# Report of the 2021 ANA Professional Policy Committee

Presented by: Susan King, MS, RN, CEN, FAAN, Committee Member
On behalf of Ann O'Sullivan, MSN, RN, NE-BC, CNE, ANEF
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

42 equitable payment for nursing services and to allow nurses to practice at the top of their
43 training, while also advocating for patient access to needed, quality care.
44
45 **Summary of Dialogue Forum Discussion**

46 - Overall, there was support for this recommendation.
47 - One commenter applauded ANA's consideration of moving to this position, increased
48 political awareness, and savvy. Single payer unlikely in the U.S.
49 - One commenter noted that we all want to have basic health costs covered by either
50 single payer or universal care. How do we ensure that with universal care, competing
51 insurance companies do not raise prices and cost limiting access? How will we avoid a
52 multi-tiered system where the rich get better coverage?
53 - Another commenter noted that this is important so that we can be at the table
54 regardless of who pays, to define "basic health rights for all."
55 - One commenter reflected that ANA is challenged when restricted to speak to only one
56 system. Removing restrictions allows access to discussion to the variety of systems.
57 - Another commenter referenced that the Future of Nursing 2030 report speaks to this
58 issue regarding payment/reimbursement for nursing services and ensuring access,
59 quality, and equity. This direction is in line with the National Academy of Medicine
60 report.
61 - One commenter noted that "universal healthcare" is a term that is misunderstood given
62 history. We are advocating for any system of health care coverage that is equitable and
63 assures access to nursing services. Nomenclature that incorporates reimbursement for
64 nurses etc. is important.
65 - The submitters noted that the definition of universal healthcare included in the
66 background document was the World Health Organizations definition: universal
67 health coverage ensures that *all people have access to needed health services*
68 *(including prevention, promotion, treatment, rehabilitation and palliation) of*
69 *sufficient quality to be effective while also ensuring that the use of these services*
70 *does not expose the user to financial hardship.* The submitters noted that this
71 was included for context and may change should this recommendation move
72 forward.
73
74 **Comment Period**

75 - One commenter noted that while a single payer system was their preferred approach,
76 they recognized that there is not wide-spread support for this financial approach;
77 therefore, the commenter endorses the proposed recommendation. The commenter
78 agreed with the recommendation of defining "universal healthcare."



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79 - Another commenter noted that "incorporating appropriate reimbursement of all
80 needed services" should ensure that APRNs are reimbursed at 100% of the fee pay
81 schedule.
82 - A commenter concurred with the recommendation noting that it provided ANA with
83 more flexibility, supports ANA being at policy making tables, and was more in keeping
84 with the political climate.
85 - Another commenter agreed with the recommendation but felt the use of the term
86 "rescinding" is harsh. Would recommend a gentler term, such as "revision."
87 - One commenter noted that it seems awkward trying to fit comprehensive nursing
88 services into a position that is really trying to move from single payer to universal
89 coverage. Nursing is in the draft position, but what universal coverage means is not. I do
90 not support the recommendation without the WHO definition of "universal coverage"
91 (universal health coverage ensures that all people have access to needed health services
92 (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient
93 quality to be effective while also ensuring that the use of these services does not expose
94 the user to financial hardship). ANA needs to stand strong for a reformed health care
95 system that fulfills the WHO definition. To do less during this time of focus on equity
96 and racism seems especially inappropriate.
97 Several people in the dialogue forum suggested a second position for the full
98 incorporation of nursing services, which I agreed with. Perhaps, instead, a second
99 paragraph about nursing services (I'm not all that fond of the term "nursing services".
100 Isn't there another way of describing access to appropriate nursing care at every level,
101 in every setting where healthcare is provided?)
102 - The Wisconsin Nurses Association support the recommendation as presented.
103
104 **The Professional Policy Committee reflected on the comments made regarding the need to**
105 **define the term universal health care coverage.** The board included the World Health
106 Organizations' definition of universal coverage in the background document as context but
107 noted an ongoing need for flexibility as this recommendation hopefully moves forward into
108 implementation. The Committee is very sympathetic to both the attendees' desire for a
109 definition and the board's desire for flexibility. The Professional Policy Committee chose not to
110 include the WHO definition in the recommendation; however, it strongly urges the ANA Board
111 of Directors to quickly establish a definition of "universal health care coverage."
112
113 **RECOMMENDATION:**
114 1. ANA adopts the position to:
115 Endorse universal health care coverage that assures equitable access to comprehensive
116 nursing services, incorporating appropriate reimbursement of all needed services and
117 full practice authority for all nurses in the health care delivery system; *therefore,*



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118 rescinding its 1999 House of Delegates approved policy endorsing single-payer as the
119 most desirable option for financing a reformed health care system.
120
121 **Background Document:** Health Care Delivery Systems that Fully Incorporate Nursing Services
122
123

## 124 Dialogue Forum #2: Precision Health and Genomics

125 This Dialogue Forum topic was submitted by Kathleen Calzone, PhD, RN, AGN-BC, FAAN,
126 Maryland Nurses Association; Laurie Badzek, LLM, JD, MS, RN, FAAN, Pennsylvania State Nurses
127 Association; and Mary Anne Schultz, PhD, MBA, MSN, RN and Evangeline Fangonil-Gagalang,
128 PhD, MSN, RN, ANA\California. This proposal was submitted in 2020.
129

130 **Issue Overview**

131 Genomics is the entire set of genetic instructions found in a cell, including their
132 interactions with each other, the environment, and the influence of other psychosocial
133 and cultural factors. Precision Health is an approach to wellness which is underpinned
134 by genomics and is respectful of individual lifestyle, behaviors and environmental
135 contexts of our uniqueness. Precision Health and Genomics (PH&G) can increase
136 therapeutic efficacy, safety, quality, and reduce healthcare costs. As these are clinically
137 relevant throughout the entire healthcare continuum from before birth to after death
138 has implications for the entire nursing profession regardless of level of academic
139 training, role, or clinical specialty. There exists confusion amongst providers and their
140 organizations as to implications of PH&G and as a result there is no consensus or
141 direction from national provider organizations including nursing societies. Nursing, as
142 the most trusted healthcare provider has both a clinical, moral, and ethical obligation to
143 establish a multi-faceted initiative to overcome organizational and nursing practice
144 deficits in PH&G. Therefore, these phenomena are deserving of the time, attention, and
145 resources of our nation's largest, and arguably, most influential, provider organization--
146 the American Nurses Association.
147

148 **Summary of Dialogue Forum Discussion**

149 • Attendees voiced support for this report and recommendations.
150 • Several attendees acknowledged a lack of awareness of this science and the potential
151 impact on healthcare.
152 • One commenter noted that this is an essential topic, and it is imperative we are
153 proactive as opposed to being reactive to genomics and impact on healthcare.
154 • One concern raised was the potential for racial and social inequities as it pertains to
155 precision health services. Often these services are for insured individuals. As we look to



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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 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



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192 be further ahead of nursing in this issue and the practice of PH&G would certainly be an
193 inter-professional practice.

194 • ANA's Individual Member Division supports the recommendations.
195 • The Wisconsin Nurses Association support the revised recommendations are presented.
196 • Thank you for the opportunity to comment on the Precision Health and Genomics
197 (PH&G) dialogue forum. It is understood from the background documents that ethics is
198 an essential and foundational element of PH&G work. Additionally, ethics and privacy
199 issues were mentioned in the live discussion on June 1st. Since the proposed
200 recommendations are not exhaustive, it may be helpful to consider a statement that is
201 explicit to message a firm grounding of this work in an ethics, privacy, and security
202 framework. Thank you, again, for this work to elevate the practice of nursing and
203 improve the health of individuals.
204

205 **RECOMMENDATIONS:**

206 1. ANA launch a strategic initiative to integrate Precision Health and Genomics (PH&G) into
207 basic and advanced nursing practice. This would include but not be limited to:
208 a. Recognizing a framework grounded in ethics, privacy, security, and cost-
209 effectiveness.
210 b. Establishing entry level and advanced nursing competencies for Precision Health
211 that will inform policy and practice recommendations.
212 c. Updating the Genomic Nursing Competencies for Nurses with Graduate Degrees
213 (the basic Genetic and Genomic Nursing Competencies [2006] are in the final
214 phases of updating).
215 d. Integrating the PH&G competencies into all nursing scopes and standards of
216 practice inclusive of practice specialties.
217 e. Assessing the state of PH&G Nursing capacity in the existing nursing workforce to
218 inform an education initiative and provide the basis by which to measure
219 outcomes.
220 f. Addressing deficits in nursing knowledge, skills, and attitudes (KSAs) uncovered
221 in the PH&G nursing capacity assessment. This should include demonstration
222 projects leading to evidence-based best practices underpinned by policy.
223 g. Promoting intra-professional education and collaboration for the advancement
224 of this knowledge and practice.
225

226 **Background Document:** Precision Health and Genomics
227
228



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229 ## Dialogue Forum #3: APRN Full Practice in Nursing Homes

230 This Dialogue Forum topic was submitted by Marilyn Rantz, RN, PhD, FAAN and Lori Popejoy,
231 RN, PhD, FAAN, both members of the Missouri Nurses Association.
232
233 **Issue Overview**
234 Nursing homes are in desperate need of transformation. APRNs working in nursing
235 homes can tip the scales to transform critical systems of care in nursing homes so
236 residents can get timely early illness recognition and management. There are current
237 restrictions on APRN practice in nursing homes that need to be removed so they can be
238 hired directly by nursing homes and also bill Medicare for care services that are billable
239 under Medicare. Currently, physicians CAN be hired directly by nursing homes AND also
240 bill Medicare for the care services they provide to the nursing home residents. However,
241 APRNs are RESTRICTED from doing the same. This is an old, overlooked restriction that
242 must be removed so that nursing home residents have unrestricted access to APRN
243 care.
244
245 **Summary of Dialogue Forum Discussions**
246 • Attendees expressed significant support for this report and the proposed
247 recommendation.
248 • There were several comments reflecting on the need to continue to advocate for full
249 practice authority for APRNs to increase access to care and promote quality.
250 • There was some discussion related to the use of unlicensed personnel to provide
251 medications in long term care facilities. The Professional Policy Committee considered
252 this issue to be outside the purview of the initial policy submission.
253 • Several attendees raised questions and concerns about the proposed language included
254 in Appendix 1. *Recommended Changes in Social Security Act 42 U.S.C. and Related*
255 *Federal Regulations in CFR x483.40 for Access to Advanced Practice Registered Nurses*
256 *(APRNs) for Nursing Facility Residents* (pg. 8 – 1396r (b)(6)(A)-(B)). This language speaks
257 to requirements for collaboration or supervision with physicians and runs counter to
258 existing requirements in states where APRNs have full practice authority.
259 • An attendee also suggested another approach could be a state-level opt out, like the opt
260 out of physician anesthesia care. It was noted that in 2001, CMS changed the federal
261 physician supervision rule for nurse anesthetists to allow state governors to opt out of
262 the facility reimbursement requirements.
263 • It was noted that this change could have a significant, positive impact on access to care
264 for critical access rural communities.
265 • It was also suggested that consideration be given to addressing the requirement that
266 the medical director must be a physician.



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267 As a result of comments noted on lines 163-172, the Professional Policy Committee revised the
268 original recommendation to address the policy change being sought as opposed to the specific
269 proposed language included in Appendix 1.
270
271 Initial recommendation proposed by submitters:
272 Advocate for the inclusion of the language "including those employed by the facility"
273 when referring to an APRN working within a nursing home within CFR x483.40.
274 Appendix 1 outlines the recommended changes developed by faculty of the University
275 of Missouri School of Law and is provided to assist in locating the language needing to
276 be changed. Suggested wording is provided.
277
278 **Comment Period:**

279 • ANA's Individual Member Division (IMD) submits a comment noting that in order for the
280 IMD to support the PPC Recommendation for Dialogue Forum #3: APRN Full Practice in
281 Nursing Homes, the IMD respectfully requests that the recommendation be revised so
282 that it reads: "The American Nurses Association advocates for change(s) in the Social
283 Security Act and related Federal Regulations that would authorize the compensation of
284 Advanced Practice Registered Nurses (APRNs) employed directly by skilled nursing
285 facilities for Medicare-billable services they provide to nursing home residents."
286 • The Wisconsin Nurses Association support the revised recommendations as presented.
287 • Should consider allowing APRNs to serve as the medical directors of adult care homes.
288 This would require ANA to continue to advocate for removal of barriers to care that
289 APRNs face, such as removing the permission slip/collaborative practice agreement
290 requirement.
291 It should be stated that APRN's should be allowed to receive the same reimbursement
292 rate that a physician receives.
293 • I am fully in support of this initiative but wanted to suggest the following: If ANA is going
294 to advocate for changes to CFR x483.40, perhaps we can also address a long standing
295 problem with CFR x483.152, which relates to "Requirements for approval of a nurse aide
296 training and competency evaluation program." This section requires that RN's seeking to
297 be instructors for nursing assistant training programs must have one-year clinical
298 experience in the long-term care setting. Section 5 (i) reads: "at least 1 year of which
299 must be in the provision of long-term care facility services." This is an antiquated
300 provision and severely limits the number of RNs who can qualify to teach in nurse aid
301 training programs. NHNA tried to address this issue in 2019/2020 but efforts were
302 sidelined due to the COVID-19 pandemic and limited resources of a small C/SNA. Lack of
303 clinical instructors has limited the pipeline for new certified and/or licensed nursing
304 assistants to support RNs and impact instruction programs all around the country.



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305 - I concur with the revised recommendation from the ANA PPC. Our country and our
306 nursing home residents desperately need this legislation NOW!
307 - ANA's Department of Policy and Government Affairs noted that the proposed change
308 regarding employment of APRNs and the ability to bill may be more appropriate for
309 Medicaid regulation, as opposed to Medicare. Applying the language of the proposed
310 resolution for Medicare SNF's may require a statutory change in addition to the
311 proposed regulatory changes. Policy/GOVA's recommendation is to advance a
312 resolution that states the general goal of removing barriers to practice in Medicare and
313 Medicaid long-term services and support (including home and community-based care).
314 Implementation of the current resolution or alternative could include development of a
315 position statement that clarifies policy options.
316
317 **REVISED RECOMMENDATION proposed by the Professional Policy Committee:**
318 1. The American Nurses Association advocate for changes that would authorize APRNs to
319 directly bill for services provided for skilled nursing care, long-term care, and home and
320 community-based care, including those services provided as an employee.
321
322 **Background Document: APRN Full Practice in Nursing Homes**
323
324

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

327 This Dialogue Forum topic was prepared by the Professional Policy Committee.
328
329 *No recommendations were proposed by the Professional Policy Committee in advance of the*
330 *Dialogue Forum. In this report, the Professional Policy Committee proposes two*
331 *recommendations for consideration during the online comment period.*
332
333 **Issue Overview**
334 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
337 likely inevitable in future events, particularly during a large-scale event of long duration,
338 there are strategies that can and should be implemented to mitigate the overall impact.
339 The focus of this Dialogue Forum is to receive feedback to inform ANA moving forward.
340
341 **Summary of the Dialogue Forum Discussion:**
342 - There were multiple references to the need for education, for both students and as
343 professional development, based on identified competencies to support future response



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344 to disasters and pandemics. The profession needs all nurses to understand basic
345 emergency response principles.
- 346 Consider using FEMA coursework and the American Red Cross education
347 modules.
- 348 It would be helpful to have a uniform protocol/policy allowing upper-level
349 student nurses or new nurse graduates before licensure to do some limited
350 pandemic response tasks such as vaccination without faculty supervision.
- 351 Would have been good to have "virtual touch bases" to share learnings in real
352 time when there was little to no guidance.
- 353 All nurses need to engage in personal and professional preparation for
354 responding to a disaster.

- 355 Several attendees spoke to the negative impact that the lack of trust on government
356 and health care institutions had on the overall response and support for public health
357 mitigation measures.
- 358 Work environment issues raised:
  - 359 Lack of staffing and in states with staffing committees the ability of facilities to
360 put on hold staffing committee recommendations due to "emergency
361 conditions."
    - 362 Hospitals have hired many high paid travel nurses to fix staffing holes.
363 There are pros and cons to this. It is helping staffing, but some travel
364 nurses are not motivated to learn hospital policies or get to know staff
365 members which is harmful to patient care and unit cohesion.
  - 366 Cross-training and the challenges of using non-ICU nurses in the ICU setting.
367 Despite training and education, the staff were not confident on how to provide
368 care.
  - 369 Need more training about the movement into team-based models to delivering
370 care during resource constraints.
  - 371 Community plan to share staff from one hospital to another.
  - 372 How to move staff from one state to another – we benefitted from outside
373 nurses coming into our state in the beginning.
- 374 Sufficient supplies of equipment:
  - 375 Significant challenges with personal protective equipment (PPE), including re-use
376 and decontamination.
  - 377 There was PPE shortages in pandemic designated- and non-designated units;
378 these challenges extended to supply chain issues contributing to access issues
379 and increase purchasing costs. Highlighted was the need for entities outside of



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380 the hospital system (primary care, remote, ACS) to have a connection to needed
381 resources (PPE, vaccines, etc.).
382 ○ Need to look at policies related to national stockpile.
383 ○ There were facilities "with resources" and those "without", challenges with
384 regard to equitably access – in the beginning there was some hording, then there
385 was sharing, and then there was hoarding again.
386 ○ Facility policies associated with how and when PPE could be accessed by
387 employees.
388 ○ Nurses were to speak up on PPE access. There was a disconnect to what leaders
389 said was available versus what nurses reported.
390 • Multiple commenters spoke to ongoing concerns about the mental health issues that
391 nurses are currently experiencing and likely to experience into the future as a result of
392 dealing with the pandemic.
393 ○ Nurse-to-nurse sharing was critical.
394 ○ Nurses are exhausted.
395 ○ We have wonderful resources for self-care, but we cannot keep up the needed
396 pace to continue with long-term disaster situations.
397 • One commenter noted that "crisis" standards of care seem to be for relatively short-
398 term/emergencies, not weeks or months long emergent circumstances. There are
399 significant qualitative and quantitative differences between the aftermath of a
400 hurricane or tornado and the constant assault of a pandemic.
401 • It was also noted that state-level committees found that health systems that are
402 generally in competition had a hard time working collaboratively to the detriment of
403 decision-making. Nurses felt that sometimes the conversations were "too politically
404 correct" and that they, as nurses, needed to become more forthright.
405 • One commenter noted that findings from a survey on crisis standards of care found that
406 45% of the participants responded that they did not know if their crisis standards of care
407 were up to date. Another interesting point was that 32% indicated that healthcare
408 facilities did not actively communicate crisis standards of care guidance within their
409 communities. Clear guidance on how to inform the staff and community about crisis
410 standards of care needs to be part of developing future policy.
411 ○ Did not know where to find the crisis standard of care plan.
412 • Consider a policy of presumption that nurses working clinically that acquire COVID were
413 infected because of their work and also address financial compensation.
414 • Need to advocate for all nurses and caregivers across all areas. Hospice and other
415 specialty areas were excluded from PPE allocations and were not included in waivers
416 from CMS until much later in the year.



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417 • It is important for everyone to also know and understand when it is time to return to
418 the "normal standard."
419 • Need to leverage the Code of Ethics for Nurses to underscore our obligation to protect
420 ourselves and each other, our family members, and our patients from spread of
421 infectious disease.
422 • Consideration needs to be given to how we will reintegrate patients back into the
423 healthcare system. Our EDs are full and hospital census is at capacity and capability as
424 we see those who did not receive care during the pandemic – these are sick patients.
425 "Getting back to normal" does not look "normal" at all.
426 • Liability protections when there are changes in the standard of care.
427
428 **Comment Period:**
429 • During the pandemic, many Crisis Standards of Care (CSC) were activated, in whole or in
430 part, in states around the country. To ensure that a comprehensive understanding of
431 the impact these CSCs had on care delivery, ANA should reach out to states which
432 activated their CSC during the pandemic to explore some of their lessons learned. I
433 recently attended a Project Echo for Emergency Care Providers to discuss their
434 perspectives on CSC and how they were implemented within their organizations. As part
435 of this Project Echo, a brief survey was conducted to see how CSC were perceived and
436 how they impacted patient care. The results of this real-time survey were interesting.
437 ANA could consider a similar approach for nurses, particularly those working in the ICU
438 caring for COVID patients. Some of the questions that could be asked are: Did your
439 organization implement CSC? In what areas were they implemented (vents, O2,
440 medications, etc.)? Do you know the ethical underpinnings of your organization's CSC?
441 Do you know how these underpinning relate to the Code of Ethics for Nurses?
442 • Concur with the recommendations from the ANA PPC.
443 • The discussion of this topic was very broad - not sure how the ANA Board would
444 prioritize. Would suggest looking at the proposed National Coronavirus Commission Act
445 of 2021 to help with focus, with emphasis on these areas: 1. the preparedness and
446 response of specific types of institutions that experienced high rates of COVID-19,
447 including hospitals, SNFs, assisted living and LTC; prisons, jails and immigration
448 detention centers; elementary and secondary schools 2. management, allocation, and
449 distribution of relevant resources including PPE, testing supplies and other medical
450 equipment. And, of course, advocacy for nurses at all levels in all practice settings,
451 including mental health care and COVID long haulers.
452 • The Wisconsin Nurses Association support the recommendations as presented.
453



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454 **Proposed recommendations from the Professional Policy Committee:**
455 1. ANA report back to the 2022 Membership Assembly on actions taken to further address
456 crisis standards of care and advance the preparation of nurses and the profession to
457 respond to future disasters and pandemics.
458 2. C/SNAs consider the information contained in the Committee's report and encourage
459 the LCEC to coordinate the sharing of innovations, best practices and lessons learned
460 and request that the LCEC report back to the 2022 Membership Assembly on efforts at
461 the state level to advance preparation for responding to disasters and pandemics.
462
463 **Background Document:** Lessons Learned: COVID-19 Pandemic Crisis Standards of Care
464



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