

AMERICAN NURSES ASSOCIATION

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NURSING'S  
LEGISLATIVE

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—AND—

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REGULATORY  
INITIATIVES

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—FOR THE—

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110TH CONGRESS

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DEPARTMENT OF  
GOVERNMENT  
AFFAIRS



*SILVER SPRING, MD*  
2007

## AMERICAN NURSES ASSOCIATION

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Published by the Department of Government Affairs  
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The American Nurses Association is the only full-service professional organization representing the interests of the nation's 2.9 million registered nurses through its 54 constituent member nurses associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

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# 110TH CONGRESS LEGISLATIVE AND REGULATORY PRIORITIES FOR AMERICAN NURSES ASSOCIATION: ADVOCACY FOR ALL OF NURSING

The American Nurses Association (ANA) is the nation's only full-service professional organization representing the nation's registered nurse population. From the halls of Congress and federal agencies, to board rooms, hospitals and other health care facilities, to institutions of higher learning, ANA is the strongest voice for high-quality patient care, advances in the nursing profession, and workplace advocacy.

ANA is headquartered in Silver Spring, Maryland, just outside Washington, DC. We represent the interests of the nation's 2.9 million registered nurses through 54 constituent member state and territorial associations and over 155,000 members. Our members represent RNs in all educational preparation in all practice settings. More than one-half of these member associations also serve as collective bargaining units for their members, making ANA the largest labor organization for the nursing profession.

ANA promotes health care policies that advance the goals of nursing and foster better public health. Our legislative and regulatory agenda is focused on the issues that underlie ANA's core initiatives: the nursing shortage, appropriate staffing, workplace rights, workplace health and safety, and patient safety/advocacy.

For more than 100 years, ANA has built a proud history of advocacy for access to high-quality health care services for all Americans. ANA is also committed to promoting registered nurses as essential providers in all health care settings. This publication outlines ANA's specific legislative and regulatory priorities for the 110th United States Congress. We hope you find this publication a useful resource. Please contact ANA's Government Affairs Department with any questions regarding our advocacy agenda. We can be reached at (301) 628-5094 or [gova@ana.org](mailto:gova@ana.org). More information is available on our website: [www.anapoliticalpower.org](http://www.anapoliticalpower.org)



NURSING'S LEGISLATIVE AND  
REGULATORY INITIATIVES FOR  
THE 110TH CONGRESS

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*Nursing  
Shortage*

Immigration and the Nursing Workforce

Title VIII: Funding for Nursing  
Workforce Development Programs

## IMMIGRATION AND THE NURSING WORKFORCE

### POSITION

The American Nurses Association (ANA) supports the ability of individual nurses to choose to practice in the location of their choice. However, we oppose the use of immigration to solve nursing shortages and efforts to weaken current certification requirements for nurses educated in foreign schools of nursing.

### BACKGROUND

The Illegal Immigration Reform and Immigrant Responsibility Act (P.L.104-208) requires all foreign health care professionals, except physicians, to be certified by the Commission on Graduates of Foreign Nursing Schools (CGFNS) or another independent, government-certified organizations qualified to issue credentials. The certification process must verify that the foreign health care worker's education, training, or experience meets all applicable statutory and regulatory requirements for entry into the United States. In addition, any foreign license submitted by the health care worker must be validated. Foreign-educated nurses must have passed an examination testing both nursing skill and English language proficiency.

The Nursing Relief for Disadvantaged Areas Act of 1999 (P.L. 106-95) created a new H-1C temporary visa specifically for foreign-educated nurses. The H-1C provided a limited visa designed to allow no more than 500 nurses into the country annually. The H-1C visa authority expired in 2005.

The H-1B temporary visa has typically not been available to nurses, as professions utilizing the H-1B must demonstrate that bachelors' preparation is the minimum requirement for entry into the profession in the United States. As the current minimum for entry into practice as an RN in the US is a two-year associate degree in nursing, the INS has historically denied H-1B applications for staff nurses. However, the H-1B may be used for advanced practice registered nurses.

Past efforts to weaken requirements for temporary nurse visas have resulted in the exploitation of immigrant nurses. There are numerous, disturbing examples from the expired H-1A nurse visa. These nurses were employed as lower-paid aides, were made to work unreasonable hours in unsafe conditions, and were misled about the temporary nature of their visas.

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## RATIONALE

ANA maintains that it is inappropriate to look overseas for temporary workforce relief when the real problem is the fact that support for domestic schools of nursing is failing to meet demand and the U.S. health care industry has failed to maintain a work environment that retains experienced U.S. nurses in patient care. Over-reliance on foreign-educated nurses by the health care industry serves only to postpone efforts to address the needs of nursing students and the U.S. nursing workforce.

In addition, there are serious ethical questions about recruiting nurses from other countries when there is a world-wide shortage of nurses. The removal of foreign-educated nurses from areas such as South Africa, India, and the Caribbean deprives their home countries of highly-trained health care practitioners upon whose skills and talents their countries heavily rely. ☺

## TITLE VIII: FUNDING FOR NURSING WORKFORCE DEVELOPMENT PROGRAMS

### POSITION

The American Nurses Association (ANA) urges Congress to significantly increase funding for the Nursing Workforce Development programs administered by the Health Resources and Services Administration (HRSA) under Title VIII of the Public Health Service Act.

### BACKGROUND

The Nursing Workforce Development programs administered by HRSA are the primary source of federal funding for nursing education. Title VIII was expanded and improved by the Nurse Reinvestment Act. The major grant programs areas are:

*Advanced Education Nursing* – Provides grants to nursing schools, academic health centers, and other entities to enhance education and practice for nurses in master’s and post-master’s programs. These programs prepare nurse practitioners, clinical nurse specialists, nurse midwives, nurse anesthetists, nurse educators, nurse administrators, and public health nurses.

*Workforce Diversity Grants* – Provides grants to increase opportunities for individuals who are from disadvantaged backgrounds, including students from economically disadvantaged families as well as racial and ethnic minorities underrepresented in the nursing profession.

*Nurse Education, Practice, and Retention Grants* – Supports schools and nurses at the associate and baccalaureate degree level. Grants are provided to schools of nursing, academic health centers, nursing centers, state and local governments and other public or private nonprofit entities. Some grants (such as grants promoting the Magnet Hospital best practices for nursing administration) are also available to health care facilities.

*National Nurse Service Corps* – The Nurse Education Loan Repayment Program repays 60 to 85 percent of nursing student loans in return for at least two years of practice in a facility designated to have a critical shortage of nurses. The Nursing Scholarship Program supports students enrolled in nursing school. Upon graduation, scholarship recipients are required to work full-time for at least two years in a facility designated to have a critical shortage of nurses.

*Nurse Faculty Loan Program* – Establishes loan programs within schools of nursing to support students pursuing masters and doctoral degrees. Upon graduation, loan recipients are required to teach at a school of nursing in exchange for cancellation of up to 85 percent of their educational loans, plus interest, over four years.

*Comprehensive Geriatric Education Grants* – Provides grants to train nurses who provide direct care for the elderly, to support geriatric nursing curriculum, to train faculty in geriatrics, and to provide continuing education to nurses who provide geriatric care.

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## RATIONALE

The growing nursing shortage is impacting every aspect of the U.S. health care delivery system and contributing to diminished patient care. The Bureau of Labor Statistics reports that registered nursing will have the second greatest job growth of all U.S. professions in the time period spanning 2004–2014. HRSA projects that, absent aggressive intervention, in the year 2020 the shortage will grow to more than 1 million RNs—representing a shortage of 36 percent. Title VIII holds the promise of addressing many of the challenges facing nursing. But, this promise can not be met without a significant increase in funding for HRSA’s Nursing Workforce Development programs. 🇺🇸



NURSING'S LEGISLATIVE AND  
REGULATORY INITIATIVES FOR  
THE 110TH CONGRESS

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*Appropriate  
Staffing*

Acute Care Staffing

Mandatory Overtime

Nurse Staffing Reporting

## ACUTE CARE STAFFING

### POSITION

The American Nurses Association (ANA) supports the establishment of nurse-patient ratios to address the current staffing crisis, but feels strongly that these ratios must be set, not by legislators or government officials, but in the workplace in direct coordination with nurses themselves, and based on unit-by-unit circumstances and needs. ANA supports efforts to mandate establishment of valid and reliable nurse staffing systems in acute care and to require standard, public reporting of nurse staffing levels and mix and patient outcomes.

### BACKGROUND

During the past decade, health care providers have implemented aggressive measures to reduce the costs of health care. As nurses' salaries are typically the largest hospital personnel expense, they have been targeted for aggressive cuts. These cost-cutting efforts have often resulted in RN staffing levels that are inadequate to protect the safety and quality of patient care. These changes have occurred at the same time that patient acuity and the use of sophisticated technology have increased, and the length of stay has decreased. Combined, these factors have created a situation that threatens patient safety and contributes to the nursing shortage by driving nurses from the bedside.

Unfortunately, there are no national staffing requirements for acute care settings, nor is there a mechanism for standardized public reporting of acute care staffing. This lack of enforceable staffing standards and quality measurement has allowed dramatic changes in staffing methodology to go unchecked.

Many variables—factors including acuity of patients, level of experience of nursing staff, layout of the unit, level of ancillary support—are key to establishing the “right” nurse-patient ratio for any one unit. For this reason, ANA supports a staffing plan approach, as reflected in the Registered Nurse Safe Staffing Act (S.73), federal legislation which would hold hospitals accountable for the development and implementation of valid and reliable nurse staffing plans. Specifically under S. 73 the staffing system must:

- Be created with input from direct-care RNs or their designated representative;
- Be based on the number of patients and patient acuity level, with consideration given to patient admissions, discharges, and transfers on each shift;
- Reflect the level of preparation and experience of those providing care;
- Reflect staffing levels recommended by specialty nursing organizations; and
- Provide that an RN not be forced to work in a particular unit without having first established that he or she is able to provide professional care on such a unit.

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This is not a one-size-fits-all approach to staffing. Instead, it provides hospitals with the flexibility of tailoring nurse staffing to the specific needs of patients based on factors including how sick the patient is, the experience of the nursing staff, technology, and support services available to the nurses. Most importantly, this approach treats direct-care registered nurses as professionals, and empowers them to have a decision-making role in the care they provide.

## RATIONALE

More than a decade of research shows that nurse staffing levels and skill mix make a difference in the outcomes of hospitalized patients. These studies show that when there are more nurses, there are lower mortality rates, better care plans, lower costs, and fewer complications.

In June, 2002, the Joint Commission on Accreditation of Healthcare Organizations released a report (*Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis*) stating that inadequate nurse staffing was a contributing factor in 24 percent of all unanticipated events that resulted in patient death, injury, or permanent loss of function.

A study published in *The Journal of the American Medical Association* (Linda Aiken, et al., Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction, *JAMA*, Vol. 20, Oct. 23, 2002) found that the odds of patient mortality rose by 7 percent for every additional patient added to the average nurse's workload.

A study published in *The New England Journal of Medicine* (Jack Needleman, et al., Nurse-Staffing Levels and the Quality of Care in Hospitals, *N.Engl.J.Med.*, Vol. 346, #22, May 30, 2002) found a strong, reliable relationship between increased RN staffing and fewer patient complications, including death.

Recognizing the important relationship between nurse staffing and patient care, the National Quality Forum recently recommended that acute care hospitals track and report the number of nursing hours per patient day for RN, LPN, and unlicensed nurses. (*National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set*, NQF, 2004.)

Identifying increased nurse staffing as a top priority for addressing medical errors, the Institute of Medicine has called for immediate improvements in nurse staffing. (*Keeping Patients Safe: Transforming the Work Environment for Nurses*, IOM, National Academies Press, November 2003.)

Preliminary evidence indicates that there is a link between mandatory staffing plan legislation and the most positive nurse work environment perceptions among RNs when compared with either the implementation of mandatory staffing ratios or with no workforce regulation. These results are based on a study examining the variations in work environment perceptions of approximately 4,000 RNs across 10 states. (*Work Environment Perceptions When Employed in States With and Without Mandatory Staffing Ratios and/or Mandatory Staffing Plans. Policy, Politics, & Nursing Practice*, 6(3), 191-197). ☺

## MANDATORY OVERTIME

### POSITION

The American Nurses Association (ANA) opposes the use of mandatory overtime, and supports the Safe Nursing and Patient Care Act which would limit the number of overtime hours a nurse may be required to work.

### BACKGROUND

Nurses report a dramatic increase in the use of mandatory overtime as a staffing tool and fear potential consequences for the safety and quality of care provided to their patients. Today, overtime (mandatory and voluntary) is the most common method facilities use to cover staffing insufficiencies. Many nurses contend employers insist they work an extra shift (or more) or face dismissal for insubordination and being reported to the state board of nursing for patient abandonment. An ANA survey of nearly 5,000 nurses conducted in 2000 revealed that more than 67 percent are working unplanned overtime every month.

Federal regulations place limits on the amount of time that can be worked in other industries in which the work directly affects public safety (e.g., aviation and transportation). Those regulations also set requirements for defined periods of time that workers must rest or be off duty before returning to work. Health care is exempt from such overtime regulations.

A 2003 report from the Institute of Medicine (IOM) (*Keeping Patients Safe: Transforming the Work Environment of Nurses*) noted that long work hours pose one of the most difficult threats to patient safety. The IOM noted that fatigue slows reaction time, decreases energy, diminishes attention, and otherwise contributes to medical errors. The study concluded that elimination of mandatory overtime is essential to safe patient care and healthier nurses.

A 2004 report commissioned by the Agency for Health Care Research and Quality, and published in the July/August *Health Affairs* reconfirms the link between overtime and medical errors. This report, *The Working Hours of Hospital Staff Nurses and Patient Safety*, found that the risk of making an error greatly increased when nurses worked shifts that were longer than 12 hours, when they worked significant overtime, or when they worked more than 40 hours per week. The study found that the likelihood of making an error was three times higher when nurses worked shifts lasting more than 12.5 hours. Disturbingly, in nearly 40 percent of the shifts studied, nurses worked at least 12.5 consecutive hours. More than 25 percent of the participants in the study reported working mandatory overtime at least once during a one-month period. Overall, nurses reported being unable to leave work at the end of their scheduled shift more than 80 percent of the time.

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## RATIONALE

ANA is concerned about the impact of mandatory overtime on the ability of our nation's acute care nurses to provide high-quality health care services. ANA believes that the elimination of mandatory overtime for the nation's nurses is a critical step in efforts to improve the quality of health care, and reduce medical errors. 🙏

## NURSE STAFFING REPORTING

### POSITION

The American Nurses Association (ANA) supports standard, public reporting of nurse staffing levels, staffing mix, and patient outcomes. Publicly available information on staffing and nursing sensitive indicators is needed to provide health care consumers with reliable information about the health facilities on which they rely.

### BACKGROUND

Numerous studies have shown that the amount of nursing care provided to patients is a key determinate of quality care. Research published in the October 23, 2002 *Journal of the American Medical Association* demonstrated that registered nurse staffing levels have a significant impact on preventable deaths in hospitals, and that the odds of patient mortality increase 7 percent for every additional patient added to the average registered nurse's workload. The Joint Commission on the Accreditation of Healthcare Organizations reported in 2002 that inadequate nurse staffing contributes to nearly a quarter of all unexpected incidents that kill or injure hospitalized patients.

Yet, there is no reliable means for patients to obtain information on nurse staffing. Centers for Medicare and Medicaid Services (CMS) home health comparisons do not include any information about the quantity of nursing care, and CMS' own studies have shown that the nursing home staffing data reported to CMS is highly inaccurate.

The Patient Safety Act, federal legislation supported by ANA, would address these concerns by requiring health care facilities to report information on nurse staffing. Hospitals, nursing homes, home health agencies, hospice, ambulatory surgical centers, and renal dialysis facilities would be required to submit quarterly reports detailing their registered nurse (RN), licensed professional nurse (LPN), and unlicensed patient care personnel staffing. This information would be broken down in terms of the total hours of nursing care per patient for each unit and each shift. Information showing the average number of patients per RN, LPN and unlicensed assistants, would also be required. In addition, these providers would report risk-adjusted patient mortality rates (in raw numbers and in diagnostic-related groups), and the incidence of other adverse patient outcomes. Nursing facilities would also report their retention rates for RNs, LPNs, and certified nurse assistants.

The CMS would be required to make the information publicly available, including publication on the Health and Human Services website. CMS would also share this information with state agencies responsible for licensing or accrediting the facility, and with any member of the public who requests it. CMS would be required to directly audit

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the data require by skilled nursing facilities, and would establish a means to audit the information from other sources through their regular participation agreements. In addition, CMS would be required to compare nursing homes against each other based on their staffing levels.


The bill also provides important protections to health facility employees who notify state or federal authorities, and/or accreditation agencies about conditions in the facility that are dangerous or potentially dangerous to patients.

## RATIONALE

The Centers for Medicare and Medicaid Services (CMS), in collaboration with the Hospital Quality Alliance (HQA) is already engaged in public reporting of some quality measures through the Hospital Compare website ([www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)). There, consumers can get information online on “how often hospitals provide some of the recommended care to get the best results for most patients.” According to CMS “this quality information not only helps you make good decisions about your health care, but also encourages hospitals to improve the quality of health care they provide.” ANA believes that adding nurse staffing information to this information would go a long way in furthering this important goal.

The National Quality Forum (NQF) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) support public reporting of nurse staffing and other nursing sensitive indicators.

Recognizing the important relationship between nurse staffing and patient care, in 2004 the NQF recommended that acute care hospitals track and report the number of nursing hours per patient day for RN, LPN, and unlicensed nurses. This recommendation was among 15 national voluntary consensus standards for nursing-sensitive care endorsed in the document by NQF. (*National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set*)

In 2005 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) added its support for the NQF-recommended measures by publishing *Implementation Guide for the NQF Endorsed Nursing-Sensitive Care Performance Measures*. 



NURSING'S LEGISLATIVE AND  
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THE 110TH CONGRESS

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*Workplace  
Rights*

Barriers to the Practice of Advanced Practice Registered Nurses

Home Health: Plan of Care Designation

Medicaid Coverage of Advanced Practice Nursing

Whistleblowing/Patient Advocacy Protections for Nurses

## BARRIERS TO THE PRACTICE OF ADVANCED PRACTICE REGISTERED NURSES

### POSITION

The American Nurses Association (ANA) supports the removal of barriers and discriminatory practices that interfere with full participation by advanced practice registered nurses in the health care delivery system.

### BACKGROUND

The Balanced Budget Act of 1997 (P.L. 105-33) expanded reimbursement opportunities for advanced practice registered nurses (APRNs) by removing geographical and practice site restrictions for Medicare Part B reimbursement. However, APRNs continue to face significant barriers presented by other changes in the health care delivery system. These barriers include restrictive reimbursement policies of both the Medicaid program and of private insurer as well as numerous state laws and regulations. Among the latter are those which limit prescriptive authority, require supervision by or collaboration with another health care provider, limit direct reimbursement, prohibit or limit institutional privileges, and make it difficult to obtain liability insurance.

As managed care organizations have grown to dominate health care delivery, increasing numbers of managed care organizations have become multi-state corporations that establish their own set of rules. These rules include the exclusion from access to managed care organization provider panels and the imposition of additional practice restrictions. In addition, organized medicine has recently launched an aggressive campaign to limit scope of practice for APRNs through federal and state legislative and regulatory initiatives. If successful, these efforts to impose physician control over nursing practice will create additional barriers and limit access to APRN services for patients and reduce their choice of providers.

New strategies need to be developed and implemented to promote the recognition of APRNs as cost-effective valuable providers, to counteract these additional barriers and to counteract the increased efforts by organized medicine to limit APRN practice. ANA believes that the solution to the removal of these practice barriers must be addressed at both the federal and state levels as well as throughout health care systems, including federal systems, private insurers, fee-for-service structures, and managed care.

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## RATIONALE

The removal of arbitrary practice restrictions is crucial to achieving universal access and coverage of health care services. The full participation of registered nurses in the health care system will make access to health care affordable, available, acceptable, and accountable.

ANA has consistently supported reimbursement and practice policies to ensure that all nurses are able to participate in health care systems without artificial barriers preventing their ability to practice and to be paid for those services.

ANA supports legislation that prohibits discrimination by individual health plans based on the type, license, class, or speciality of a health care provider. Health plans must be required to make public, in advance, the criteria used to select participating providers and must have a sufficient mix of providers to ensure enrollees adequate access to covered services. States must not have the authority to impose on any class of health care professionals arbitrary practice restrictions that are not based on the licensure of those professionals. Specific language should direct states to eliminate practices that prevent registered nurses from delivering health care within the scope of their education, abilities, and competence.

ANA supports initiatives that remove arbitrary practice restrictions or prohibit policies that promote barriers for APRN practice including any laws, regulations, or policies that limit or prohibit prescriptive authority, require supervision by another health care provider, limit direct reimbursement, prohibit or limit institutional privileges, and make it difficult to obtain liability insurance. ☺

## HOME HEALTH PLAN OF CARE DESIGNATION

### POSITION

The American Nurses Association (ANA) supports the ability of advanced practice registered nurses (APRNs) to certify homebound status, and to develop and sign the plan of care for Medicare patients receiving home health services.

### BACKGROUND

Medical advances have made it possible for a growing number of chronically ill and terminally ill patients to receive care in the comfort of their own homes. Homecare allows many patients the ability to live normal lives during the course of their therapy, and allows terminally ill patients precious time with their families and loved ones. In many cases, homecare is more cost effective than institutionalized care. For these reasons, the Medicare home health benefit has grown considerably since the early 1990s. In 2004, 2.8 million Medicare patients received home health services.

In order to receive home health services, Medicare beneficiaries must be certified as “homebound.” This means that patients must leave their homes infrequently and only with considerable and taxing effort. In addition, patients must require at least one skilled nursing or therapy service, and a plan of care must be developed and submitted to Medicare. Today, only physicians and podiatrists may sign plans of care or certify a patient as homebound.

APRNs—including nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists—are health care practitioners who furnish the same services traditionally provided by physicians, including diagnosing illnesses, performing physical exams, ordering and interpreting laboratory tests, and determining treatment plans. In most states, APRNs are able to practice independently or in collaboration with physicians. Medicare law allows APRNs to be paid directly for many of the services that they provide.

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## RATIONALE

ANA believes that APRNs should be able to certify patients for home health services and to develop and sign their plans of care. APRNs represent a growing proportion of the health care workforce. APRNs most often practice in rural and other underserved areas, where physicians are scarce. Numerous studies have shown that APRNs are able to provide care that is at least as high in quality as that provided by physicians.

Frequently, APRNs must delay admitting patients into home health due to the need to locate a physician who will allow them to use their name on Medicare paperwork. These delays in care inconvenience patients and their families. In addition, delays can result in increased cost to the Medicare system when patients are unnecessarily left in more expensive institutional settings. ☺

## MEDICAID COVERAGE OF ADVANCED PRACTICE NURSING

### POSITION

Medicaid should cover all services that advanced practice registered nurses (APRNs) are legally authorized to perform under state law. The American Nurses Association (ANA) urges Members of Congress to cosponsor the Medicaid Advanced Practice Nurses and Physician Assistants Access Act and to support the recognition of all APRNs as eligible providers under the State Children's Health Insurance Program.

### BACKGROUND

Advance practice registered nurses (APRNs) are registered nurses (RNs) who have attained advanced expertise in the clinical management of health problems. APRNs include nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. Typically, an APRN holds a master's degree with advanced didactic and clinical preparation beyond that of the RN. Most APRNs have extensive practice experience as RNs prior to entering graduate school. Practice areas include, but are not limited to: family, gerontology, pediatrics, women's and adult health, neonatology, mental health, midwifery, and anesthesiology.

Federal law requires fee-for-service Medicaid to cover health care services provided by some APRNs (pediatric nurse practitioners, family nurse practitioners, and certified nurse midwives). Some states have also opted to cover the services of certified registered nurse anesthetists and clinical nurse specialists, primarily because these practitioners are willing to provide needed services in physician shortage areas. Multiple studies have shown that the quality of care provided by APRNs is equivalent or better than that provided by MDs.

The Balanced Budget Act of 1997 (BBA, P.L. 105-33) encouraged states to move Medicaid patients into managed care and to use primary care case managers as gatekeepers to care in the fee for service program. The BBA granted the states the option to recognize pediatric nurse practitioners, family nurse practitioners, and certified nurse midwives as primary care case managers, while at the same time allowing them to refuse to recognize these practitioners. In addition, the BBA provided only a very vague reference to the types of providers that must be included in managed care panels. Plans must only show that they provide access to "a sufficient number, mix, and geographic distribution of providers." In effect, the BBA inadvertently allowed APRNs to be excluded as Medicaid providers in primary care case management and managed care.

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## RATIONALE

Medicaid beneficiaries should have access to the full range of services provided by APRNs, including case management services. Each year many Americans go without the health care services that they require because physicians simply are not available to care for them. This problem plagues rural and urban areas alike. Medicaid beneficiaries are particularly vulnerable, since in recent years a number of health professionals have chosen not to care for them or have been unwilling to locate to the communities where many beneficiaries live. APRNs are an exception to this trend; they frequently accept patients that others will not treat and serve in provider shortage areas. The proper utilization of APRNs will increase access to health care and decrease expenses related to preventable acute care admissions and emergency room visits. ☺

## WHISTLEBLOWING/PATIENT ADVOCACY PROTECTIONS FOR NURSES

### POSITION

The American Nurses Association (ANA) supports legislation to protect the nurse's right to speak out about activities, practices, or conditions that threaten the health and safety of their patients or the environment.


### BACKGROUND

Whistleblowing is the public disclosure of unlawful or hazardous activities or practices by members of one's own organization. This action often occurs after employees have exhausted existing channels for correcting problems or when employers are unresponsive or have retaliated in the past.

Whistleblowing by nurses usually results from concern about issues that jeopardize the health or safety of patients or place the employee at risk due to occupational safety and health violations. Although nurses are responsible for patient care and well-being, they often are powerless when another health care provider engages in unethical or life-threatening practices. There have been a number of legal cases involving nurses who have "blown the whistle" on their employers. In particular, nurses have been instrumental in identifying violations of research standards and refusal of care to newborns.

In 1989, Congress enacted the Whistleblower Protection Act to protect federal workers. This law was expanded in 1994 to cover workers in veterans' facilities hired under Title 38, as well as government corporation employees. However, current whistleblower laws remain a patchwork of incomplete coverage. Fear of reprisal and lack of protection prevent many employees from taking the risk of speaking out to protect public health and safety. Reprisals may include dismissal, harassment, or blacklisting.

### RATIONALE

ANA contends that an over-reliance on individual scrutiny has failed to address the burgeoning system problems that have fostered poor patient care. For registered nurses, patient advocacy is at the heart of their professional commitment. It is a priority of nursing organizations representing the full spectrum of nursing specialties, including advanced practice and staff nurses, whether or not its members engage in collective bargaining: this is because patients depend on nurses to ensure that they receive proper care. Patients must be assured that nurses and other health care professionals, acting within the scope of their expertise, will be able to speak for them without fear of retaliation. 



NURSING'S LEGISLATIVE AND  
REGULATORY INITIATIVES FOR  
THE 110TH CONGRESS

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# *Workplace Health and Safety*

Health Care Worker Safety

Safe Patient Handling and Movement

## HEALTH CARE WORKER SAFETY

### POSITION

Nurses have the right to a safe and secure workplace in which to provide quality patient care. The American Nurses Association (ANA) is working to protect nurses from workplace injury and infection in a variety of ways, including lobbying for legislative and regulatory initiatives and adequate resources to ensure a workplace that is free from avoidable physical dangers.

### BACKGROUND

Working in a health care facility is reported to be one of the most dangerous jobs in the United States. The Department of Labor reports that a health care worker in a nursing facility is more likely to be injured on the job than a coal miner. Health and safety threats in the nursing workplace include: infectious diseases, physical violence, ergonomic injuries related to the movement and repositioning of patients, exposure to hazardous chemicals and radiologicals, and sharps injuries.

In a national survey of RNs conducted by ANA in 2001, 88 percent of working nurses reported that health and safety concerns influence their decisions to continue working in the field of nursing as well as the kind of nursing work they choose to perform. Fewer than 20 percent of the nurses in this survey felt very safe from work-related injury and illness in their current work environment, 40 percent had been injured on the job in the past year. Over three-quarters of the nurses surveyed (76 percent) indicated that unsafe working conditions interfere with their ability to deliver quality care.

Often, these injuries and infections could be avoided by the proper use of technology, environmental controls, and protective equipment. Yet, nurses are often denied access to these protections. ANA maintains that it is incumbent upon the federal government and individual health care facilities to: provide adequate workplace safeguards such as risk-reducing devices and equipment; enforce protective procedures that minimize risks; educate staff concerning risks; provide personal protective equipment; utilize safety engineered sharps, and; cooperate with research into actual and potential risks.

*Continued* →

## RATIONALE

Improving the health and safety of the health care workplace is a key to solving the growing nursing shortage. As Congress works to develop ways to stop the exodus of nurses from the bedside, and to attract new and dedicated nurses to the profession, the importance of including health and safety considerations in our strategies for improving working conditions should not be overlooked nor underestimated. ☺

## SAFE PATIENT HANDLING AND MOVEMENT

### POSITION

The American Nurses Association (ANA) supports actions and policies that result in the elimination of manual patient handling. Patient handling, such as lifting, repositioning and transferring has conventionally been performed by nurses. The performance of these tasks exposes nurses to increased risk for work-related musculoskeletal disorders. With the development of assistive equipment and devices, such as lifting equipment and lateral transfer and friction reducing devices, the risk of musculoskeletal injury can be eliminated or significantly reduced. A Safe Patient Handling and Movement (SPHM) program decreases injury to nurses, other health care workers and patients, while reducing work-related health care costs and improving the safety of patient care delivery.

### BACKGROUND

Over the past decade, much attention has been given to the health and safety concern among health care workers. The extent of musculoskeletal disorders among the U.S. nursing workforce is particularly distressing when considered in the context of the current nursing shortage. Estimates report that 12% of nurses leave the profession annually due to back injuries and greater than 52% complain of chronic back pain. Specifically, injuries secondary to patient handling tasks compound factors driving the shortage such as aging of the nursing workforce, declining retention and recruitment rates, and lowering social value of nursing.

Despite the recognition that manual patient handling is a high-hazard task, the incidence of musculoskeletal disorders persists at high rates for nurses and other nursing personnel—signaling the need for continued action. Emerging efforts to prevent musculoskeletal injuries have concentrated on reducing exposures through the use of assistive equipment and devices for patient handling. Last year, nine states (CA, FL, HI, IL IA, MA, MI, NJ, WV) introduced Safe Patient Handling and Movement legislation, while five states enacted legislation (OH, TX, NY, WA, RI). ANA supported these legislative initiatives, and will continue to seek new ways to advance this issue on both the state and federal level.

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## RATIONALE

Over the last two decades, health care has rapidly become one of the most dangerous industries in the United States. Unfortunately, health care workers, particularly nursing personnel, experience a disproportionate rate of occupational illness and injuries compared to the private sector in general. More than any other work-related injury or illness, musculoskeletal disorders (MSDs) are responsible for lost work time, the need for protracted medical care, and permanent disability among health care workers.

- Every day the average nurse lifts 1.8 tons per shift, as a result, nurses suffer debilitating and often career-ending and life-altering injuries from repeatedly lifting, moving, transferring, and repositioning patients.
- Back injuries affect up to 38% of all nurses.
- Patient handling, transfers and manual lifting are significant risks factors for back injuries.
- Recent changes in the health care environment have lowered staffing levels; such downsizing requires individual nurses to care for more patients even as fewer people are available to assist.

ANA has strong evidence that current working conditions in health care are contributing to increased injury and disease among nurses as well as driving the exodus from bedside nursing care. Additionally, technologically feasible and cost-effective solutions to controlling ergonomic hazards (such as mechanical patient lifting equipment and patient lateral transfer devices) now exist and have been successfully implemented in hospitals and nursing homes across the country. 🇺🇸



NURSING'S LEGISLATIVE AND  
REGULATORY INITIATIVES FOR  
THE 110TH CONGRESS

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*Patient  
Safety/Advocacy*

Access to Health Care Coverage

Medical Malpractice Liability/Tort Reform

Medicare Reform/Prescription Drugs

Genetic Nondiscrimination

Health Care Quality Measures and Information

Stem Cell Research

## ACCESS TO HEALTH COVERAGE

### POSITION

The American Nurses Association (ANA) is committed to comprehensive health care reform that will ensure universal access to health care (preferably through a single-payer system). ANA also continues to support progressive, incremental steps to cover the millions of Americans who lack health care coverage and to oppose efforts to exempt new insurance pools such as association health plans (AHPs) from state insurance laws and regulations.

### BACKGROUND

The U.S. system of private, employer-based health insurance has served a crucial role in expanding the availability of health care coverage and ensuring a stable financial base for the health care system. However, this system has never reached all Americans, nor was it designed to provide coverage for all. The Medicare and Medicaid programs were enacted in 1965 to fill two of the most gaping holes in the system by providing coverage for those over 65 (and later, the permanently disabled) and for a large segment of the poor.

Since 1994, when efforts at comprehensive health care reform were defeated, a number of notable efforts have been made to increase health care access for specific target populations, including the Health Insurance Portability and Accountability Act (HIPAA) and the State Children's Health Insurance Program (S-CHIP). ANA has supported efforts to increase access to quality health care, even when they are limited to a specific population and not intended to be comprehensive in scope.

However, ANA opposes and remains deeply concerned about efforts to expand coverage by creating new categories of insurance plans that are exempt from state mandated health insurance requirements. Proposals taking this approach, such as AHPs, would pre-empt important protections provided by state laws and regulation that guarantee a minimal level of coverage. They ensure that plans cover services such as maternity care, cancer screenings, mental health services, and home health care. By removing coverage for cost-effective primary and preventative care benefits such as well-child care, this pre-emption could drive up the cost of health care. ANA is particularly concerned that these AHPs would be exempt from state laws that guarantee access to advanced practice registered nurses (APRNs) such as nurse midwives, nurse practitioners, and clinical nurse specialists.

As of December 2005, at least 32 states required insurance coverage of services provided by nurse practitioners, 30 states required coverage for nurse midwives. This guaranteed coverage can be especially vital to individuals in underserved rural or urban areas where

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APRNs represent key access to primary care. ANA believes that AHP-type plans would do little to cover the uninsured and are not an acceptable answer to the very real access and affordability concerns facing small businesses and their employees.

ANA has developed a proposal based on improving the Medicare program and expanding it into a program of health care coverage for all Americans. This proposal for a universal Medicare system would take the best of Medicare—a social health insurance program that has succeeded in providing coverage to virtually all elderly and disabled Americans for 40 years—and use it as the basis for a comprehensive, seamless program to ensure that every American citizen or resident has access to needed health care benefits.

## RATIONALE

The number of uninsured Americans remains unacceptably high, at nearly 43 million people, or 15 percent of the U.S. population. Too many Americans are simply not reached by employer-based insurance, private plans, or existing public programs. They include those who work for employers that do not provide health benefits, part-time or seasonal workers in positions that do not offer benefits, the self-employed, families who do not qualify for Medicaid, and people for whom coverage is available but who cannot afford to pay the premiums.

The uninsured experience worse health and die sooner as compared to individuals who are covered by health insurance. The Institute of Medicine reports that lack of insurance at the community level is associated with financial instability for health care providers and institutions, reduced hospital services and capacity, and significant cuts in public health programs, all of which impact access to certain types of care for all residents, even those who have coverage. ☺

## MEDICAL MALPRACTICE LIABILITY/TORT REFORM

### POSITION

The American Nurses Association (ANA) supports a balanced, multi-pronged legislative approach to address the current medical malpractice liability problem, which includes:

- Systemic changes to improve patient safety and reduce medical errors, such as establishment of a nation-wide mandatory, state-based error reporting system; the enactment of whistle blower protections; and other reforms identified in the statement on “Building Safe Health Care Systems for Informed Patients” that was adopted by the ANA House of Delegates in 2000;
- An independent commission to study and report to Congress and the President on the factors that have contributed to the current problem and on the impact that limitations on health care liability litigation and recoveries have had at the state level;
- Common-sense liability reforms, such as periodic payment of future damages, adoption of the collateral source rule, and providing liability protections for health care workers providing care in emergency situations; and
- More vigorous oversight and regulation of professional liability insurance industry practices and premiums;
- Opposition to dollar caps on health care liability litigation, which ANA views as premature, before receipt of the report of an independent commission on the liability issue.

### BACKGROUND


As the costs of medical malpractice liability insurance have continued to rise, posing a threat to patient access and provider availability, the issue of medical malpractice/tort reform has generated increasing attention and concerns from the health care, legal and insurance communities as well as from state and national policy makers, consumers, and the media. The resolution of the Medical Malpractice/Tort Reform issue is a priority for the Bush Administration, and many organizations are being asked to engage in advocacy on this issue. Multiple factors have contributed to the recent cycle of medical malpractice rate increases including the health care liability system, failure to adequately prevent medical errors, short staffing in many health care facilities, and the need for reforms within the insurance industry.

Although there is general agreement among the stakeholders that this issue remains a problem for some specialties and in some areas of the country, there is little agreement on the causes and even less agreement about possible solutions to address the issue. Physicians and insurance companies—which are on one side of the issue lobbying for

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caps on non-economic damages—are pitted against the trial lawyers, who are advocating for insurance reform. Consumer advocacy groups are lobbying for legislation on medical errors, including disclosure rules and safety standards. They maintain that high malpractice premiums also reflect weak insurance profits and investment decisions, not just frivolous malpractice suits.

## RATIONALE

A problem that arises from multiple factors cannot be solved by legislation that addresses only one of these factors, such as the imposition of limits on health care liability litigation and recoveries. The impact of such limitations at the state level is the subject of much debate and an impartial evaluation of what has happened in the states is needed in order to inform the decisions of policy makers on whether such limitations should be adopted at the federal level. 

## MEDICARE REFORM/PRESCRIPTION DRUGS

### POSITION

The American Nurses Association (ANA) supports the creation of a standard, affordable prescription drug benefit within the Medicare program. ANA maintains that the Medicare program should provide all beneficiaries with affordable access to needed medications and health care services.

### BACKGROUND

America's nurses have long supported our nation's efforts to create a health care system that assures access, quality, and services at affordable costs. ANA has also historically supported the mission and philosophical underpinning of the Medicare program. We were the first health professional association to endorse the creation of Medicare in the 1960s.

In 2003, Congress passed the Medicare Prescription Drug and Modernization Act (MMA, P.L. 108-173). This law made the largest wholesale changes to the Medicare program since its inception, and created a new Medicare Part D to cover the costs of prescription drugs. Beginning in 2006, Medicare beneficiaries were offered a voluntary prescription drug benefit through private health plans. These plans will include premiums and deductibles averaging roughly \$600 in 2007. The benefit maintains a large coverage gap, during which beneficiaries will receive no drug benefits, although they will continue to pay premiums. Some individuals with lower incomes will receive more generous benefits, while wealthier seniors will have to pay more for their Medicare Part B premium.

The MMA explicitly prohibits the government from negotiating with pharmaceutical manufacturers for lower prescription drug prices, and has thus failed to provide access to less expensive drugs from foreign countries. This prohibition on direct prescription drug price negotiation restrains Medicare from using its market power to secure lower cost medications. Medicare plans now pay more on average for common medications than the VA and the state Medicare programs.

ANA did not support the MMA because it contains an insufficient prescription drug benefit, one that will continue to leave beneficiaries with prohibitively high medication costs. In addition, the law relies heavily upon the private market to deliver the meager prescription drug benefit. History shows that these private plans are incapable of meeting the needs of America's seniors and the disabled population.

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## RATIONALE

ANA supports the creation of a benefit that ensures that all Medicare beneficiaries have reliable and affordable access to needed medications and health care services. In evaluating and responding to Medicare prescription drug benefit proposals, ANA evaluates whether or not the benefit advances this overarching goal. ANA support is based on the following principles:

- The benefit must offer comprehensive coverage that ensures affordable access to needed prescription drugs for all Medicare beneficiaries and grants assistance with cost-sharing to lower-income beneficiaries.
- All Medicare beneficiaries must be eligible for prescription drug coverage regardless of their income or health status.
- The benefit must be based on a standard, national Medicare benefit package that covers needed drugs and biologicals.

Regarding cost containment, ANA supports Medicare and/or its contractors being able to negotiate prices with pharmaceutical companies. CMS must begin to investigate methodologies for objectively determining appropriate drug prices under Medicare. ☞

## GENETIC NONDISCRIMINATION

### POSITION

The American Nurses Association (ANA) supports the enactment of federal legislation that protects individuals from discriminatory treatment and adverse consequences on the basis of their genetic information by employers and/or insurers.

### BACKGROUND

Genomics, the study of the genome and its use of genes, has gained much attention through successes like the Human Genome Project, where experts have mapped the human genome. Even before 2003, when the human genome sequence was completed, hundreds of tests were being developed through genomic research to screen for genetic diseases.

Genomic issues are of interest to patients, providers, insurers, and/or employers alike. First are the patients, who want to take advantage of advancements in genetic screening and treatment, have the treatment covered by their health insurance, and still be able to keep a job if it turns out they have a disease or a predisposition to one. Second, health care providers also have an interest in getting the best care for the patient while preserving the patient-provider relationship. If there are no protections against discrimination, people will be less likely to authorize genetic tests: this could often prevent people from being tested or even participating in genetic research studies needed to understand, treat, and prevent diseases.

Third, the payers (i.e., health insurance companies) are interested in protecting their profits, and therefore want to know if those they are covering have a genetic disease or are pre-disposed to a disease that might require significant expenditure in health care treatments. Finally, there are the employers who are increasingly concerned about how to reduce their burden of the high costs of health care. These gaps in privacy protection and corresponding lack of legal protection makes it easy to see how an asymptomatic person with a genetic disease may be denied health care coverage, even if they never end up getting sick.

A proposed way to prevent discrimination of genetic information in the workplace and in health insurance is to enact federal laws banning such practices and enforce stiff penalties to violators. ANA has supported genetic anti-discrimination legislation ever since its initial introduction in the 104th Congress in 1996. This year, Rep. Louise

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Slaughter (D-NY) is once again championing this issue with the introduction of the Genetic Information Nondiscrimination Act of 2007 (H.R. 493). The bill would:

- Set limits on genetic testing to prevent genetic discrimination by health insurance companies and employers,
- Prohibit mandated testing, and
- Stop insurance companies from setting premiums or deciding on eligibility based on genetic information.

Introduction of a companion bill in the Senate is anticipated. President Bush has also urged Congress and business leaders to work together to pass a bill that would prevent employers from denying people jobs—and insurance companies from denying eligibility—based on genetic profiles.

#### RATIONALE

As a strong proponent of comprehensive health care reform that would make appropriate health care accessible for all Americans, ANA has consistently supported genetic nondiscrimination legislation. ANA supports legislation that would prevent insurance providers from regressive policies which ultimately defeat the risk sharing purpose of insurance. This position is supported by the Code of Ethics for Nurses, which requires nurses to safeguard the patient's right to privacy by protecting information of a confidential nature and furthermore states that the rights, well being, and safety of the patient should be the determining factor in arriving at any professional judgment concerning the disposition of confidential information. 🙏

## HEALTH CARE QUALITY MEASURES AND INFORMATION

### POSITION

ANA advocates for the development and implementation of a valid health care quality measuring system to assess performance results that are understood and accepted by all participating providers. In addition, ANA supports the public reporting of transparent and comprehensible information so that consumers can be empowered to make value-based decisions about their health care. To accomplish these ends, ANA will continue to actively advocate for the inclusion and reporting of ANA-developed nursing-sensitive quality indicators as a way to improve quality patient care.

### BACKGROUND

Today, in response to variations in the quality of health care and rising health care costs, many policy makers and purchasers of health care services are experimenting with strategies to link payment more directly to the quality of care provided. Through a number of public reporting programs, demonstration projects, pilot programs, and voluntary efforts the current payment system is being transformed by rewarding providers for delivering high quality, efficient clinical care. An increasing number of purchasers/payers of health care services, including the Centers for Medicare and Medicaid Services (CMS) are embracing value-based purchasing or pay-for-performance programs along with public reporting of performance in an effort to improve the quality and cost-effectiveness of care while achieving high value for their health care dollars.

The core of any of these pay-for-performance programs are the measures used to rate the providers performance. The selection of quality measures is a topic that is particularly controversial for health care providers. It is impossible to determine performance and tie it to levels of reimbursement unless there is a valid measuring system to assess the outcomes that are understood and accepted by the participating providers. These concerns are among the significant factors to be considered in the health care environment where the quality of work may be difficult to measure and where many health care professionals are resistant to a change in the way they practice.

Quality measures can be process measures or outcomes measures or a combination of both. Some programs utilize patient outcome measures to assess the results of treatments for a particular disease or condition in terms of mortality, morbidity, health status, and quality of life. Other programs focus on improving the delivery of health care services and collect data on process measures such as indicators related to the methods and procedures used to provide health care services. In addition, many programs may include non-clinical performance measures as ways to determine levels of payment. For example, patient satisfaction scores, the adoption and use of information technology, and productivity measures (such as number of patients seen and/or prescribing patterns) are also being used as part of performance criteria in some value based purchasing programs.

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The definition and unification of quality measures that can be used across a large number of reporting initiatives, the implementation of risk adjustments for clinical outcome measures and the identification of the level and type of incentives that will effectively impact professional practice without compromising care are among the significant challenges that have yet to be resolved.

## RATIONALE

ANA has pioneered efforts to improve patient care, including the collection and dissemination of health care quality data. ANA's National Database of Nursing Quality Indicators (NDNQI) has been collecting data on nursing practice and patient outcomes in acute care for seven years.

ANA has participated in the National Quality Forum (NQF), which has endorsed over 100 quality indicators and performance measures encompassing a broad array of health topics including hospital care, patient safety, diabetes, cardiac surgery, nursing services, and nursing home care and is in the process of endorsing measures in ambulatory care, behavioral health, prescription medication use, deep vein thrombosis, and measures of care in academic health centers.

ANA has also successfully worked with JCAHO to develop the measurements for the 15 NQF nursing-sensitive quality indicators in preparation for reporting them in pay-for-performance programs.

ANA strongly supports the Patient Safety Act, legislation that would require health care facilities to make information publicly available about their staffing levels, patient care outcomes, and specific kinds of errors and avoidable patient care problems. Enactment of this legislation would take a strong step towards ensuring quality care by providing the public with the information they need to make informed decisions. 

## STEM CELL RESEARCH

### POSITION

The American Nurses Association (ANA) supports the ethical use of stem cells for research and therapeutic purposes that impact health.

### BACKGROUND


In 1998 a scientist at the University of Wisconsin published a report that described the establishment of a human embryonic cell line created from the successful removal of cells from unused embryos at a fertility clinic. This and other cell lines developed in the same way can be used for important healthcare research. While similar research can be done with adult stem cells, adult cells have not produced the full range of cell types that embryonic cells produce. Stem cells have the ability to divide and to transform into specialized cells. Human embryos that remain frozen and unused after in-vitro fertilization represent one of the most promising sources of embryonic stem cells. If these embryos are donated and used for stem cell research they may contribute to alleviating suffering and enhancing quality of life instead of remaining frozen or being discarded.

In 2001, President Bush announced that federal funds could only be used to support research using human embryonic stem cells lines that were derived before that date. The NIH Human Embryonic Stem Cell Registry currently lists about 21 embryonic stem cell lines. New and vigorous cell lines must be obtained to have appropriate samples, representing the diversity of our population, available for research.

ANA recognizes that stem cell research raises significant ethical considerations. ANA supports federal funding of stem cell research conducted within strict scientific and ethical guidelines, and believes that this funding should be free of conditions that may unnecessarily impede its progress and achievements. ANA also supports the ethical use of somatic cell nuclear transfer (SCNT or “therapeutic cloning”) and rejects the use of stem cell technology, or any technology, for the purposes of reproductive cloning.

While ANA recognizes there are opposing views on stem cell research, we believe the benefits to be realized for the many individuals who suffer from diseases and disabilities outweigh this dissent. Stem cell research is helping us understand fundamental cellular specialization and the application of that understanding.

### RATIONALE

Stem cell research will have a significant impact on health and quality of life. Research and therapeutic processes use adult, fetal and embryonic stem cells to explore the possibilities of growing new organs and tissues to replace those that are damaged or diseased. Collectively, these sources promise to achieve research goals and to develop new therapies. ANA recognizes the potential for stem cell research to provide relief through prevention, diagnosis and/or treatment for patients with a wide variety of complex diseases. 



# NURSING'S LEGISLATIVE AND REGULATORY INITIATIVES FOR THE 110TH CONGRESS

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