



# Public Policy Agenda 2011/12



**Quality Patient Care**



**Access to Emergency & Trauma Care**



**Workplace Safety**



**Emergency Preparedness**



**Injury Control & Prevention**

The Emergency Nurses Association (ENA) is the only professional nursing association dedicated to defining the future of emergency nursing and emergency care through advocacy, expertise, innovation and leadership.

Founded in 1970, ENA serves as the voice of more than 38,000 members and their patients through research, publications, professional development, injury prevention and patient education.

To learn more, visit **[www.ena.org](http://www.ena.org)**.



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Cover photo: Courtesy of the Hospital of the University of Pennsylvania Emergency Department.

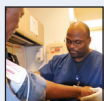
ENA publishes its *Public Policy Agenda* biennially to:

- Focus and establish the priority issues to be addressed.
- Inform members, government officials, colleague organizations and the media about ENA's public policy concerns.
- Provide a framework for ENA to review and report on actions that address ongoing policy concerns.

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### ENA in Brief

Founded in 1970, the Emergency Nurses Association (ENA) is the world's largest membership organization devoted to the advancement of emergency nursing practice and emergency care. ENA has more than 38,000 individual members representing a wide range of emergency nursing roles from staff nurses to nurse managers, flight, pediatric, prehospital and trauma nurses, as well as clinical nurse specialists, nurse practitioners, administrators, directors, educators and students.

ENA's mission is to advocate for patient safety and excellence in emergency nursing practice. It strives to achieve this through its 50 state councils and more than 170 local chapters across the United States. ENA serves its members by providing the latest information concerning emergency nursing practice, education, research, and management and professional issues.

The discipline of emergency nursing is grounded on the solid foundation of an evolving body of knowledge based on research. In 2009 ENA created two institutes. The mission of the Institute for Quality, Safety and Injury Prevention is to advance quality and safety for emergency nursing and emergency care to improve outcomes through best practice tools, advocacy and education. The Institute for Emergency Nursing Research's mission is to conduct and facilitate research and research activities for ENA and its members to support evidence-based practices for emergency nursing and emergency care.

ENA's premier publication, the *Journal of Emergency Nursing*, is the leading peer-reviewed academic journal addressing the specialty of emergency nursing. This bimonthly publication covers topics such as current clinical practice, research, organizational information and public policy issues of concern to the emergency nursing community.

ENA is on the forefront of emergency nursing education and supports research related to improving emergency care through the ENA Foundation.

## Government Affairs at ENA

An elected, 11-member board of directors is responsible for the direction and oversight of ENA's government affairs program. ENA members have a voice through the board, general assembly, national committee activities and work groups; state councils; and local chapters. At the national level, this program is administered by a government affairs staff at ENA's Washington, DC area office.

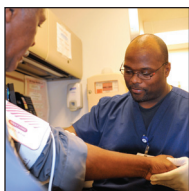
ENA's government affairs program is designed to: (1) advocate for quality patient care, injury prevention and wellness promotion; (2) represent the interests and concerns of emergency nursing professionals; (3) provide a strong unified voice for emergency nursing through legislative and regulatory representation; and (4) facilitate member participation. The association addresses current emergency nursing practice concerns by meeting with government officials, issuing position statements, initiating legislation, providing legislative and regulatory testimony and serving as a national network for mobilizing its members.

The Public Policy Agenda reflects the priorities of the ENA membership and the issues on which the board of directors initiates action. Highlighted throughout by the following color coding are those objectives that support ENA's three clinical priorities: emergency department crowding, violence in the emergency department and care of the psychiatric patient.

■ Crowding/Boarding

■ Workplace Violence

■ Psychiatric Emergency Patient Care



# Quality Patient Care

For 2011–2012, ENA will strive to improve patient safety and enhance quality of care through evidenced-based practice by:

- Collaborating with appropriate stakeholders to promote policies that develop coordinated systems to maximize continuity of care for patients with mental illness and/or substance use disorders, children, the elderly and other special patient populations.
- Monitoring the mental health parity and health care reform laws to ensure the implementation of mental health and substance use disorder provisions to the full extent of each law's intent.
- Advocating for legislation to fund research and to develop education programs and assessment tools for health care providers related to the care of psychiatric, children, elderly and other special patient populations.
- Promoting increased funding for policy initiatives that help alleviate the nurse and nurse faculty shortages and increase the retention and recruitment of registered nurses (RNs).
- Endorsing public policies that remove restrictions on the role and scope of practice of RNs and advanced practice nurses (APRNs).
- Supporting the use of APRNs in appropriate health care settings.
- Opposing restrictions on administering procedural sedation medications by qualified emergency department nurses.
- Promoting staffing models versus mandated staffing ratios.

With mental illness and addictive disorders accounting for nearly 30% of all illness-related disability, the number of people seeking care in emergency departments for mental illness and co-occurring disorders is climbing. In 2007, 12 million emergency department visits involved a diagnosis related to mental health disorders (66%), substance abuse (25%) or both (9%).

The U.S. is expected to see a 73% rise in the number of 65- to 75-year-olds between 2005 and 2025. If current trends continue, visits to emergency care facilities by older patients could almost double to 11.7 million visits by 2013. At the other end of the spectrum, 89% of children's emergency

visits have occurred at nonchildren's hospitals, but only 6% of those hospitals had all of the drugs and equipment deemed necessary to treat common pediatric emergencies. Emerging complex health and social needs of these and other special patient populations will demand adequately prepared emergency department staff.

Quality health care delivery in the U.S. is threatened on multiple fronts. Today's shortage of appropriately prepared nurses – although eased somewhat in various locales during the recent recession – still outpaces the level of investment necessary to meet the nation's growing health care demands.

ENA firmly believes that efforts that are not evidence-based and which restrict scope of practice – such as the use of specific medications, prescriptive authority or protocols – are impractical and not in the best interests of quality patient care.

With over 50.7 million Americans under or uninsured, APRNs are increasingly serving as experienced providers in emergency care settings and have significantly eased the burden of the 116.8 million Americans who sought treatment in emergency departments in 2007. A shortage of over 40,000 primary care providers is predicted by 2020. Research indicates that patients receiving primary care from APRNs have at least equivalent clinical outcomes as those cared for by physicians.

ENA opposes mandated staffing ratios or other unilateral methods for determining nurse staffing in the emergency department. Best practice staffing must account for variability in the number of visits, census patterns, patient acuity, nursing interventions and activities and length of stay.

## Current Policy Statements

[Mental Health Parity in Health Care Reform](#) – December 2010

[Improving Flow/Throughput to Reduce Emergency Department Crowding](#) – December 2010

[Older Adults in the Emergency Setting](#) – December 2010

[Guidelines for Care of Children in the Emergency Department](#) – August 2010

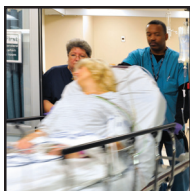
[EMSC Reauthorization](#) – April 2010

[Title VIII Nursing Workforce Development Programs](#) – March 2010

[Medicaid Emergency Psychiatric Care](#) – June 2009

[Procedural Sedation Consensus Statement](#) – March 2008

[Advanced Practice in Emergency Nursing](#) – March 2007



# Access to Emergency & Trauma Care

For 2011–2012, ENA will:

- Support evidence-based government initiatives aimed at addressing the systemic issue of crowding including holding or boarding of patients in the emergency department and the restrictions of alternative settings for patient care.
- Advocate for policy initiatives that promote coordinated, regionalized emergency and trauma care systems.
- Support increased funding for the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Advocate for patients' rights to access emergency and trauma care.
- Promote national access to primary care through policy initiatives that enhance the services of local community health centers, nurse-managed and neighborhood clinics.

ENA opposes holding or boarding in the emergency department. This practice is not in the best interest of patients. Evidence-based research demonstrates that the consequences of holding or boarding include: ambulance diversion, increased hospital length of stay, medical errors, increased patient mortality and patients leaving before receiving care. When the normal capacity of the emergency department has been exceeded, other inpatient and outpatient units should be considered as alternative sites of care.

The U.S. is in the midst of an unprecedented public health crisis affecting the delivery of emergency and trauma care. Factors leading to this crisis are symptomatic of a system that has failed to meet the requirements of a society with diverse health care needs. Fifty million people in the U.S. have no Level I/II trauma center access within the “golden hour” of care. ENA believes emergency and trauma care must be regionalized to help ensure that patients are transported to the right hospital at the right time for the right care.

Largely excluded from the current health care system, people with mental and substance use disorders rely on “safety net” services, such as emergency care. ENA supports increased funding for SAMHSA, which works to reduce the impact of



substance abuse and mental illness by funding research and state block grants. Unmet health care jeopardizes the health and wellness of individuals while increasing unnecessary costs to society.

These systemic issues are complex and interrelated, challenging health care providers in every emergency department across the nation. They are supported by the following facts:

- **Sixty-two percent of the nation's emergency departments report being “at” or “over” operating capacity.**
- **Between 1997 and 2007, the number of annual emergency department visits rose by 23% – from 94.9 million to 116.8 million – while the number of 24-hour emergency departments declined by 5%, from 4,114 in 1997 to 3,925 in 2007.**
- **Escalating economic issues are causing an increasing number of trauma center and emergency department closures or cutbacks.**
- **A 30% decline in inpatient psychiatric beds over the past two decades has contributed to boarding psychiatric patients at a level that is double that of other emergency department-admitted patients.**
- **The delays in access to primary care equate to sicker patients presenting to the emergency department.**

## Current Policy Statements

[Access to Health Care](#) – December 2010

[Improving Flow/Throughput to Reduce Emergency Department Crowding](#) – December 2010

[Health Care Reform & Trauma-EMS Programs](#) – March 2010

[SAMHSA Modernization Act](#) – February 2010

[Medicare Mental Health Inpatient Equity Act](#) – February 2010

[Nurse Managed Health Clinic Investment Act](#) – May 2009

[Mental Health on Campus Improvement Act](#) – February 2009

[Hospital Inpatient Prospective Payment Systems](#) – June 2008

[Protecting the Medicaid Safety Net Act](#) – April 2008

[Holding Patients in the Emergency Department](#) – May 2006



# Workplace Safety

For 2011–2012, ENA will champion a culture of safety by:

- Advocating for public policies that mitigate and deter acts of violence in the emergency department.
- Promoting public policies that provide education and training of health care workers regarding violence in the workplace.
- Supporting OSHA's development of an all hazard workplace standard.
- Advocating for research funding to identify best practices for creating a safe work environment, such as screening, brief intervention and referral to treatment services for all emergency patients for risk of suicide, violence and substance use disorders.
- Supporting legislation and regulations that protect the health and well-being of emergency health care providers.
- Collaborating with other organizations to advocate for legislative and regulatory initiatives that increase the development and use of safety devices, environmental modifications and education on potential occupational hazards.

Workplace violence is generally defined as any physical assault; emotional or verbal abuse; or threatening, harassing or coercive behavior in the work setting that causes physical or emotional harm. The average annual rate for nonfatal violent crime for all occupations in the U.S. is 12.6 per 1,000 workers, compared to 21.9 for nurses. Violence in the workplace may be even more common than these statistics indicate due to a lack of incident reporting.

Violence in the emergency department is epidemic and emergency nurses are particularly vulnerable. The 24-hour accessibility of the emergency department; the lack of adequately trained, armed or visible security guards; and an overall stressful environment are among the reasons the emergency department setting is vulnerable to violence. ENA's

2010 Emergency Department Violence Surveillance Study of 3,211 emergency department nurses found that every week between 8 and 13% of emergency department nurses report being victims of physical violence. Fifteen percent of the nurses who reported experiencing physical violence said they sustained a physical injury as a result of the incident and in almost half of the cases – 44.9% – no action was taken against the perpetrator.

Many health care workers are at risk for possible transmission of communicable, preventable diseases. Maintenance of immunity and access to new vaccines as they become available are, therefore, an essential part of prevention and infection control programs for health care workers.

Nurses are at risk of harm from the environment in which they work. Factors influencing this situation include ergonomic injuries, needle stick injuries, an increase in morbid obesity and an aging workforce. ENA's 2009 Emergency Department Workplace Injury Study of 2,294 emergency nurses found that 20% experienced a workplace injury during the previous year; 72% of injuries were related to moving/transporting/lifting patients. Legislated federal and state safety policies must focus on environmental redesigns that maximize efficiency, address issues of moving and lifting patients and increase personal safety. Corresponding education to reduce the incidence of avoidable harm must be implemented.

### Current Policy Statements

[Violence in the Emergency Care Setting](#) – December 2010

[Bloodborne Pathogens Standard](#) – August 2010

[Communicable Diseases in the Emergency Department](#) – May 2010

[Hazardous Material Exposure](#) – October 2009

[Pandemic Influenza Vaccine Prioritization](#) – January 2007

[Latex Allergy](#) – December 2005

[Smallpox Vaccination](#) – December 2005

[Percutaneous Sharps/Needle Stick Injuries](#) – July 2003



# Emergency Preparedness

For 2011–2012, ENA will:

- Advocate for sufficient state and federal funding for training, equipment and coordination of resources for “first receivers” involved in the provision of medical care connected to the management of natural and man-made disasters.
- Collaborate with other organizations for a standardized, unified approach in the surveillance, communication, resource allocation and coordinated response to all hazards including contagious diseases.
- Partner with other organizations to support a national system that ensures a confidential, accurate and timely verification of professional credentials for all emergency care providers.
- Advocate for the inclusion of the unique needs of special populations in any planning, education or training for emergency preparedness.

Since 9/11, millions of dollars have been invested in strengthening disaster preparedness. This funding has primarily been used for equipment procurement and training involving chemical and biological contamination. Experience has shown that in disasters of mass contamination, only a portion – as little as 20% – of the victims remain on scene for decontamination and medical care. The remaining 80% will present at a local emergency department. However, emergency nurses have limited education and experience protecting themselves from threats of chemical and/or biological exposure or caring for patients who have been victims of disasters. Allocation of emergency preparedness monies to hospitals has been disproportionately low

compared to the share of the medical response to disaster events delivered by emergency departments. Continued and increased funding for hospitals and their staffs is important in order to meet the current deficits in training, equipment, supplies, resources, communications and coordination.

The involvement of emergency nurses and other health care providers is vital to prepare hospitals and communities across the country for potential disasters. Web-based reporting of disease symptoms by emergency departments, as a valued component of the public health infrastructure, can improve the timeliness and accuracy of national surveillance programs and improve the overall response to possible bioterrorism attacks.

Health care providers are critical volunteers in time of disaster. ENA supports a nationalized, uniform method to expedite verification of health care professionals' identity, licensing, education and employment – ensuring that these professionals can be deployed in a manner that will be of greatest benefit during a major disaster.

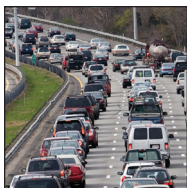
### Current Policy Statements

[All-Hazards – September 2008](#)

[National EMS Information System – April 2007](#)

[Emergency Medical Countermeasures Enterprise Strategy for CBRN Threats – October 2006](#)

[Emergency Care Crisis: A Nation Unprepared for Public Health Disasters – July 2006](#)



# Injury Control & Prevention

For 2011–2012, ENA will:

- Support legislation that strengthens awareness of the value of injury and illness prevention.
- Promote legislation and enforcement interventions in the areas of traffic safety including motor vehicle occupant protection (e.g., booster seats, child passenger safety, primary seat belt laws), graduated driver licensing, lower legal limits of intoxication and other strategies (e.g., ignition interlock devices) aimed at reducing the number of impaired drivers on our roadways.
- Support legislation to restrict the use of texting while driving.
- Advocate for legislation and regulatory initiatives that increase the research, development and use of safety devices (e.g., helmets, booster seats, seatbelts), engineering modifications and education and public awareness programs.

Preventable injury continues to be the number one killer of persons between the ages of one and 44. This problem is of epidemic proportions affecting all population groups and costing the nation more than \$600 billion each year. During the past 100 years the average life expectancy has increased from 45 to approximately 80 years of age. Only 10% of the factors that have contributed to this dramatic improvement are a result of advances in medical care. The remaining 90% can be attributed to advances in public education, prevention and regulatory requirements improving job safety and public health.

As many as 90% of injuries can be prevented. Unintentional injuries occur in the areas of transportation, recreational activities, occupational environments and residential settings. Intentional injuries are classified as homicide, suicide, abuse and assault. A demonstrable relationship exists between alcohol and substance abuse and the incidence of both unintentional and intentional injury. Drunk driving is no accident. It is the most frequently committed crime in the U.S. The installation of ignition interlock devices, for repeat offenders or those with high blood alcohol content, is an effective countermeasure that substantially lowers the opportunity to commit the crime of operating vehicles illegally.

Motor vehicle collisions continue to be the leading cause of injury-related death in the U.S. with distracted driving contributing to hundreds of thousands of injuries and deaths each year. Seventy-two percent of all drivers and 86% of all teen drivers admit to some form of distracting behavior while driving, from texting to eating.

### Current Policy Statements

[Safe Teen and Novice Driver Uniform Protection \(STANDUP\)](#) – September 2010

[Alcohol Screening and Brief Intervention](#) – October 2009

[Motor Vehicle Occupant Protection](#) – September 2008

[Motor Vehicle Safety](#) – July 2008

[Motor Vehicle Crash Data \(FARS and NASS\)](#) – June 2008

[Injuries: Sport and Recreation](#) – December 2007

[Cameron Gulbransen Kids and Cars Act](#) – May 2007



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