to improve mental and behavioral health and prevent burnout among health care providers.Specifically, the Department of Health and Human Services (HHS) must award grants to train health care providers on suicide prevention, other behavioral health issues, and strategies to improve well-being; and establish or expand programs to promote mental and behavioral health among health care providers involved with COVID-19 (i.e., coronavirus disease 2019) response efforts. HHS must also study and develop policy recommendations on preventing burnout and improving mental and behavioral health among health care providers, removing barriers to accessing care and treatment, and identifying strategies to promote resiliency. Additionally, the Centers for Disease Control and Prevention must conduct a campaign to encourage health care providers to seek support and treatment for mental and behavioral health concerns.

(Notably, Representatives Angie Craig and Tom Emmer signed onto the bill after our Hill visits.)

Report of the National Commission to Address Racism in Nursing

Not everything that is faced can be changed, but nothing can be changed until it is faced".

— James Baldwin

RACISM: Assaults on the human spirit in the form of biases, prejudices, and an ideology of superiority that persistently cause moral suffering and perpetuate injustices and inequities.

(National Commission to Address Racism in Nursing, April 2021)

Numerous leading nursing organizations have formed the National Commission to Address Racism in Nursing – including representatives from the State Nurses Associations and the Organizational Affiliates.

"Together, we are leading a national discussion to address the racism that nurses from marginalized and underrepresented races and ethnicities experience from predominantly white groups, and those who view themselves as superior. Our work is urgent to create safe and liberating environments for all nurses as well as the profession that exemplifies inclusivity, diversity, and equity." Dr Ernest Grant

Leaders of the Commission include:
- Martha A Dawson, President/CEO of the National Black Nurses Association
- Ernest Grant, President of ANA
- Debra A. Toney, President of the National Coalition of Ethnic Minority Nurse Associations
- Daniela Vargas, at-large member, Latinx Nurse
- G. Rumay Alexander, Scholar-in-Residence, ANA

Vision Statement

The nursing profession exemplifies inclusivity, diversity, and equity creating an antiracist praxis and environments.

Mission Statement

Set as the scope and standard of practice that nurses confront and mitigate systemic racism within the nursing professional and address the impact that racism has on nurses and nursing.

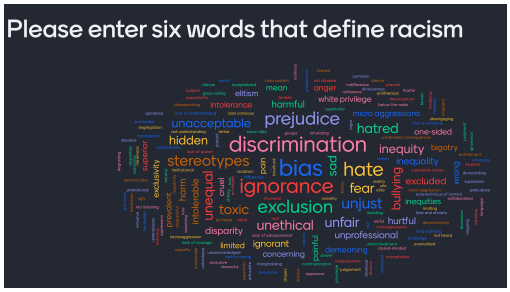
ANA Website Commission to Address Racism in Nursing Page includes:

- Background information on the Commission
- Report: Defining Racism (June 2021)
- Summary Report: Listening Sessions on Racism in Nursing (June 2021)
- Commission Member bios

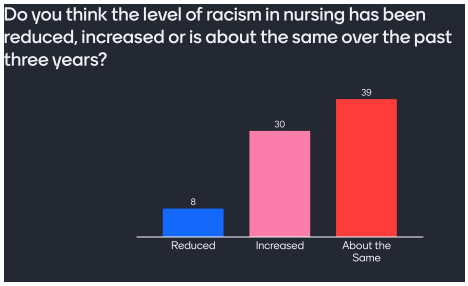
There are also links to these reports on the MNORN website under the section "Resources"

Membership Assembly participants and others were given a briefing on the work of the Commission, including a report on the Listening Sessions on Racism in Nursing. During this time, participants were asked three polling questions. Here are the responses:

1. Please enter six words that define racism



2. Do you think the level of racism in nursing has been reduced, increased, or is about the same over the past three years?



3. Do you feel equipped to deal with racist behaviors in your workplace?

Here are some deliverables the Commission is continuing to work on:

- Understand and own the negative impacts of and seek to change racism in nursing through engagement, listening sessions, storytelling, etc.

- Use the American Nurses Association's scope and standards of professional nursing practice framework to set antiracist behaviors into action which dismantle systemic racism within the nursing profession.

- Establish a scope of practice statement that describes the role of the profession and individual nurses in identifying and addressing racism in nursing and the implications for the profession, patient care, and the healthcare system.

- Institute standards of practice that describes the actions and behaviors expected of the profession, individual nurses, and organizations to address racism in nursing.

We will continue to provide updates to the work of the Commission as available.

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Report on the 2021 Dialogue Forums

This year's Dialogue Forum Topics included:

1. Health Care Delivery Systems that Fully Incorporate Nursing Services
2. Precision Health and Genomics
3. APRN Full Practice in Nursing Homes
4. Lessons Learned: COVID-19 Pandemic Crisis Standards of Care

The virtual Dialogue Forums consisted of several steps. First, there was a presentation of the topic by the submitters. Second, participants were able to make comments, both verbally and in the chat. The Professional Policy Committee compiled both verbal and written comments and created a draft proposal incorporating these comments. Participants were able to make further comments on the draft proposals during a "comment period." The Professional Policy Committee reviewed the comments received, and wrote final proposed recommendations for each topic, which was what the voting representatives voted for after

the close of the Membership Assembly. This process made for a robust discussion within a virtual environment.

As you might remember, MNORN members discussed these topics during two meetings held in May. Comments/recommendations from MNORN members are reflected in each of the Dialogue Forum discussions and several were included in the final recommendations. Thank you to all who participated in the May meetings. You truly helped prepare the MNORN members who represented you at the Membership Assembly - and your voices were heard at ANA!!

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.

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."

- 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.
- 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 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 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:
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.

Recommendation Adopted. (Vote: in support, 172 voters; in opposition, 18 voters)

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 Fangonil-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 the underserved and vulnerable populations are 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

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 does 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:
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:

- Recognizing a framework grounded in ethics, privacy, security, and cost- effectiveness.
- Establishing entry level and advanced nursing competencies for Precision Health that will inform policy and practice recommendations.
- 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).
- Integrating the PH&G competencies into all nursing scopes and standards of practice inclusive of practice specialties.
- 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.
- 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.
- Promoting intra-professional education and collaboration for the advancement of this knowledge and practice.

Recommendations adopted. (Vote: in support, 175 voters; in opposition, 15 voters)

Background document: **Precision Health and Genomics**

Dialogue Forum #3: APRN Full Practice in Nursing Homes (This 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, 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:

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

Recommendation adopted. (Vote: in support, 187 voters; in opposition, 3 voters)

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
335 initiating a uniform, well-understood crisis standard of care when there were not
336 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 hoarding, 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 ED's 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.

<u>Comment Period:</u>

- 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[1] 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.

Recommendations adopted. (Vote: in support, 189 voters; in opposition, 1 voter)

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

[1] ANA Leadership Council Executive Committee. The Leadership Council is comprised of the President and Executive Director of each state nurses association and the individual member division

ANA Elections

ANA's Membership Assembly elected the following members to serve two-year terms on the 9-member board of directors:

- Treasurer Joan Widmer, of the New Hampshire Nurses Association
- Vice President Susan Swart, of ANA-Illinois
- Director-at-Large, Amy McCarthy, of the Texas Nurses Association.
- Director-at-Large, Recent Graduate Marcus Henderson, of the Pennsylvania State Nurses Association

Their terms of office will begin in January 2022.

Those continuing their terms on the ANA board in 2022 are: President Ernest Grant, of the North Carolina Nurses Association; Secretary Stephanie Pierce, of the Louisiana State Nurses Association; Director-at-Large, Staff Nurse Amanda Buechel, of ANA-Illinois; Director-at-Large Jennifer Gil, of ANA-Massachusetts; Director-at-Large Brienne Sandow, ANA-Idaho.

Elected to serve on the Nominations and Elections Committee are: Gayle Peterson, of ANA-Massachusetts; Larlene Dunsmuir, of the Oregon Nurses Association; Nelson Tuazon, of the Texas Nurses Association and Linda Taft, of ANA-Michigan.