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Removal of ANA Language to Increase Access to Vaccination Compliance

Steven G. Pochop Jr.
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Removal of ANA Language to Increase Access to Vaccination Compliance

UNIVERSITY OF SAN DIEGO
Hahn School of Nursing and Health Science
Beyster Institute of Nursing

DOCTOR OF NURSING PRACTICE PORTFOLIO

by

Steven G. Pochop, Jr.

A portfolio presented to the

FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the
requirements for the degree

DOCTOR OF NURSING PRACTICE

[May 2021]

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Acknowledgments

Interestingly, when I started the graduate program at USD to become a DNP PNP/FNP, I had an entirely different picture of whom I would acknowledge when we were told of this option in our portfolio. Now that I am nearing completion, there is one person that I would like to acknowledge for helping me through every difficult time and obstacle that I have overcome in pursuit of this dream. My son, Steven G. Pochop III., affectionately known as Tripp, is the most deserving of an acknowledgement in anything good that happens in my life, his face provides a constant reflection of the man I aspire to become.

In his eyes, I saw when I had spent too long at the computer working on some paper or project and he taught me how to balance my priorities more effectively. When I hear him behind me and feel him give me a hug, I am reminded of the kids and the families I am serving with the accomplishment of this degree. Finally, when I hear him say, “I love you Daddy”, I am reminded that although this degree is a great accomplishment in my life, it does not define who I am as a man, a provider, or a father. The man that I am is who exists in the perception of a three-year boy.

Today, I may be a hero playing PJ Masks with him, and yet, tomorrow I might be the disciplinarian that he may not want to be around for a few minutes. His vision of what a man is supposed to be will be grown through my example or lacking through my faults. When I was tired and I did not feel like pushing through the exhaustion, the studying, and the far-too-many late nights or early mornings, it was Tripp that gave me the strength and intestinal fortitude to turn another page and make another drug card. I love you Son and hope that I make you proud every day. Proverbs 20:7.

Documentation of Mastery of DNP Program Outcomes

Professional Role

I have learned how to navigate the transition into the role of being provider versus the role of being a caregiver and nurse. They are not mutually exclusive and being a nurse laid the foundation for the compassionate care I will provide in the advance practice role. Additionally, the role of a being a nurse practitioner is not entered into lightly; I acknowledge that I have a specialized area of practice and a responsibility to operate in that capacity and not in an unlimited scope.

Multidisciplinary Collaboration

The role of the provider does not exist on a metaphorical island. I do not possess the wealth of knowledge to care for each patient holistically. I have a responsibility to provide care for my patients with the understanding that there are many professionals with more expertise than my own and to rely on them and their judgement in situations that I lack. It is not my knowledge or my skills that grant me success as a provider, but rather, my ability to recognize my deficits and to ask for help when it is needed.

Practice Guidelines

My authority to practice resides in the endorsement of the United States Navy, the State of California, and in whatever practice I am employed. My practice is a privilege and not a right, as such, I am expected to perform under the guidance and regulations of the entities which allow me to perform in the role of an NP. My responsibilities are to my patients over their entire lifespan, and to my professional obligations to strive to better the delivery of the healthcare system I have been charged to care for and to protect. I will achieve and maintain national certification and exercise only within my scope of practice.

Final Manuscript

Removal of ANA Language to Increase Access to Vaccination Compliance

Steven G. Pochop, Jr.

University of San Diego

Removal of ANA Language to Increase Access to Vaccination Compliance

Background

The prevalent culture regarding vaccinations in 2015 was one of fear and resistance. The American Nurses Association (ANA) recognized the potential ensuing impact this philosophy had on vaccine preventable illnesses and revised its immunization and vaccine policy statement (ANA Enterprise, 2015). Recent outbreaks of national and global diseases once declared eliminated by the World Health Organization (WHO) unequivocally signaled the necessity of another revision of policy that would make opting out of vaccinations less achievable, an obligatory action for the safety of the general public. In the outpatient pediatric clinic setting in patients eighteen years old and younger, does the implementation of the removal of the American Nurses Association (ANA), endorsement of religious exemptions for vaccinations compared to Measles, Mumps, and Rubella vaccination rates before the religious exemption endorsement removal occurred, result in increased MMR vaccination rates and decreased incidence of MMR in the following six to twelve months?

This evidence-based project recommended that the ANA Membership Assembly National Conference in Washington D.C. vote to remove its religious exemption support from current policy and add new guidance that required requisite yearly recertification for those seeking medical exclusions from vaccination. Within the United States commonplace occurrences of falsified alliances to religious establishments and unabashed indifference of the religious exemption's authored purpose compromise the safety of the general populace and of those who are sincerely unable to receive vaccinations. The urgency of this project implementation lobbying the removal of ANA

language supporting religious exemptions cannot be overstated; the pressing concern became not a matter of the location of the next preventable outbreak but a matter of time, and that, most exigent.

In 2019, the United States experienced the largest measles outbreak in a quarter of a century, and shortly after, on its heels, the global COVID 19 pandemic began. When the American Nurses Association (ANA) last amended its vaccine policy guidance in 2015, it was representative of the prevalent culture of vaccine hesitancy and non-compliance due to fear of thimerosal derivatives believed to be contained in vaccines and for philosophical reasons. The measles outbreak of 2019 across 31 states suggested that stronger language and fewer exemptions are incorporated into ANA's position statement on vaccinations and immunizations. "Before 1962, no formal nationwide immunization program existed. Vaccines were administered in private practices and local health departments and paid for out-of-pocket or provided by using state or local government funds with some support from federal Maternal and Child Health Block Grant funds" (Alan R. Hinman, MD, Walter A. Orenstein, MD, & Anne Schuchat, MD, 2011, p. 49). When President Kennedy signed the Vaccination Assistance Act in 1962, the general population was frequently exposed to debilitating and often fatal illnesses such as polio with its 'dungeon-esque' iron lung wards, and measles, mumps, rubella, varicella and pertussis, but that is not the situation in today's social media connected population. The devastating effect of what these illnesses produce is far-removed from the memories and experiences of today's parents, potential parents and largely, the general patient population under sixty years of age.

There has been an 80-100% decrease in all vaccine preventable illnesses since vaccines were mandated as illustrated below. “In the United States, policy interventions, such as immunization requirements for school entry, have contributed to high vaccine coverage and record or near-record lows in the levels of vaccine-preventable diseases” (Omer, Salmon, Orenstein, deHart, & Halsey, 2009, p. 1981).

The CDC currently only utilizes their Vaxview website to track and display exemption data received by each state via surveys or through local government reports when each child is enrolled into kindergarten but not as a tool to ascertain vaccination follow-up, exemption clearance, or recertification. Per the CDC, an estimation of children of kindergarten age who are ready to enter public or private schooling and have been immunized in accordance with state regulations or who have received an exemption excluding a required vaccination are reported each school year. (Centers for Disease Control & Prevention, 2019). In the most recent school year (SY), (2018-18), ten states reported MMR vaccination rates below the ninety-second percentile, not including Wyoming, of which a status of the survey “not conducted” was assigned (Centers for Disease Control & Prevention, 2019b). The MMR vaccination percentage threshold needs to achieve or maintain at or above 90 to 95% to achieve herd immunity because of the disease’s extremely high contagion properties (Oxford Vaccine Group, 2016).

Logically, suppose a child receives an exemption before kindergarten enrollment. In that case, it is within reason that there exists the probability that their exemption will remain unchallenged and ‘non-renewed’ through college (Belluz, 2019) unless mandated by a college or university enrollment protocol or workplace standard. Unfortunately, the collection methods are relegated to a federally funded immunization program and school

nurses and ‘other school personnel’ to manage and report (Mellerson, 2018), again increasing the likelihood that a large preponderance of unvaccinated children has gone unreported or underreported.

Data for children beyond kindergarten, teenagers (13-17 years old), and adults are collected via the National Immunization Survey (NIS). “The National Immunization Surveys (NIS’s) are a group of phone surveys used to monitor vaccination coverage among children 19–35 months and teens 13–17 years, and flu vaccinations for children six months–17 years” (Centers for Disease Control & Prevention, 2019, para. 1). The surveys are not conducted via a telephone call in the traditional sense; instead, the telephone conversation is the conduit in which a custodial caregiver or parent provides consent to obtain the name of the household’s children’s vaccination provider. Once consent, ages, and names of children have been given; “a questionnaire is mailed to each child’s vaccination provider(s) to collect the information on the types of vaccinations, number of doses, dates of administration, and other administrative data about the health care facility” (Centers for Disease Control & Prevention, 2019, para. 2).

“Allowance of religious and philosophical exemptions was associated with lower MMR and DTaP vaccination coverage and higher exemption rates “(Shaw et al., 2018, p. 7). This seems relatively straightforward based on the project data review: parents who can easily forego vaccination will forego vaccination. Vanderbilt University Medical Center provided the following insights on their website regarding immunizations and religion, “Most religions have no prohibition against vaccinations; however, some have considerations, concerns or restrictions regarding vaccination in general, particular reasons for vaccination, or specific vaccine ingredients” (Grabenstein, 2013, pp. 2011-

2023), presenting a compelling argument for removing religious exemption verbiage from the ANA's Immunization Position Statement.

Purpose

The project's purpose is the recommendation of the removal of the ANA's endorsement for religious exemptions from vaccinations in their policy statement due to misapplication of the exemption that compromised public safety. Additionally, a new standard of practice recommending the requirement of annual medical exemption recertifications by a qualified provider will be added to the Immunization statement. In states without philosophical exemptions for vaccines, religious exemptions are exponentially higher, indicating parents are using religious exemptions as a loophole to avoid vaccinations. This project intervention will usher in a state/national cessation of abuse of the religious exemption when other organizations at those levels all remove support for the exemption.

Evidence for Problem

A review of the literature was conducted using the following search engines: CINAHL Complete, Cochrane Library, PubMed, Clinical Key and Google Scholar. Keywords utilized were exemption(s), measles, MMR, philosophical, religious, vaccine(s), and vaccination. The search yielded over seventy articles from the past ten years from peer-reviewed publications. Articles were ranked according to levels of evidence; fifteen articles were chosen after the extensive review of the search article yield. "In a 12-year retrospective study in New York state, rates of religious exemption nearly doubled with the overall annual state mean prevalence of religious exemptions for one or more vaccines coming in at 0.4% from 2000–2011 and increasingly significantly

from 0.23% in 2000 to 0.45% in 2011 (P=0.001), according to Jana Shaw, MD, of SUNY Upstate Medical University in Syracuse, N.Y., and colleagues." A 2018 study illustrates the comparison of vaccination coverage related to exemption rates and states that "We found that state policies that refer to Advisory Committee on Immunization Practices recommendations were associated with 3.5% and 2.8% increases in MMR and DTaP vaccination rates. Health Department–led parental education was associated with 5.1% and 4.5% increases in vaccination rates. Permission of religious and philosophical exemptions was associated with 2.3% and 1.9% decreases in MMR and DTaP coverage, respectively, and a 1.5% increase in both total exemptions and nonmedical exemptions, respectively" (Shaw et al., 2018).

Evidence-Based Practice Model

The Iowa Model was chosen as the framework for this project because of its proven applicability in research. Titler describes it as both "a heuristic model that has been effective in improving the quality of care at the University of Iowa Hospitals and Clinics (UIHC) through conduct and utilization of nursing research and, an outgrowth of the Quality Assurance Model Using Research (QAMUR)" (Titler et al., 1994). Interestingly, the QAMUR is based on another research model, the Conduct and Utilization of Research in Nursing (CURN) Project (Watson, Bulechek, and McCloskey, 1987). The CURN project was "developed in 1975-1980 by the Michigan State Nurses Association with thirty-four hospitals participating" (Horsley, 1983).

The Iowa Model's strength resides in the evolution of three research models culminating as one; its creation provides practice change implementation guidelines with well-established roots in nursing research. The Iowa Model's flowchart design was

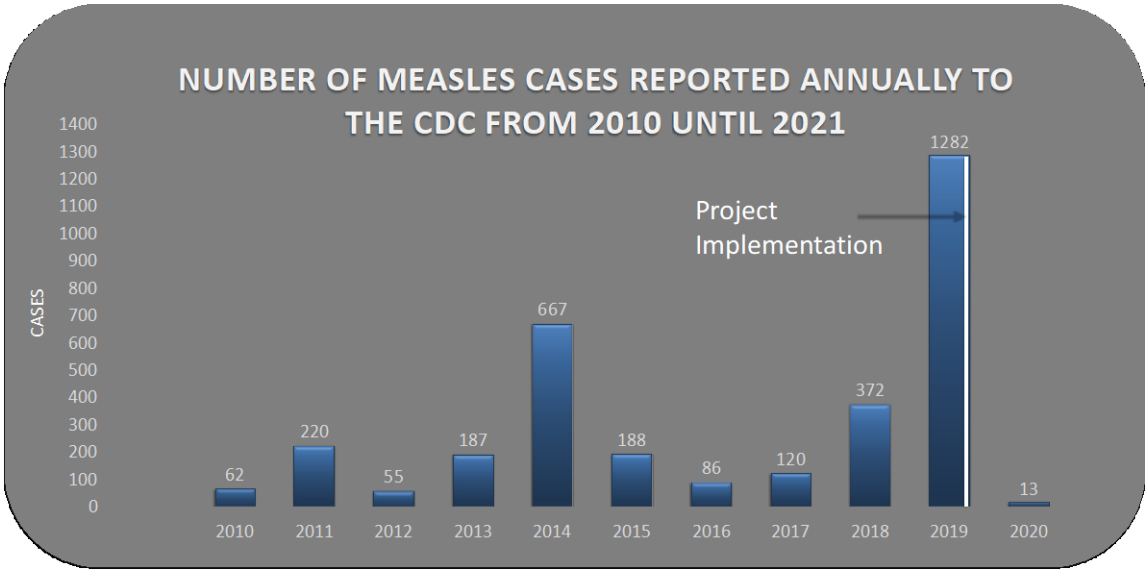
navigable and incorporated multiple opportunities to address areas that were lacking or overlooked (Titler et al., 2001). Other models considered were challenging to comprehend and were not suited to the proposed evidenced-based project undertaking. The inherent feedback loops engaged the consideration of alternatives and, many times, forced a reassessment of the project's goals (Melnyk & Fineout-Overholt, E., 2019). The model's greatest strength was its history of success within the clinical setting, which instilled confidence as inaugural research began for the EBP.

Project Plan Process

The project's design centered on data retrieved from the CDC regarding the vaccination rates from the United States retrieved from the Vaxview and a systematic review of data from various state and federal websites that recorded similar data. Although participants were not required in-person for the study, federally mandated vaccination programs allowed a comprehensive representation of those who had received vaccinations against the general population encompassed by the mandate. The intervention consisted of submitting a proposal to remove support from the American Nurses Association for religious exemptions and then monitoring the incidence of measles reported throughout the United States before and after implementing the project and revision of the ANA Immunization Position Statement. The outcomes, measured by data retrieved from the CDC website, are illustrated in Figure 1 below.

Figure 1

Number of Measles Cases Reported Annually to the CDC from 2010 until 2021



Note. Adapted *from Number of Measles Cases Reported Annually to the CDC from 2010 until 2021*, by the Centers for Disease Control and Prevention, 2021 (https://www.cdc.gov/measles/cases-outbreaks.html). In the public domain.

Results/Evaluation

The recommendation to remove religious exemption endorsement and the requirement for annual recertification for medical exemptions to vaccinations was approved and included in the ANA's Immunization Position Statement. In Figure 1 (above), the arrow represents when project implementation began and illustrates the decrease in measles as reported by the CDC's number of national cases from implementation until 2020; data for 2021 is not yet available.

Following project implementation, New York and Maine became the fourth and fifth states to remove all personal exemptions from vaccinations. Acting in concert, the philosophical or personal belief exclusion towards the MMR vaccination was removed as a requirement for childcare centers, public and private schools in Washington and the

state of Arkansas required reports from public and private schools that provided information and percentages on non-vaccinated children.

In 2020, Colorado established a goal of 95% of each academic institution's student population either being fully immunized or a certificate of completion from an online educational course be submitted by those who sought a nonmedical exemption. The state further required this information to be published and provided to students and their families (State of Colorado, 2021).

Agencies such as the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices (ACIP) now govern the Board of Health's Regulations for the Immunization of School Children in the Commonwealth of Virginia. Nationally, there has been a 99% decrease in measles prevalence since project implementation, with only 13 cases of measles reported in 2020 and none in the first quarter of 2021, the lowest number reported in over a decade.

Cost-Benefit Analysis for Sustainability

The cost of implementing the EBP project was $0.00, excluding the travel and lodging costs to present the proposal for the EBP to the American Nurses Assembly. However, other costs considered were the training of health care personnel, electronic medical record reconfigurations to include hard and soft stops upon discovery of a needed vaccination, and funding needed to educate the population against a culture of vaccine hesitancy misinfodemics. Included in the money saved algorithm was the average cost of each measles diagnosis, the cost of individual vaccinations, and the annual

salaries of those required to diagnose, treat and vaccinate each patient. An estimate of the benefits for the potential increase in revenue is provided in Figure 2, seen below.

Figure 2

Cost-Benefit Analysis

Benefits Costs	$46.2M $915K	
Cost Benefit Analysis	Program Benefits = $46.2M Total Program Costs = $915K	For every dollar spent, there is a $50.49 cost savings $50.49 savings / $1 dollar invested
Return on Investment	Net Program Benefit – Cost of Program (X) 100 Program Costs $46.2 M - $915K (X) 100 $915K	= ROI = 4,950% ROI

Although there was a relatively short implementation period for the EBP, the effects are equally as sustainable as they are long-lasting with avenues to continue implementing projects at local, state, and national levels that support the overarching goals of the initial EBP.

Implications for Practice

Vaccine-preventable illnesses will begin a downward trend until finally declared again eradicated by the World Health Organization. The removal of the ANA's endorsement for religious vaccinations will signal similar national organizations to limit opt-out opportunities towards vaccinations, and vaccination rates will increase while the incidence of preventable diseases will decrease. Implications for nurse practitioner clinical practice include developing a cognitive awareness of religions and their ordinates regarding vaccinations. Research into adverse vaccination events and the continually changing culture of vaccinations will provide insight into future clinical practice and vaccination exemptions and requirements needed to combat pandemics such as COVID-

19. Lastly, herd immunity will develop to a threshold that safely protects those who cannot be vaccinated (i.e., immunocompromised individuals).

Conclusion

Removal of ANA endorsement of religious exemptions to vaccinations has propagated a culture of vaccination compliance that ensures the safety of individual patients and that of the general populace, and it protects those who exempt from vaccination because of medical contradictions.

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Appendix A

Letter of Support from Clinical Site

Dear Dr. Burkard and Ms. Bird

On behalf of ANA's Professional Policy Committee, I am pleased to inform you that your policy submission, *Removal of Outdated ANA Language to Increasing Access to Vaccination Compliance*, has been accepted for consideration during the 2019 Membership Assembly. Membership Assembly, ANA's highest policy body, is scheduled to meet from June 21-22 in Washington, DC. *Removal of Outdated ANA Language to Increasing Access to Vac* pics that will be discussed following a review of over 60 pro occur the afternoon of June 21.

We have tentatively scheduled 40 minutes to discuss *Removal of Outdated ANA Language to Increasing Access to Vaccination Compliance* and its implications for nursing practice. In anticipation of this meeting, ANA asks that you develop a short background document that outlines the issue, particularly as it relates to nursing. This document should end with 3 questions that will be used to stimulate a dialogue with the attendees. The purpose of the background document is to provide a basic level of information to attendees PRIOR to the meeting so that they can prepare to engage in the discussion at the meeting. **In order to support the development of this document and the overall session, Stacey Taylor will contact you to schedule a conference call.** The deadline for receiving the short background document is **April 26.**

In order to support your participation in Membership Assembly, ANA will cover the cost of transportation and 1 or 2 nights at the hotel for one presenter – depending on your needs. Stacey and I will work with you in making your travel plans.

Congratulations on the selection of *Removal of Outdated ANA Language to Increasing Access to Vaccination Compliance*. I look forward to working with you to have a robust discussion at ANA's Membership Assembly. As a reminder, Stacey will be in touch to schedule a conference call. In the meantime, please do not hesitate to contact me (cheryl.peterson@ana.org / 301-628-5089) if you have any questions.

Marketa, you are included because this proposal was submitted by a ASNA member.

Sincerely,
Cheryl Peterson

Cheryl A. Peterson, MSN, RN
Vice President for Nursing Programs
American Nurses Association
8515 Georgia Avenue
Silver Spring, MD 20910
301-628-5089
Cheryl.peterson@ana.org
www.nursingworld.org

Appendix B

Poster Abstract

Abstract Title: Removal of ANA Language to Increase Access to Vaccination Compliance

Background: In 2015, the American Nurses Association (ANA) revised their immunization and vaccine policy statement to represent the prevalent culture of vaccine hesitancy and noncompliance for religious and philosophical reasons. The measles outbreak of 2019 across 31 states suggests that stronger language and fewer exemptions be incorporated into ANA's position statement on vaccinations and immunizations.

Purpose of Project: To recommend removal of ANA's endorsement for religious exemptions from vaccinations in their policy statement due to misapplication of the exemption that compromised public safety. Additionally, the standard of practice should require annual medical exemption recertification by a qualified provider.

EBP Model/Frameworks: The Iowa Model's intuitive architecture helped identify a knowledge gap during the 2019 measles crisis in the United States and triggered my research of removing all but non-medical exemptions from vaccinations as a national initiative. The Iowa Model was particularly designed to manage the efforts of clinicians after a triggering event to facilitate research and question development.

Evidenced Based Interventions: Mississippi, Virginia, and California exists as evidence-based models for decreasing vaccination preventable illness after removing verbiage for religious exemptions to vaccinations at the state legislative levels demonstrating a marked decline in disease prevalence.

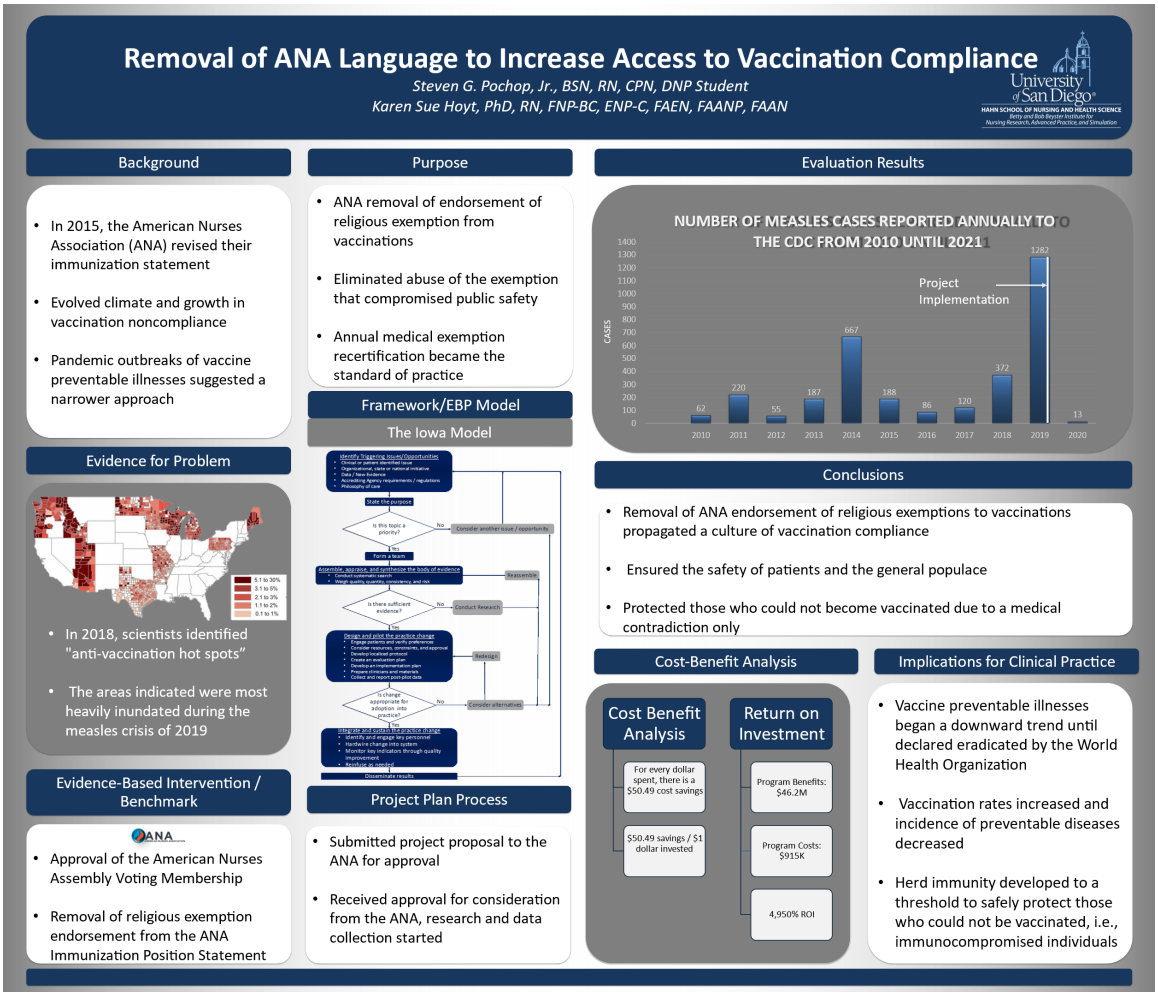
Evaluation/Results: The measurable increase in vaccination rates corresponding to the decrease in vaccine preventable illnesses as reported by the number of national cases by the CDC. The correlation of vaccination rates in states that allow religious and personal vaccination exemptions compared with the occurrence of preventable illnesses. Nationally, there has been a 99% decrease in measles prevalence since project implementation.

Implications for Practice: Vaccine-preventable illnesses will begin a downward trend until finally declared eradicated by the World Health Organization. The removal of the ANA's endorsement for religious vaccinations will signal similar national organizations to limit opt-out opportunities towards vaccinations and vaccination rates will increase while incidence of preventable diseases will decrease. Lastly, herd immunity will develop to a threshold that safely protects those who cannot be vaccinated, (i.e., immunocompromised individuals).

Conclusions: Removal of ANA endorsement of religious exemptions to vaccinations will propagate a culture of vaccination compliance that ensures the safety of individual patients and that of the general populace and it protects those who exempt from vaccination because they cannot become vaccinated due only to medical contradictions.

Appendix C

Poster



Appendix D

PowerPoint Stakeholder Presentation

1

2


ANA
AMERICAN NURSES ASSOCIATION
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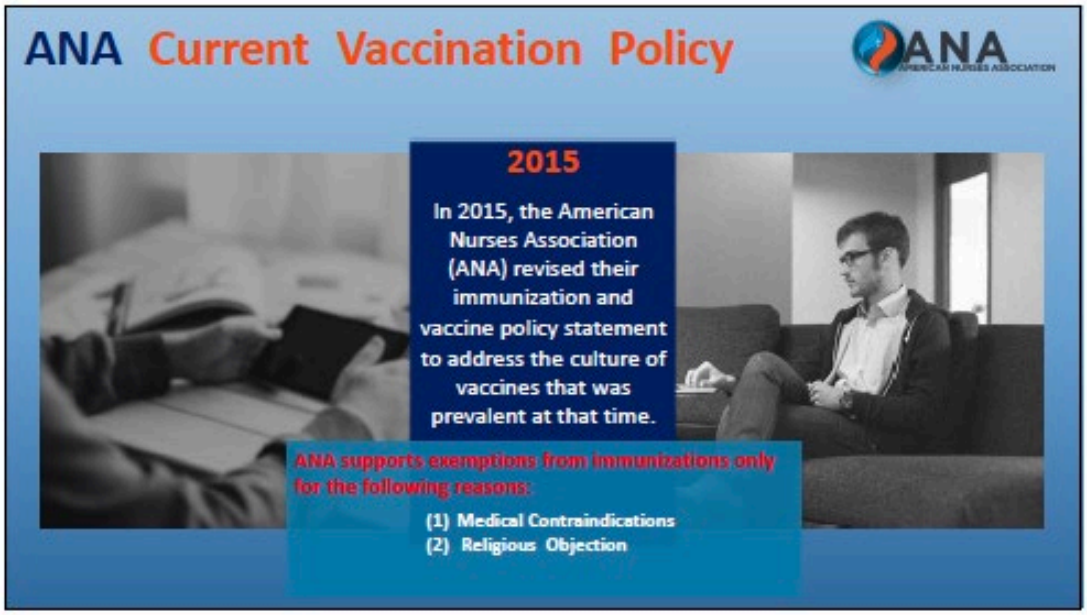
1 Proposal Objective
2 ANA's Current Policy on Vaccination
3 Measles Outbreak Crisis
4 Proposed Policy Change

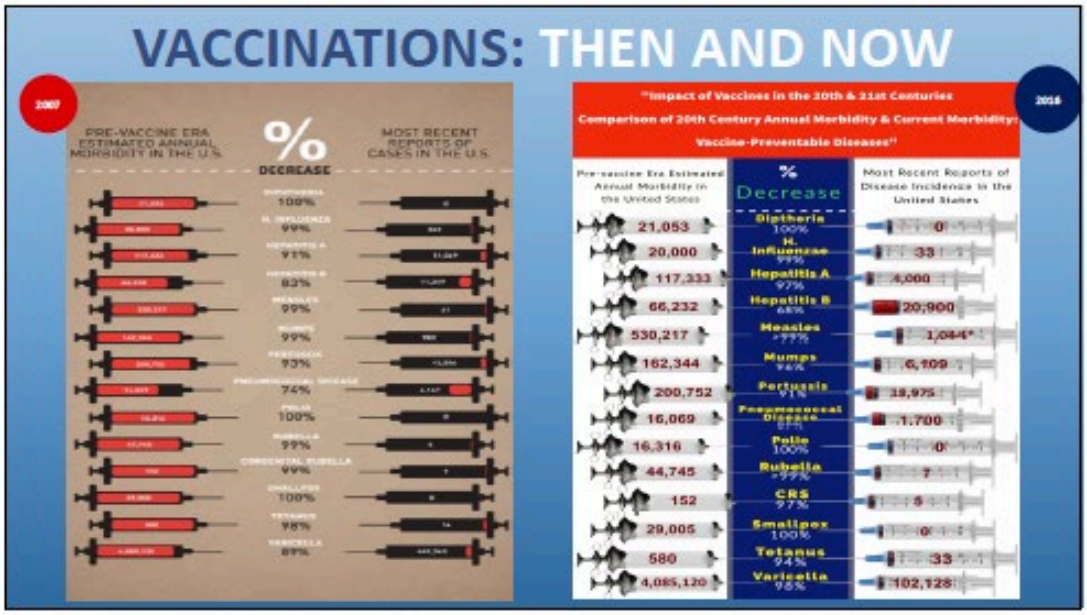
3


ANA
AMERICAN NURSES ASSOCIATION
01
PROPOSAL OBJECTIVE
Removal of Outdated ANA Language to Increase Access to Vaccination Compliance

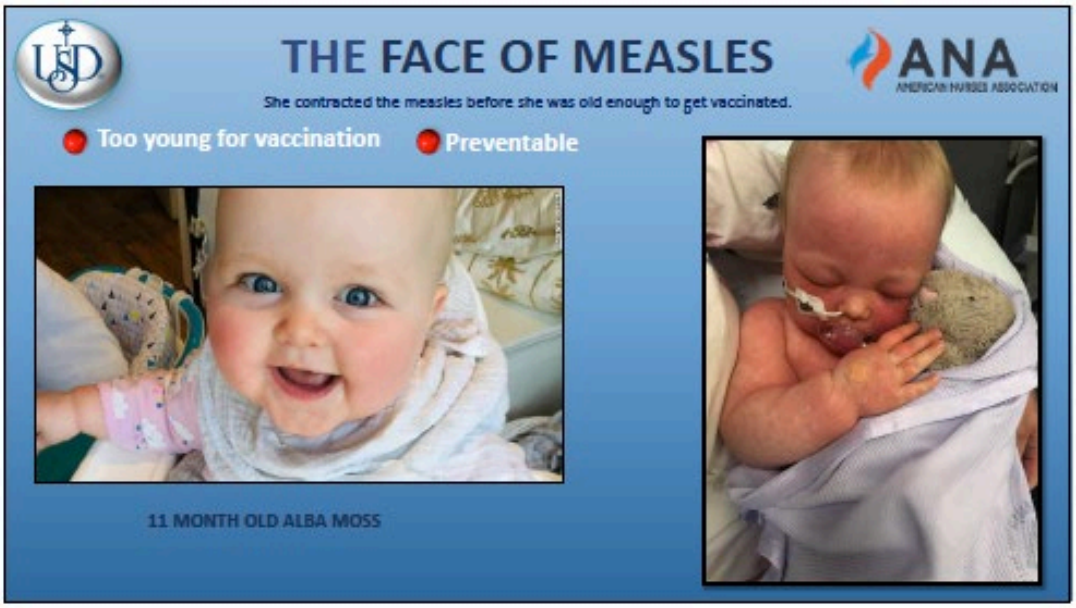
4


ANA Current Vaccination Policy
ANA
AMERICAN NURSES ASSOCIATION
2015
In 2015, the American Nurses Association (ANA) revised their immunization and vaccine policy statement to address the culture of vaccines that was prevalent at that time.
ANA supports exemptions from immunizations only for the following reasons:
(1) Medical Contraindications
(2) Religious Objection

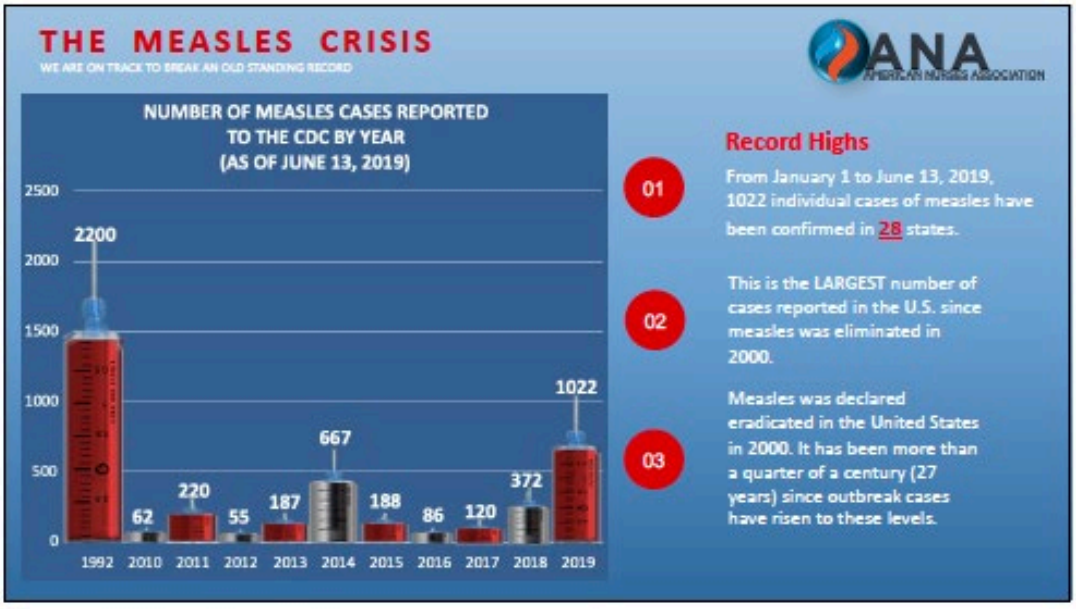
5

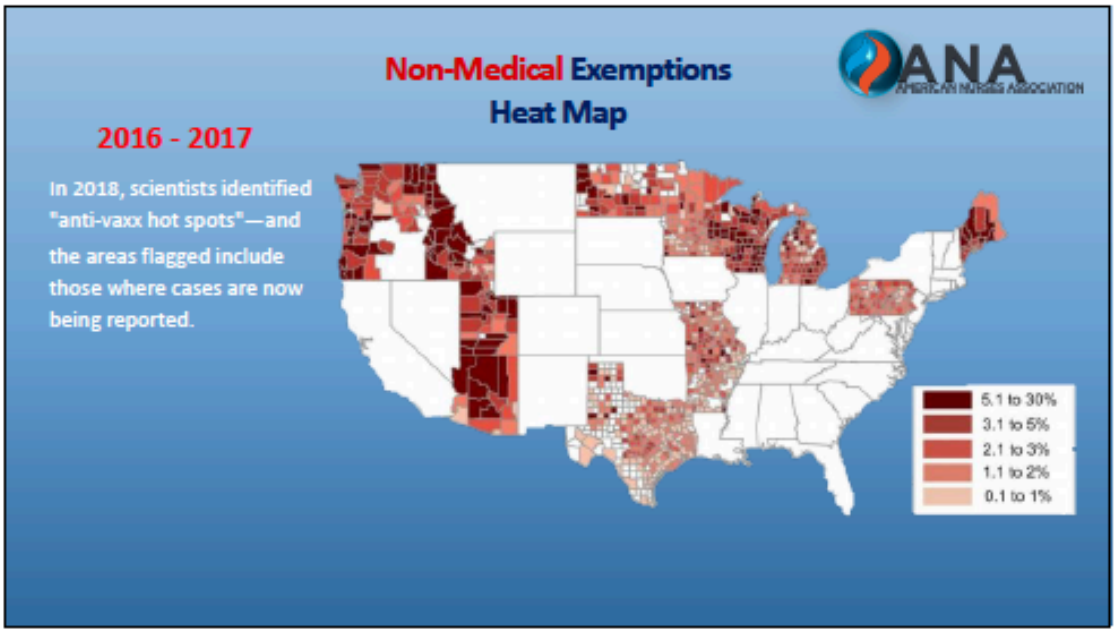

VACCINATIONS: THEN AND NOW
2007
PRE-VACCINE ERA ESTIMATED ANNUAL MORBIDITY IN THE U.S.
%
DECREASE
MOST RECENT REPORTS OF CASES IN THE U.S.
100%
99%
91%
83%
99%
99%
93%
74%
100%
99%
99%
100%
98%
89%
"Impact of Vaccines in the 20th & 21st Centuries
Comparison of 20th Century Annual Morbidity & Current Morbidity: Vaccine-Preventable Diseases"
2016
Pre-vaccine Era Estimated Annual Morbidity in the United States
% Decrease
Most Recent Reports of Disease Incidence in the United States
21,053
Diptheria 100%
0
20,000
H. Influenzae 99%
33
117,333
Hepatitis A 97%
4,000
66,232
Hepatitis B 68%
20,900
530,217
Measles >99%
1,044*
162,344
Mumps 96%
6,109
200,752
Pertussis 91%
15,975
16,069
Pneumococcal Disease 89%
1,700
16,316
Polio 100%
0
44,745
Rubella >99%
7
152
CRS 97%
5
29,005
Smallpox 100%
0
580
Tetanus 94%
33
4,085,120
Varicella 95%
102,128

6

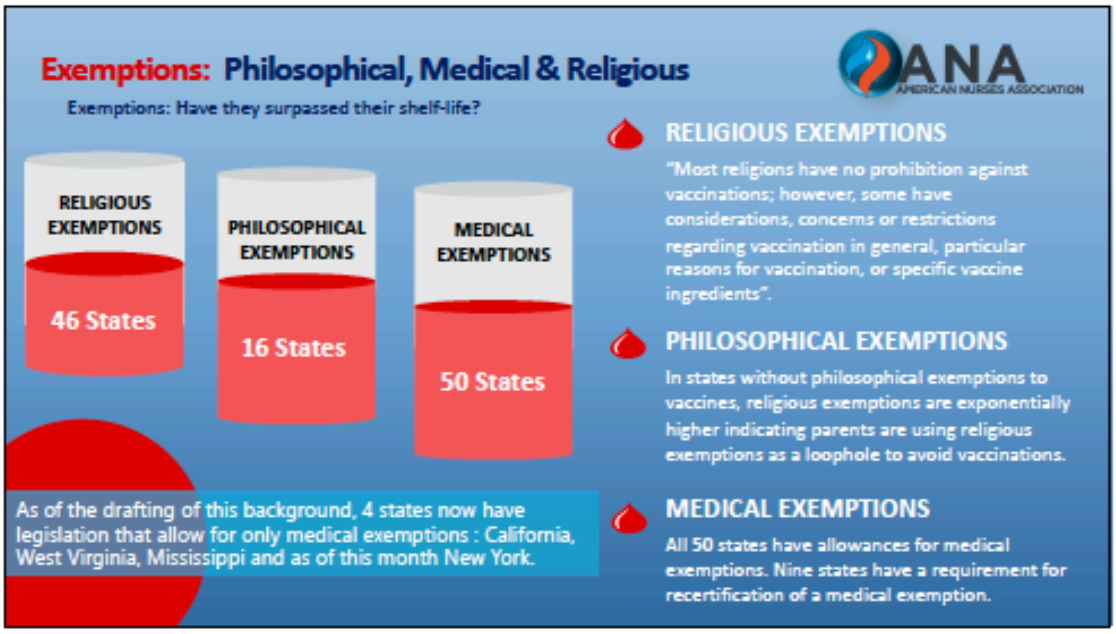

THE FACE OF MEASLES
ANA
AMERICAN NURSES ASSOCIATION
She contracted the measles before she was old enough to get vaccinated.
Too young for vaccination
Preventable
11 MONTH OLD ALBA MOSS

7

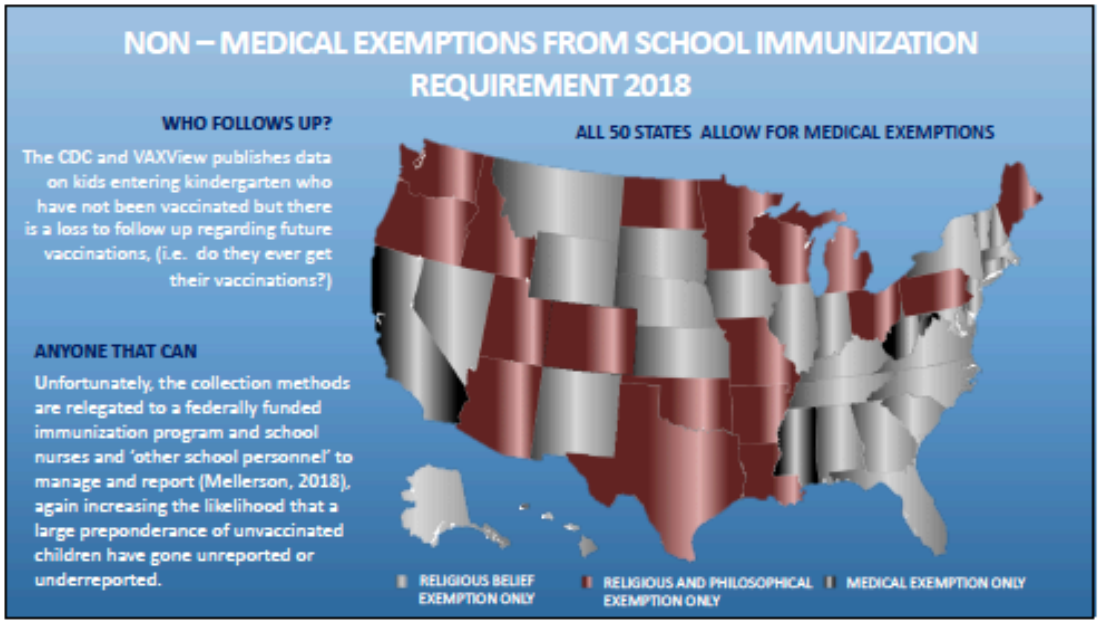

THE MEASLES CRISIS
WE ARE ON TRACK TO BREAK AN OLD STANDING RECORD
ANA
AMERICAN NURSES ASSOCIATION
NUMBER OF MEASLES CASES REPORTED
TO THE CDC BY YEAR
(AS OF JUNE 13, 2019)
2500
2000
1500
1000
500
0
2200
62
220
55
187
667
188
86
120
372
1022
1992 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019
01
Record Highs
From January 1 to June 13, 2019, 1022 individual cases of measles have been confirmed in 28 states.
02
This is the LARGEST number of cases reported in the U.S. since measles was eliminated in 2000.
03
Measles was declared eradicated in the United States in 2000. It has been more than a quarter of a century (27 years) since outbreak cases have risen to these levels.


Non-Medical Exemptions
Heat Map
ANA
AMERICAN NURSES ASSOCIATION
2016 - 2017
In 2018, scientists identified "anti-vaxx hot spots"—and the areas flagged include those where cases are now being reported.
5.1 to 30%
3.1 to 5%
2.1 to 3%
1.1 to 2%
0.1 to 1%

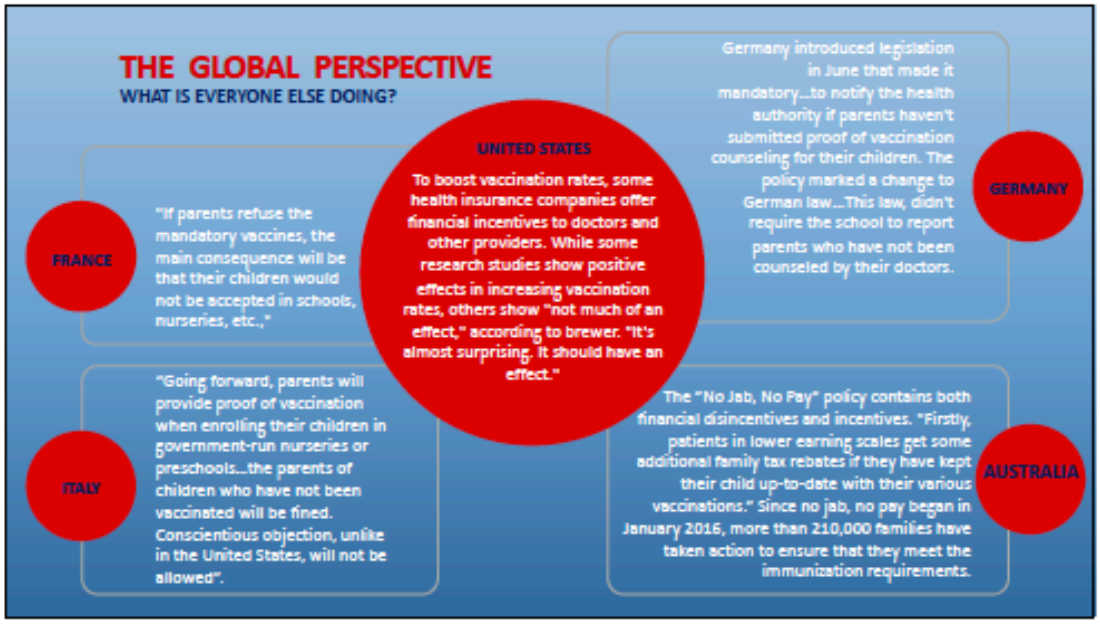
9


Exemptions: Philosophical, Medical & Religious
ANA
AMERICAN NURSES ASSOCIATION
Exemptions: Have they surpassed their shelf-life?
RELIGIOUS EXEMPTIONS
46 States
PHILOSOPHICAL EXEMPTIONS
16 States
MEDICAL EXEMPTIONS
50 States
As of the drafting of this background, 4 states now have legislation that allow for only medical exemptions : California, West Virginia, Mississippi and as of this month New York.
RELIGIOUS EXEMPTIONS
"Most religions have no prohibition against vaccinations; however, some have considerations, concerns or restrictions regarding vaccination in general, particular reasons for vaccination, or specific vaccine ingredients".
PHILOSOPHICAL EXEMPTIONS
In states without philosophical exemptions to vaccines, religious exemptions are exponentially higher indicating parents are using religious exemptions as a loophole to avoid vaccinations.
MEDICAL EXEMPTIONS
All 50 states have allowances for medical exemptions. Nine states have a requirement for recertification of a medical exemption.

10


NON – MEDICAL EXEMPTIONS FROM SCHOOL IMMUNIZATION REQUIREMENT 2018
WHO FOLLOWS UP?
The CDC and VAXView publishes data on kids entering kindergarten who have not been vaccinated but there is a loss to follow up regarding future vaccinations, (i.e. do they ever get their vaccinations?)
ANYONE THAT CAN
Unfortunately, the collection methods are relegated to a federally funded immunization program and school nurses and 'other school personnel' to manage and report (Mellerson, 2018), again increasing the likelihood that a large preponderance of unvaccinated children have gone unreported or underreported.
ALL 50 STATES ALLOW FOR MEDICAL EXEMPTIONS
RELIGIOUS BELIEF EXEMPTION ONLY
RELIGIOUS AND PHILOSOPHICAL EXEMPTION ONLY
MEDICAL EXEMPTION ONLY

11


THE GLOBAL PERSPECTIVE
WHAT IS EVERYONE ELSE DOING?
UNITED STATES
To boost vaccination rates, some health insurance companies offer financial incentives to doctors and other providers. While some research studies show positive effects in increasing vaccination rates, others show "not much of an effect," according to brewer. "It's almost surprising, it should have an effect."
FRANCE
"If parents refuse the mandatory vaccines, the main consequence will be that their children would not be accepted in schools, nurseries, etc.,"
GERMANY
Germany introduced legislation in June that made it mandatory...to notify the health authority if parents haven't submitted proof of vaccination counseling for their children. The policy marked a change to German law...This law, didn't require the school to report parents who have not been counseled by their doctors.
ITALY
"Going forward, parents will provide proof of vaccination when enrolling their children in government-run nurseries or preschools...the parents of children who have not been vaccinated will be fined. Conscientious objection, unlike in the United States, will not be allowed".
AUSTRALIA
The "No Jab, No Pay" policy contains both financial disincentives and incentives. "Firstly, patients in lower earning scales get some additional family tax rebates if they have kept their child up-to-date with their various vaccinations." Since no jab, no pay began in January 2016, more than 210,000 families have taken action to ensure that they meet the immunization requirements.

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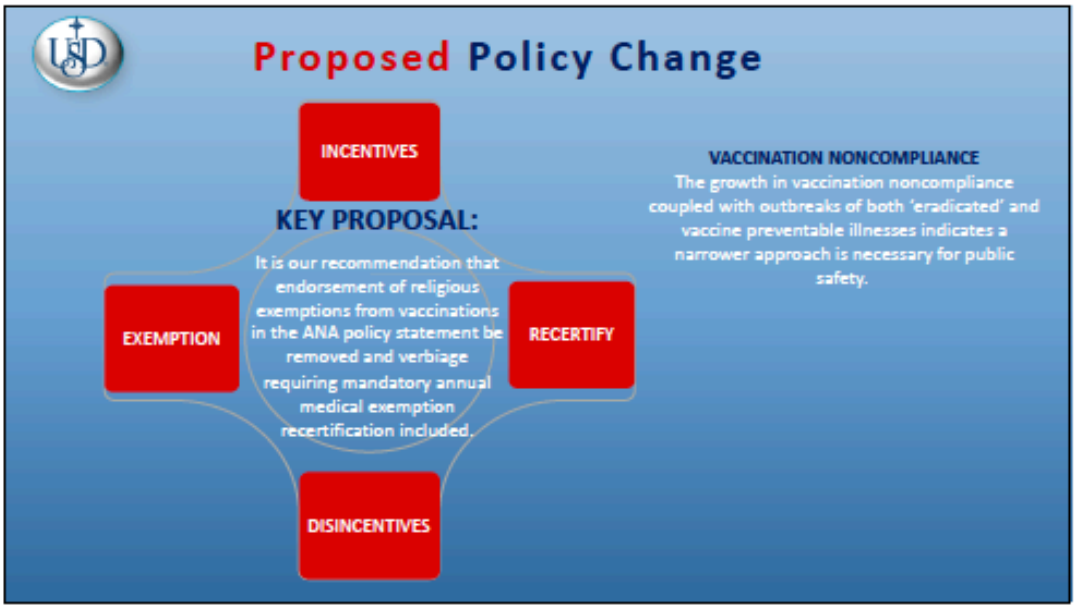
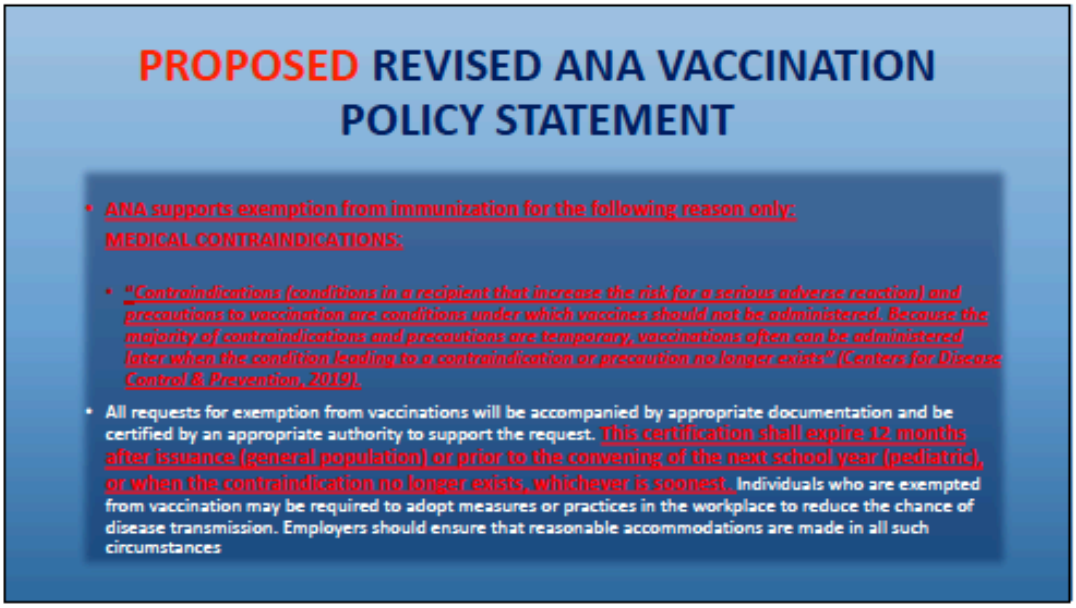

Proposed Policy Change
INCENTIVES
KEY PROPOSAL:
It is our recommendation that endorsement of religious exemptions from vaccinations in the ANA policy statement be removed and verbiage requiring mandatory annual medical exemption recertification included.
EXEMPTION
RECERTIFY
DISINCENTIVES
VACCINATION NONCOMPLIANCE
The growth in vaccination noncompliance coupled with outbreaks of both 'eradicated' and vaccine preventable illnesses indicates a narrower approach is necessary for public safety.

13


PROPOSED REVISED ANA VACCINATION POLICY STATEMENT
ANA supports exemption from immunization for the following reason only:
MEDICAL CONTRAINDICATIONS:
"Contraindications (conditions in a recipient that increase the risk for a serious adverse reaction) and precautions to vaccination are conditions under which vaccines should not be administered. Because the majority of contraindications and precautions are temporary, vaccinations often can be administered later when the condition leading to a contraindication or precaution no longer exists." (Centers for Disease Control & Prevention, 2019).
All requests for exemption from vaccinations will be accompanied by appropriate documentation and be certified by an appropriate authority to support the request. This certification shall expire 12 months after issuance (general population) or prior to the convening of the next school year (pediatric), or when the contraindication no longer exists, whichever is soonest. Individuals who are exempted from vaccination may be required to adopt measures or practices in the workplace to reduce the chance of disease transmission. Employers should ensure that reasonable accommodations are made in all such circumstances

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Appendix E

AACN DNP Essentials/NONPF Competencies/USD DNP Program Outcomes

Exemplars

AACN DNP Essentials & NONPF Competencies	USD DNP Program Objectives	Exemplars Provide bulleted exemplars that demonstrates achievement of each objective
DNP Essential I: Scientific Underpinnings for Practice **NONPF: Scientific Foundation Competencies** *The scientific foundation of nursing practice has expanded and includes a focus on both the natural and social sciences including human biology, genomics, science of therapeutics, psychosocial sciences, as well as the science of complex organizational structures. In addition, philosophical, ethical, and historical issues inherent in the development of science create a context for the application of the natural and social sciences.*	**2.** Synthesize nursing and other scientific and ethical theories and concepts to create a foundation for advanced nursing practice.	♦ Incorporated Neuman Systems and Roy's Models during patient care and education, (i.e. BP Screenings conducted during NP week). **(4 hours)** ♦ Utilized the Ottawa Model of Research and Orem's Self-Care Deficit Tool when authoring/researching project paper in DNPC 611. **(2 hours)** ♦ Explored foundational epidemiology including societal impact causality and disease prevalence for project paper in DNPC 625. **(2 hours)** ♦ Evaluated healthcare delivery and EBP application during Grand Rounds assignments in DNP 520. **(6 hours)** ♦ Authored and submitted ANA Professional Proposal that was adopted into ANA forum dialogue to be accepted as new policy for vaccinations. **(504 hours)** ♦ Drafted a manuscript for publication for the ANA/C, The Nursing Voice. **(30 hours)** ♦ Published in the ANA/C nursing voice once as first author and once as second author. **(40 hours)** ♦ Authored third subsequent article in a 3-part series for *The Nursing Voice*,

AACN DNP Essentials & NONPF Competencies	USD DNP Program Objectives	Exemplars Provide bulleted exemplars that demonstrates achievement of each objective
DNP Essential I: Scientific Underpinnings for Practice **NONPF: Scientific Foundation Competencies** *The scientific foundation of nursing practice has expanded and includes a focus on both the natural and social sciences including human biology, genomics, science of therapeutics, psychosocial sciences, as well as the science of complex organizational structures. In addition, philosophical, ethical, and historical issues inherent in the development of science create a context for the application of the natural and social sciences.*	**2.** Synthesize nursing and other scientific and ethical theories and concepts to create a foundation for advanced nursing practice.	♦ Incorporated Neuman Systems and Roy's Models during patient care and education, (i.e. BP Screenings conducted during NP week). **(4 hours)** ♦ Utilized the Ottawa Model of Research and Orem's Self-Care Deficit Tool when authoring/researching project paper in DNPC 611. **(2 hours)** ♦ Explored foundational epidemiology including societal impact causality and disease prevalence for project paper in DNPC 625. **(2 hours)** ♦ Evaluated healthcare delivery and EBP application during Grand Rounds assignments in DNP 520. **(6 hours)** ♦ Authored and submitted ANA Professional Proposal that was adopted into ANA forum dialogue to be accepted as new policy for vaccinations. **(504 hours)** ♦ Drafted a manuscript for publication for the ANA/C, The Nursing Voice. **(30 hours)** ♦ Published in the ANA/C nursing voice once as first author and once as second author. **(40 hours)** ♦ Authored third subsequent article in a 3-part series for *The Nursing Voice*,

of application that involves the translation of research into practice and dissemination and integration of new knowledge.		corrections. Investigated outcome measures and implemented new tools, graphics and recommendations ultimately changing the culture surrounding vaccination policies. (See above 504 hours) ♦ Served as a committee member for the American Nurses Association Professional Policy Committee; accepted and reviewed the ANA's 2020 Call for proposals to improve the nursing profession, investigated 45 proposals and collaborated with the PPC to address and submit the final approved 6 proposals at the virtual annual ANA Membership Assembly, 2020 **(35 hours)**
DNP Essential IV: Information Systems/Technology & Patient Care Technology for Improvement & Transformation of Health Care **NONPF: Technology & Information Literacy Competencies** *DNP graduates are distinguished by their abilities to use information systems/technology to support and improve patient care and health care systems, and provide leadership within healthcare systems and/or academic settings. Knowledge and skills related to information systems/technology and patient care technology prepare the DNP graduates apply new knowledge, manage individual and aggregate level information, and assess the efficacy of patient care technology appropriate to a specialized area of practice along with the design, selection, and use of information systems/technology to evaluate programs of care, outcomes of care, and care systems. Information systems/technology provide a mechanism to apply budget and productivity*	**7.** Incorporate ethical, regulatory, and legal guidelines in the delivery of health care and the selection, use, and evaluation of information systems and patient care technology.	♦ Designed multiple presentations and executed their deliveries via programs such as Microsoft Office 365 utilizing (PPT, Word, and Excel) **(25 hours)** ♦ Created and maintained professional social media networking accounts (LinkedIn) for HCIN 540 **(2 hours)** ♦ Utilized various research tools such as PubMed, CINAHL, and Clinical Key for the formation of various projects and papers. **(10 hours)** ♦ Incorporates UpToDate, and Lexicomp databases in article reviews and advanced pharmaceutical queries when

tools, practice information systems and decision supports, and web-based learning or intervention tools to support and improve patient care.		conducting research for projects. **(2 hours)** ♦ Learned two programs for generating effective presentations via Adobe Spark© and IMovie©. Utilized gained knowledge in presentations in Reflective Philosophy and the 2019 ANA Assembly Meeting in Washington, D.C. **(30 hours)** ♦ Learned an additional program for presentations in Finance, & Adobe After Effects. **(10 hours)**
DNP Essential V: Health Care Policy for Advocacy in Health Care **NONPF: Policy Competencies** *Health care policy, whether created though governmental actions, institutional decision-making, or organizational standards, creates a framework that can facilitate or impede the delivery of health care services or the ability of the provider to engage in practice to address health care needs. Engagement in the process of policy development is central to creating a health care system that meets the needs of its constituents. Political activism and a commitment to policy development are central elements of DNP practice.*	**3.** Demonstrate leadership in collaborative efforts to develop and implement policies to improve health care delivery and outcomes at all levels of professional practice (institutional, local, state, regional, national, and/or international).	♦ Drafted ANA Bill proposal (Vaccine Proposal) in DNPC 648. **(6 hours)** ♦ Provided substantive feedback on legislative bill proposal (CA AB 890) in DNPC 648. **(2 hours)** ♦ Was an invited guest speaker on submitted policy proposal to the ANA that resulted in changing the vaccination policy guidance for the voting assembly. Specifically: 1. ANA adopts the revised position statement that includes: ♦ a. Removal of the religious exemption, and ♦ b. Require mandated annual medical exemption recertification **(72 hours)** ♦ Advocate for increased funding for social marketing education campaigns incentives for vaccine-compliant parents, and reimbursements to providers who have high vaccination compliance. **(1 hour)**

		♦ b. Advocate for the establishment of standardized, state and/or federal immunization database. **(1 hour)** ♦ c. Promote use of existing immunization resources, like ANA's Immunization materials and the Centers for Disease Control and Prevention (CDC). **(1 hour)** ♦ Presented a 10-minute delivery of policy changes and a 30-minute discussion Q&A to address the concerns of over 300 nurses in the ANA Voting Assembly. The ANA adopted the recommendations and stated it was "excellent Doctoral work". **(1 hour)** ♦ Serves on the ANA/C Legislative committee where discussions are utilized to form our official stance on future nursing legislation issues. **(10 hours)** ♦ Serves on the ANA Policy Development Committee; appointed by the President of the ANA. **(60 hours)** ♦ A member of the ANA/C Legislative Committee, he deliberated, supported and lobbied for AB 890, which was signed into law on September 20, 2020 by Governor Newsom and allowed NP's to work without physician supervision, by removing the supervisory requirement in existing law. **(6 hours)**
DNP Essential VI: Interprofessional Collaboration for Improving Patient & Population Health Outcomes	**1.** Demonstrate advanced levels of clinical practice within	♦ Leads the Certified Pediatric Nursing Program at NMCSD with active

NONPF: Leadership Competencies *Today's complex, multi-tiered health care environment depends on the contributions of highly skilled and knowledgeable individuals from multiple professions. In order to accomplish the IOM mandate for safe, timely, effective, efficient, equitable, and patient-centered care in this environment, health care professionals must function as highly collaborative teams. DNPs have advanced preparation in the interprofessional dimension of health care that enable them to facilitate collaborative team functioning and overcome impediments to interprofessional practice. DNP graduates have preparation in methods of effective team leadership and are prepared to play a central role in establishing interprofessional teams, participating in the work of the team, and assuming leadership of the team when appropriate.*	defined ethical, legal, and regulatory parameters in designing, implementing, and evaluating evidenced-based, culturally competent therapeutic interventions for individuals or aggregates. **3.** Demonstrate leadership in collaborative efforts to develop and implement policies to improve health care delivery and outcomes at all levels of professional practice (institutional, local, state, regional, national, and/or international).	coordination with the PNCB to improve pediatric healthcare delivery. **(45 hours)** ♦ Attended ANA Hill Day 2019, meeting with staffers for congresspersons including: -Hon. Diane Feinstein -Hon. Susan Davis -Hon. Scott Peters -Hon. Kamala Harris **(6 hours)** ♦ Advocated for (S296/H.R. 2150) Home Health Care Planning Improvement Act of 2019 **(2 hours)** ♦ Advocated for (S1399/H.R. 728) Title VIII Nursing Workforce Reauthorization Act **(2 hours)** ♦ Advocated for (S851/H.R. 1309) The Workplace Violence Prevention for Health Care and Social Services Workers Act. **(2 hours)** ♦ Discussed the drafting of new legislation for FY2020 to implement Safe Staffing Levels for Nurses and Patients in the state of California. **(2 hours)** ♦ Continues correspondence with state legislators Dianne Feinstein and Kamala Harris regarding nursing legislation. **(4 hours)** ♦ Supported COVID-19 education and community education efforts to suppress virus transmission in California. Donated and contributed to classmates' efforts for 150 kits which included bottled water, gloves, and masks to the homeless population. **(1 hour)**

DNP Essential VII: Clinical Prevention & Population Health for Improving Nation's Health **NONPF: Leadership Competencies** *Consistent with national calls for action and with the longstanding focus on health promotion and disease prevention in nursing, the DNP graduate has a foundation in clinical prevention and population health. This foundation enables DNP graduates to analyze epidemiological, biostatistical, occupational, and environmental data in the development, implementation, and evaluation of clinical prevention and population.*	**6.** Employ a population health focus in the design, implementation, and evaluation of health care delivery systems that address primary, secondary, and tertiary levels of prevention.	♦ Targeting the Cystic Fibrosis pediatric population is central to DNP capstone project and has been thematic in several projects for DNPC 611, 625, & 626. **(10 hours)** ♦ Co-authored group presentation for Breast Cancer Screening Prevention in DNPC 611. **(4 hours)** **SEE DNP Essential V: Health Care Policy for Advocacy in Health Care (ABOVE)**
DNP Essential VIII: Advanced Nursing Practice **NONPF: Independent Practice/Ethics Competencies** *The increased knowledge and sophistication of healthcare has resulted in the growth of specialization in nursing in order to ensure competence in these highly complex areas of practice. The reality of the growth of specialization in nursing practice is that no individual can master all advanced roles and the requisite knowledge for enacting these roles. DNP programs provide preparation within distinct specialties that require expertise, advanced knowledge, and mastery in one area of nursing practice. A DNP graduate is prepared to practice in an area of specialization within the larger domain of nursing.*	**1.** Demonstrate advanced levels of clinical practice within defined ethical, legal, and regulatory parameters in designing, implementing, and evaluating evidence-based, culturally competent therapeutic interventions for individuals or aggregates.	♦ Shadowed active duty military nurse practitioner at NMCSD., have not completed clinicals as an NP student to date. ♦ Completed **216 hours** of clinical care in the outpatient pediatric setting at NMCSD Balboa. ♦ Completed **91 hours** of clinical care in the outpatient Fast Track setting at NMCSD Balboa. ♦ Completed **57 hours** of clinical care in the outpatient setting at KM Family Practice Clinic. ♦ Completed **162 hours** at NMCSD Pediatric In-patient Ward. ♦ Completed **108 hours** at FHCSD North Park.

KM 5/31/16

Appendix F

2019 ANA Membership Assembly Dialogue Forum Topic #1

2019 Membership Assembly
Dialogue Forum Topic #1
Removal of Outdated ANA Language to Increasing Access to Vaccination Compliance

FRIDAY, JUNE 21

Submitted by: Joseph Burkard, DNSc, CRNA, ANA\California member; Steven Pochop Jr., BSN, RN, CPN, DNP student; Olivia Kearnes, BSN, RN, DNP student; and Janelle Bird, BSN, RN, DNP student.

Overview: In 2015, the American Nurses Association (ANA) revised its immunization and vaccine policy statement to address the culture surrounding vaccines that was prevalent at that time (ANA Enterprise, 2015). The contemporary evolving climate and growth in vaccination noncompliance, coupled with outbreaks of both so-called eradicated and vaccine-preventable illnesses, emphatically indicate that a narrower approach is both favorable and necessary for public safety. It is our recommendation that endorsement of religious exemptions from vaccinations in the ANA policy statement be removed and verbiage requiring mandatory annual medical exemption recertification be added. Fraudulent abuse and blatant disregard of the purported intent of the religious exemption to immunizations is widespread throughout the United States, compromising public health. Finally, it is imperative that new legislation be authored to supplement or provide funding for educational vaccination programs to inform the public while simultaneously offering incentives or deterrents to those in compliance or noncompliance, respectively. The urgency of this matter cannot be overstated, as it is imperative to avert the coming crisis; it is no longer a matter of how or where an uncontrollable outbreak occurs, but a matter of when.

Background:

A Brief History of ANA's Position

According to ANA, 2015:

> "Historically, ANA has strongly supported immunizations to protect the public from highly communicable and deadly diseases such as measles, mumps, diphtheria, pertussis, and influenza and has supported mandatory vaccination policies for registered nurses and health care workers under certain circumstances" (ANA, 2015). Recently, significant national measles outbreaks have occurred and are fundamentally attributed to an increase in the declination of vaccination rates. "ANA has reviewed current and past position statements for clarity and intent, and current best practices and recommendations from the broader health care community. Based on that review, it

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

was determined that a revised position statement is needed to clarify ANA's position and incorporate current best practices."

Previous and Proposed ANA Immunization Position Statements

- Mercury in Vaccines: June 21, 2006
- Immunizations: July 21, 2015

Culture of Immunizations: Then and Now

"Before 1962, no formal nationwide immunization program existed. Vaccines were administered in private practices and local health departments and paid for out of pocket or provided by using state or local government funds with some support from federal Maternal and Child Health Block Grant funds" (Alan R. Hinman, MD, Walter A. Orenstein, MD, & Anne Schuchat, MD, 2011). When President Kennedy signed the Vaccination Assistance Act in 1962, the general population was frequently exposed to debilitating and often fatal illnesses such as polio, with its dungeon-esque iron lung wards, and to measles, mumps, rubella, varicella, and pertussis, but that is not the situation in today's social media-connected population. The devastating effects of these illnesses are far removed from the memories and experiences of today's parents, potential parents, and the general patient population under 60 years of age.

> "Nearly everyone in the U.S. got measles before there was a vaccine, and hundreds died from it each year. Today, most doctors have never seen a case of measles.
>
> More than 15,000 Americans died from diphtheria in 1921, before there was a vaccine. Only two cases of diphtheria have been reported to CDC between 2004 and 2014.
>
> An epidemic of rubella (German measles) in 1964-65 infected 12½ million Americans, killed 2,000 babies, and caused 11,000 miscarriages. Since 2012, 15 cases of rubella were reported to CDC." (Centers for Disease Control & Prevention, 2018).

The ease with which vaccine-hesitant and anti-vaccination propaganda can be accessed presents new obstacles and barriers to our nurses and health care teams, and particularly contributes to deteriorating vaccination rates.

Pre- and Post-Vaccination Eras

There has been an 80–100% decrease in all vaccine-preventable illnesses since vaccines were mandated as illustrated below. "In the United States, policy interventions, such as immunization requirements for school entry, have contributed to high vaccine coverage and record or near-record lows in the levels of vaccine-preventable diseases." (Omer, Salmon, Orenstein, deHart, & Halsey, 2009).

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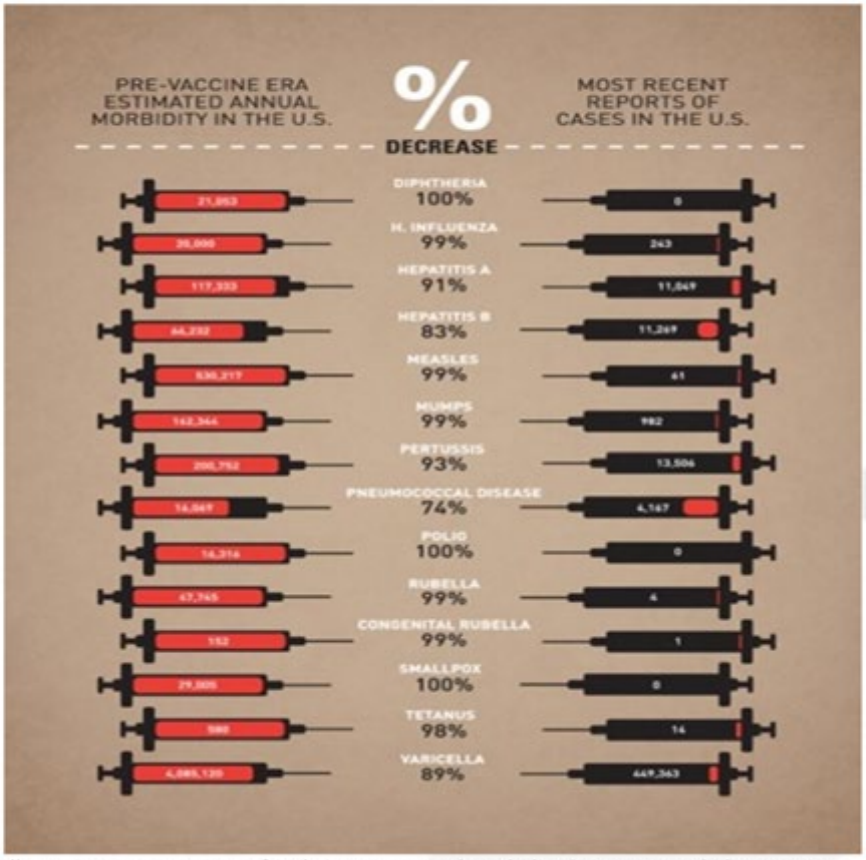

Illustration 1. Comparison of 20th Century Annual Morbidity & Current Morbidity: Vaccine-Preventable Diseases; data utilized in the graphic retrieved from the Centers for Disease Control and Prevention by artist in 2010. Retrieved March 14, 2019, from https://www.forbes.com/sites/matthewherper/2013/02/19/a-graphic-that-drives-home-how-vaccines-have-changed-our-world/#5438cc3a3302 Copyright 2010 by Leon Farrant

Outbreaks: Predictable and Rising

In 2018, scientists identified 'anti-vax hot spots'—and the areas flagged include those where cases are now being reported. In a study published in PLOS Medicine last June, researchers looked at the 18 states where non-medication exceptions (NMEs) are available. They were able to obtain vaccination data for 14 of these and found 12 where the anti-vax movement appears

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to be on the rise—particularly in the Pacific Northwest (Idaho, Oregon and Washington) and the Southwest (Arizona, Missouri, Oklahoma, Texas and Utah).

The researchers produced maps showing anti-vax hot spots, with a negative association between the NME rate and the number of children getting the MMR vaccine. 'Our findings indicate that new foci of anti-vaccine activities are being established in major metropolitan areas, rendering select cities vulnerable for vaccination-preventable diseases,' they wrote.

When comparing the findings of the study with the current outbreaks—first reported by Popular Science—there appears to be a closely matched pattern, with measles cases being reported in the hot spots identified by the researchers." (Osborn, 2019)

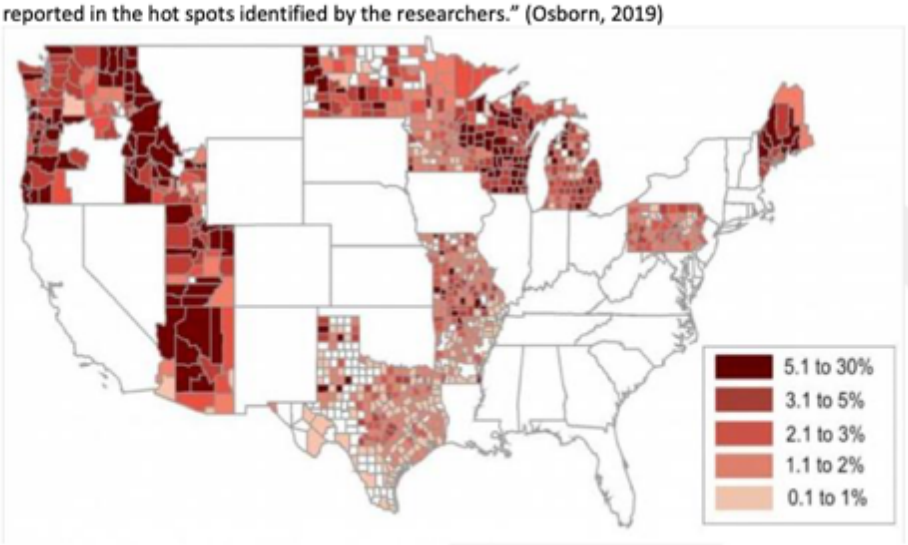

Figure 1. Heat map showing non-medical exemptions from childhood vaccinations in the U.S. Retrieved March 14, 2019, from https://doi.org/10.1371/journal.pmed.1002578.g002.

From January 1 to April 16, 2019, 555 individual cases of measles were confirmed in 20 states, 90 cases more than the week previously, as reported by the CDC. This is the second-greatest number of cases reported in the United States since measles was eliminated within the United States in 2000.

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have received vaccinations recommended or required by their state or who have received an exemption to one or more required vaccinations" (CDC 2019). In the most recent school year (SY), (2018-2019), 10 states reported MMR vaccination rates below the 92nd percentile, not including Wyoming, for which a status of survey "not conducted" was assigned (CDC, 2019b). To achieve herd immunity, the MMR vaccination threshold needs to be at or above 90–95% because of the extremely high contagion properties of the disease (Oxford Vaccine Group, 2016).

As logic follows, if a child receives an exemption prior to kindergarten enrollment, it is within reason that there exists the probability that the exemption will remain unchallenged and non-renewed through college (Belluz, 2019) unless a nursing degree is pursued. Unfortunately, the collection and reporting methods are relegated to a federally funded immunization program and school nurses and other school personnel to manage (Mellerson, 2018), again increasing the likelihood that a large preponderance of unvaccinated children have gone unreported or underreported.

Data for children beyond kindergarten, teenagers (13–17 years old), and adults is collected via the National Immunization Survey (NIS). "The National Immunization Surveys (NIS) are a group of phone surveys used to monitor vaccination coverage among children 19–35 months and teens 13–17 years, and flu vaccinations for children 6 months–17 years" (Centers for Disease Control & Prevention, 2019). The surveys aren't conducted via a telephone call in the traditional sense; rather, the telephone conversation is the conduit in which consent is received by a parent or guardian to obtain the name of the household's children's vaccination provider. Once consent and ages and names of children have been given, "a questionnaire is mailed to each child's vaccination provider(s) to collect the information on the types of vaccinations, number of doses, dates of administration, and other administrative data about the health care facility" (CDC, 2019).

A national database with local entry protocols through platforms such as Epic or Cerner may help overcome the data collection and maintenance barriers that we are currently facing. Feasibly, functionality for vaccination tracking, and delivery to patients as a subset of its design purpose may be achieved through a software build or patch utilizing the Vaccine Tracking System (VTrckS). "VTrckS is a critical component of the Vaccine Management Business Improvement Project (VMBIP), which is a secure, web-based information technology system that integrates the entire publicly funded vaccine supply chain from purchasing and ordering through distribution to participating state, local, and territorial health departments and health care providers" (CDC, 2019a).

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NON-MEDICAL EXEMPTIONS FROM SCHOOL IMMUNIZATION REQUIREMENTS 2018

ALL 50 STATES ALLOW MEDICAL EXEMPTIONS

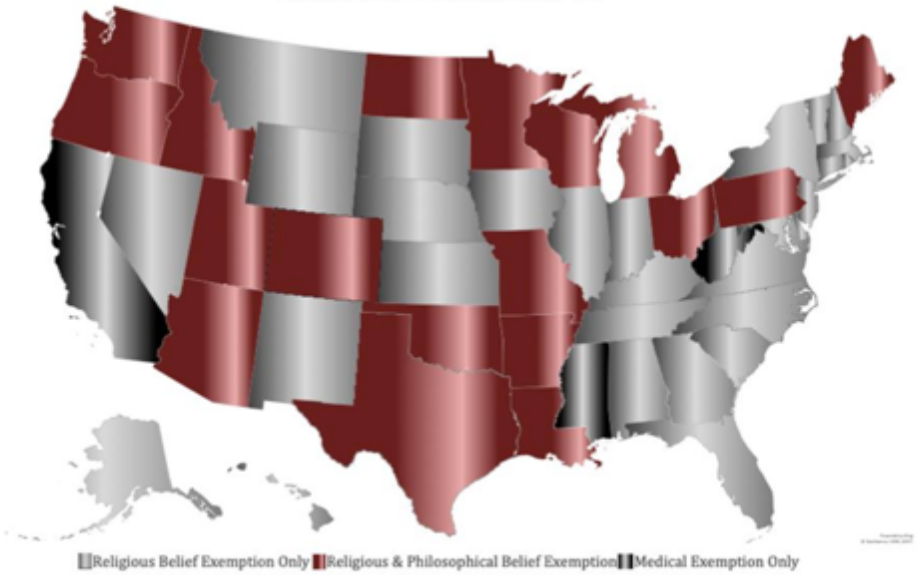

Figure 3. Non-medical Exemptions from School Immunization Requirements 2018; data utilized in the graphic by author retrieved from http://www.ncsl.org/research/health/school-immunization-exemption-state-laws.aspx

Medical Exemptions

Every state provides allowances for medical exemptions to vaccinations. However, medical exemption criteria are poorly defined and allow liberal interpretation with minimal accountability. Additionally, they lack clearly defined roles with delineated responsibilities of who is permitted to sign and authorize exemptions, the frequency of recertification, and the length of time a temporary certification can apply before expiration. This privation of foresight has enabled vaccination eluders to succeed in abusing a broken system.

Twenty-seven states have provisions in legislation that allow students who have medical exemptions to be excluded from school in the event of a disease outbreak to prevent transmission. Furthermore, 45 states allow a grace, provisional, or conditional enrollment period for children who are not up to date with vaccinations, even though minimal mechanisms

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exist to ensure vaccination compliance is attained (Shaw et al., 2018). It is exceedingly easy, certainly appealing, and almost accommodated to be a non-vaccinator in many states.

Philosophical Exemptions

Currently, 17 states have allowances for both medical and philosophical exemptions to vaccination. That philosophical exemptions exist in any capacity is perplexing. Two states (Washington and Michigan) currently experiencing measles outbreaks (defined by the CDC as three or more reported cases) have legislative provisions for both religious and philosophical exemptions. Noteworthy, however, is that five of the states that have both religious and philosophical exemptions have verbiage expressly "exclude[ing] exemptions based on philosophical beliefs if religious exemptions are allowed" (Shaw et al., 2018). It may be beneficial for ANA to suggest that while medical exemptions are allowed on a strict and necessary basis, philosophical exemptions are not recognized.

Religious Exemptions

"Allowance of religious and philosophical exemptions was associated with lower MMR and DTaP vaccination coverage and higher exemption rates" (Shaw et al., 2018). This seems relatively straightforward based on our compilation of data: Parents who can easily forego vaccination, will forego vaccination. Vanderbilt University Medical Center provided the following insights on its website regarding immunizations and religion: "Most religions have no prohibition against vaccinations; however, some have considerations, concerns or restrictions regarding vaccination in general, particular reasons for vaccination, or specific vaccine ingredients" (Grabenstein, 2013). This presents a compelling argument for nurses to become well-versed in popular theology in order to provide guidance on actual religious constraints versus perceived notions resulting in immediate gratification.

There are sound, theologically based and moral convictions toward vaccines, however, these reasons are cited in a disproportionately lower number within the overall number of religious exemptions claimed across the United States. Issues such as vaccine derivatives obtained from aborted fetus stem cells and those with porcine-derived components are abhorrent and sometimes believed forbidden in many faiths and doctrines. Notwithstanding, many of those faiths have now conceded that there no longer exists a spiritual or moral objection to immunizations. For example, J. D. Grabenstein (widely regarded as a subject matter expert on the relationship between various religions and immunizations) has published several articles on the topic. He identified the following as the more commonly known objections:

- Pork: Some vaccines contain components with porcine origins. Religions that oppose the use of pork products may have objections.
    - Muslims: "The gelatin formed as a result of the transformation of the bones, skin, and tendons of a judicially impure animal is pure, and it is judicially permissible to eat." The 1995 decision by the Islamic Organization for Medical Sciences in English and Arabic.

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- Jews: Drugs of porcine origin are derived from the pancreas, which, as extracted, is not edible in the food sense. Excipients (non-active ingredients in vaccines) are permitted. Gelatin: If no alternative is available, consumption of gelatin is permitted because it is being consumed in a non-edible form. Lactose: This is also an inedible form.

- Aborted Fetuses: Two cell lines currently used in vaccines are derived from selective abortions performed overseas in the 1960s: WI-38 from Germany in 1961 and MRC-5 from the U.K. in 1966.
  - Catholics:
    - ". . .the vaccines [containing WI-38 or MRC-5] without an alternative, the need to contest so that others may be prepared must be reaffirmed, as should be the lawfulness of using the former in the meantime insomuch as is necessary in order to avoid a serious risk not only for one's own children but also, and perhaps more specifically, for the health conditions of the population as a whole—especially for pregnant women." From the 2005 official document "Moral Reflections on Vaccines Derived from Aborted Human Fetuses."
    - "Danger to the health of children could permit parents to use a vaccine which was developed using cell lines of illicit origin, while keeping in mind that everyone has the duty to make known their disagreement and to ask that their healthcare system make other types of vaccines available."
  - Other Christian Faiths:
    - "Using technology developed from tissue of an intentionally aborted fetus, but without continuing the cell line from that fetus, may be morally acceptable." "Immunization," Christian Medical & Dental Associations 2004 (Grabenstein, 2018).

The concern is that religious exemptions are being claimed by parents who may not have deep spiritual feelings but instead are using the exemption as a loophole to escape or avoid vaccination. In states without philosophical exemptions for vaccines, religious exemptions are exponentially higher, indicating this may be the case.

- "In a 12-year retrospective study in New York state, rates of religious exemption nearly doubled, with the overall annual state mean prevalence of religious exemptions for one or more vaccines coming in at 0.4% from 2000-2011 and increasing significantly from 0.23% in 2000 to 0.45% in 2011 (P=0.001)," according to Jana Shaw, MD, of SUNY Upstate Medical University in Syracuse, N.Y., and colleagues.
- A 2018 study illustrates the comparison of vaccination coverage related to exemption rates, stating, "We found that state policies that refer to Advisory Committee on Immunization Practices recommendations were associated with 3.5% and 2.8% increases in MMR and DTaP vaccination rates. Health Department–led parental education was associated with 5.1% and 4.5% increases in vaccination rates. Permission of religious and philosophical exemptions was associated with 2.3% and 1.9% decreases in MMR and DTaP coverage, respectively, and a 1.5% increase in both total exemptions and nonmedical exemptions, respectively" (Shaw et al., 2018).

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Currently, only nine states (identified above) require medical exemption recertification. Lacking accountability and reliable tracking measures, federal and local programs are simply not equipped nor robust enough to adequately manage the nearly unsurmountable task of maintaining and reporting exemption information to the CDC.

Legal Precedence for State-Mandated Vaccinations and Minor Vaccination Emancipation Proposal

The United States Supreme Court set precedence of state-mandated vaccinations in *Jacobson v. Massachusetts* in 1905.

- In *Jacobson v. Massachusetts*, the landmark case upheld by the Supreme Court in 1905, which has since served as the foundation for public health laws, the U.S. Supreme Court endorsed the rights of states to pass and enforce compulsory vaccination laws (JUSTIA, 2019).

Minor Vaccination Emancipation Proposal

- New York currently allows minors to obtain vaccinations without parental consent if they meet any one of the following criteria: homeless, married, pregnant, incarcerated, or legally emancipated from their parents.
- "Senator Liz Krueger, a Democrat from Manhattan, and Assemblywoman Patricia Fahy, a Democrat from Albany, announced last week they will introduce a bill that would allow minors ages 14 and older to receive an immunization without parental consent" (Scagell, 2019).

Ethical and Legal Prudence

Rudimentary vaccination knowledge is essential to every nurse; it is established herein that vaccine administration is not unique to any one specific nursing specialty. Vaccines do not come without risks; it is the utilitarian benefit that makes the risk a prudent choice over non-vaccination. Frequently, reassurances are given in totalities that do not exist, e.g., "This vaccination is perfectly safe; there is nothing to worry about." However, the existence of the National Childhood Vaccine Injury Act of 1986 and our mandatory Vaccine Information Safety Sheets directly repudiate that logic. Therefore, it is crucial that patients and parents with reservations are not treated differently than any other patient receiving another intervention at our hands.

Vaccination debates involve conflictual beliefs regarding the idea of "what's right for me or my child" (Hendrix, Sturm, Zimet, & Meslin, 2015). Evaluation of the underlying ethical issues guides nurses toward upholding the ethical values within our Code of Ethics. The values of justice, beneficence, non-malfeasance, individual autonomy, and utilitarianism must be weighed to address the vaccination debate.

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- Justice – Viewing herd immunity as a social contract evokes the question of fairness: People who opt out of vaccinations for non-medical reasons continue to benefit from herd immunity, versus the people who opt in and assume the risk(s) of vaccinations while honoring the social contract.
- Distributive Justice – Who should be allowed to be exempt from vaccinations (medical v. non-medical reasons), and who should bear the burden for herd immunity?
- Retributive Justice – What consequences should those who do not bear the burden face: denial of access to public services, financial penalties?
    - Public Services or Access: quarantine
    - Penal Consequences: civil or criminal
    - Depraved Indifference (also known as depraved heart or depraved mind murder): "To constitute depraved indifference, the defendant's conduct must be so wanton, so deficient in a moral sense of concern, so lacking in regard for the life or lives of others, and so blameworthy as to warrant the same criminal liability as that which the law imposes upon a person who intentionally causes a crime" (USLegal Inc, 2016). In our present litigious culture, is there financial liability or criminal culpability for parents who claim knowledge of vaccines and refuse to vaccinate regardless of the potential outcomes to their children, the children of others, the general population, or special populations—pregnant women, the elderly?

      The crime differs from intentional murder in that it results not from a specific, conscious intent to cause death, but from an indifference to or disregard of the risks attending defendant's conduct" (USLegal, 2016).

      In *DeBettencourt v. State*, Judge Moylan submitted the following on depraved-heart murder:

      > Depraved heart murder is the form of murder that establishes that the willful doing of a dangerous and reckless act with wanton indifference to the consequences and perils involved, is just as blameworthy, and just as worthy of punishment, when the harmful result ensues, as is the express intent to kill itself. This highly blameworthy state of mind is not one of mere negligence. It is not merely one even of gross criminal negligence. It involves rather the deliberate perpetration of a knowingly dangerous act with reckless and wanton unconcern and indifference as to whether anyone is harmed or not. The common law treats such a state of mind as just as blameworthy, just as anti-social and, therefore, just as truly murderous as the specific intents to kill and to harm (*DeBettencourt v. State*, 428 A.2d 479, 1981).

    - When a parent refuses a vaccination for his or her child and that child becomes ill, there exist four potential outcomes:
        - The child remains well and never contracts a vaccine-preventable illness.
        - Medical resuscitation and hospitalization—the child becomes well.

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- Medical resuscitation and hospitalization—the child succumbs to illness.
- The child (the index case) transmits disease to another child or children and other populations, and the aforementioned bullet points occurs on an exponential level dictated by the laws of propagation and weakened herd immunity.

- Beneficence and Non-malfeasance – Vaccinations benefit society by minimizing and eradicating communicable diseases. Decreased herd immunity places society at risk for outbreaks like the numerous measles outbreaks seen currently.
- Individual Autonomy Versus Utilitarianism – Addressing how nurses approach individual beliefs against vaccinations that conflict with the overall benefits to society that vaccines provide.

Recommendations:

1. ANA adopts the revised position statement in Appendix A that includes:
   - Removal of the religious exemption.
   - Requirement of mandated annual medical exemption recertification.
2. ANA, C/SNAs and IMD:
   - Pursue programs to equip nurses with more reliable data collection strategies for tracking vaccination compliance.
   - Advocate increased funding for social marketing education campaigns, incentives for vaccine-compliant parents, and reimbursements to providers who have high vaccination compliance.

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APPENDIX A

PROPOSED DRAFT ANA Position Statement

Proposed: June 20, 2019

Purpose

Public safety from highly communicable diseases such as measles, mumps, diphtheria, pertussis, and influenza remain paramount to and is both historically and emphatically supported by the ANA Enterprise (ANA, 2014; ANA, 2006). It has become imperative to address the progressively prevalent culture of vaccine hesitancy and to increase public vaccination compliance through review of ANA past position statements and revision of best practices in the context of the global health care community and similar efforts toward the same goal. Based on that review and evidentiary research, it was determined that a revised position statement is needed to clarify ANA's position and incorporate current best practices.

Statement of ANA Position

To protect the health of the public, all individuals should be immunized against vaccine-preventable diseases according to the best and most current evidence outlined by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). All health care personnel (HCP), including registered nurses (RNs), should be vaccinated according to current recommendations for immunization of HCP by the CDC and Association for Professionals in Infection Control and Epidemiology. Whenever possible, incentivization of vaccination compliance at the provider and public levels should be afforded, and new campaigns increasing public education and awareness of vaccinations should be conceived and implemented.

ANA supports exemption from immunization for the following reason only:

Medical Contraindications:

> *"Contraindications (conditions in a recipient that increase the risk for a serious adverse reaction) and precautions to vaccination are conditions under which vaccines should not be administered. Because the majority of contraindications and precautions are temporary, vaccinations often can be administered later when the condition leading to a contraindication or precaution no longer exists" (Centers for Disease Control & Prevention, 2019).*

All requests for exemption from vaccinations will be accompanied by appropriate documentation and be certified by an appropriate authority to support the request. This certification shall expire 12 months after issuance (general population) or prior to the convening of the next school year (pediatric), or when the contraindication no longer exists, whichever is soonest. Individuals who are exempted from vaccination may be required to adopt measures or practices in the workplace to reduce the chance of disease transmission. Employers should ensure that reasonable accommodations are made in all such circumstances.

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APPENDIX B

Vaccination Campaigns: A Global Perspective

Stigmatization of the words *vaccination* and *immunization* has pushed undecided parents into the vaccine-hesitancy group. It is time to change the culture surrounding vaccinations with a campaign from frontline vaccination experts—nurses. Are we leading the vaccination front, or are we falling behind other initiatives to keep the public safe? Following are brief examples of what other countries are doing.

France: "If parents refuse the mandatory vaccines, the main consequence will be that their children would not be accepted in schools, nurseries, etc." (CNN, 2018).

Italy: "The Italian requirements, though, incorporate a few twists. Going forward, parents will provide proof of vaccination when enrolling their children in government-run nurseries or preschools, just as is done in the United States. But in Italy, the parents of children who have not been vaccinated will be fined. Conscientious objection, unlike in the United States, will not be allowed" (CNN, 2018). Italy just mandated MMR.

Germany: Germany introduced legislation in June that made it mandatory for all kindergartens to notify the health authority if parents haven't submitted proof of vaccination counseling for their children. The policy marked a change to German law, which had required parents to submit proof that they have attended vaccination counseling before enrolling their children in kindergarten. This law, which had been in place for three years, didn't require the school to report parents who have not been counseled by their doctors" (CNN, 2018).

Australia: The No Jab, No Pay policy contains both financial disincentives and financial incentives. "Firstly, patients in lower-earning scales get some additional family tax rebates if they have kept their child up-to-date with their various vaccinations," said Dr. Tony Bartone, vice president of the Australian Medical Association. Since No Jab, No Pay began in January 2016, more than 210,000 families have taken action to ensure they meet the immunization requirements, according to Australia's Department of Social Services" (CNN, 2018).

United States: To boost vaccination rates, some health insurance companies offer financial incentives to doctors and other providers. While some research studies show positive effects, with increasing vaccination rates, others show "not much of an effect," according to Brewer. "It's almost surprising. It should have an effect" (CNN, 2018).

One notion is to evolve the CDC's Assessment, Feedback, Incentives, and eXchange (AFIX) Program into a national incentivization project. "AFIX is a quality improvement program conducted by CDC's immunization program awardees to support Vaccines for Children providers in their jurisdiction. The goal of the AFIX program is to increase vaccination of children and adolescents with all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines by reducing missed opportunities to vaccinate and improving

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immunization delivery practices at the provider level" (Centers for Disease Control & Prevention, 2019).

Illustration 2. AFIX Components: Assessment | Feedback | Incentives| and eXchange Retrieved April 22, 2019, from https://www.cdc.gov/vaccines/programs/afix/index.html

"The AFIX program consists of four components: Assessment, Feedback, Incentives, and eXchange.

1. Assessment involves generating data reports on the vaccination coverage levels of selected health care providers and examining the effectiveness of providers' immunization delivery practices.
2. Feedback provides an opportunity to share with each provider his or her assessment results, discuss practice procedures and barriers, and collaborate to develop customized evidence-based quality improvement strategies.
3. Incentives recognize provider accomplishments and can be powerful motivations for providers to improve vaccination coverage rates.
4. eXchange is the regular follow-up with providers to monitor their quality improvement progress and offer support through guidance and Incentives" (Centers for Disease Control & Prevention, 2019).

APPENDIX C

Advocating for Patients Who Claim Religious Exemption to Vaccines

The *Code of Ethics for Nurses with Interpretative Statements* (2015) calls on nurses to be patient and family advocates. How do we advocate for patients who adamantly oppose vaccinations? Nurses must first know which religions do and do not actually oppose vaccines; we may be able to use the moment as a teaching point to nurture patients on their perceptions of their stated faith groups.

How do nurses respond as a collective when parents refuse vaccinations for their children on religious grounds?

- ✓ Reframe the conversation in a positive light so that patients don't feel they are being coerced or manipulated.
- ✓ Patients or parents choosing to not vaccinate will have a required referral to an Inoculation Advisor RN or APRN.
  - The Inoculation Advisor role is a specialty role in which a RN or APRN will address any concerns and questions regarding vaccinations to support and educate patients and family members and help them make an educated and informed decision.
- ✓ Studies show that stating scientific data to vaccine-hesitant parents reinforces their stand against vaccinations rather than changing their minds. Parents usually choose not to vaccinate because they believe they are making the best choice for their child(ren).
- ✓ Research is evolving that focuses on developing valid and reliable tools to assess people's choice not to vaccinate. Evidence-based practice to diagnose and understand their reasoning is a "tool" that must be incorporated into the standards of care for nursing.
  - In 2015, the U.S. National Vaccine Advisory Committee recommended "the development of an index, composed of several individual and social dimensions, to measure vaccine confidence. This index should be capable of (1) rapid, reliable, and valid surveillance of national vaccine confidence; (2) detection and identification of variations in vaccine confidence at the community level; and (3) diagnosis of the key dimensions that affect vaccine confidence" (National Vaccine Advisory Committee, 2015).
  - The 5C Model is a novel approach that assesses five identified antecedents of vaccination behavior (Betsch et al., 2018). Assessing the reasons why people do not vaccinate can facilitate appropriate interventions to increase vaccination rates.
    - Confidence – The most perceived antecedent. Confidence refers to the level of trust a person has that vaccines are safe and effective. A lack of confidence can be difficult to address when a person has fixed negative beliefs about vaccines.
    - Complacency – When a person perceives that he or she is not likely to contract a vaccine-preventable disease.

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

Approval of EBP by the ANA Membership Assembly

Third Session – Saturday, June 22, 2019

CALL TO ORDER

President Grant called the Third Session of the 2019 ANA Membership Assembly to order at 1:01pm ET on June 22, 2019.

ORDER OF BUSINESS

A quorum[3] for the transaction of business was established.

REPORT OF THE CHAIR OF THE LEADERSHIP COUNCIL EXECUTIVE COMMITTEE

Elaine Scherer, MAEd, BSN, RN, Chair of the Leadership Council Executive Committee highlighted the work of the Committee and announced the agenda for 2019 Leadership Summit to be held in December.

REPORT OF THE PROFESSIONAL POLICY COMMITTEE: DIALOGUE FORUMS

Professional Policy Committee Chair, Ann O'Sullivan, MSN, RN, CNE, NE-BC, ANEF, reported that the Professional Policy Committee facilitated four Dialogue Forums and noted that the report includes broad recommendations for each Dialogue Forum, which will be presented Dialogue Forum-by-Dialogue Forum for consideration.

Chair O'Sullivan presented the recommendations of the Professional Policy Committee for Dialogue Forum 1: *Removal of Outdated ANA Language to Increasing Access to Vaccination Compliance*. President Grant opened the floor for discussion After discussion, the Membership Assembly considered the following motion.

> ***Motion #27**, The Membership Assembly approves the following recommendations resulting from Dialogue Forum 1: Removal of Outdated ANA Language to Increasing Access to Vaccination Compliance:*
>
> 1. *ANA adopts the revised immunization and vaccine policy statement that includes*

[3] A quorum for transaction of business by the Membership Assembly shall consist of 50 percent of the total C/SNA and IMD representatives and three members of ANA's Board of Directors, one of whom is the ANA President or Vice President (ANA Bylaws Article III, Section 8.b).

a. *removal of the religious exemption, and*
b. *Require mandated annual medical exemption recertification*

2. *ANA, C/SNAs, and IMD:*
   a. *Advocate for increased funding for social marketing education campaigns, incentives for vaccine-compliant parents, and reimbursements to providers who have high vaccination compliance.*
   b. *Advocate for the establishment of standardized, state and/or federal immunization database.*
   c. *Promote use of existing immunization resources, like ANA's Immunization materials and the Centers for Disease Control and Prevention (CDC).*

*(**Carried:** 93.4% in favor; 6.6% opposed)*

Email from the Executive Director of ANA/C Regarding EBP Presentation at the 2019 ANA Membership Assembly in Washington D.C.

From: Marketa Houskova <marketa@anacalifornia.org>
Subject: USD DNP Students at ANA MA 2019 in D.C.
Date: July 10, 2019 at 8:36:47 PM PDT
To: JOSEPH BURKARD <jburkard@sandiego.edu>
Cc: ANA California <anac@anacalifornia.org>, Anita Girard <president@anacalifornia.org>

Hi Joe,

I wanted to personally thank you and congratulate you on the success of your USD DNP students that presented at ANA Membership Assembly 2019 on June 21, 2019 in Washington, D.C. They did a fantastic job and me and the full ANA\C delegation, including the ANA\C President (cc'd here) and ANA\C VP, could not have been prouder! The topic was well researched, studiously prepared and perfectly delivered. What a marvelous contribution to the profession of nursing and to the advancement of EBP.
...Plus, as a former SD resident they made me even prouder:)
I wanted to share this with you and hope you will continue to encourage your fabulous students to continue with the important work of policy development.

I was hoping the 3 students -Janelle, Olivia and Steven- would draft an article for our Fall 2019 issue of *The Nursing Voice* (digital edition) about their experience working on this important policy change and how participating in politics, advocacy & policy development is crucial for RNs (btw, increasing nursing engagement in politics & policy development is my DNP project). We are looking at a deadline of the **last week in July**.

I am attaching a group picture of CA delegation from the lobby day along with a few of the students' presentation.
Also, please visit ANA\C FB for more pictures of your students (posted on June 21, 2019)
https://www.facebook.com/American-Nurses-Association-California-161112960610577/

I am cc-ing Teresa at our office should you or the students have any questions about the digital publication. Here is our first issue: http://associationpublications.com/flipbooks/anaca/2019/Spring/ We are right now finalizing the Summer 2019 edition that is coming out later this month.

Thank you so much and again, congratulations to you and your students!
Please let me know if there is anything where we can assist or help you and your program.

~Marketa

PS:
I am assuming your students would appreciate a thank you letter or a Certificate of Accomplishment for their DNP portfolio. We would be more than happy to provide either so please let me know.

"Advocacy is our core business"

Marketa Houskova, RN, MAIA, BA
Executive Director

AMERICAN NURSES ASSOCIATION
CALIFORNIA

ANA/C Nursing Journal: The Nursing Voice

Part 1/3: USD DNP Students at ANA Membership Assembly 2019

USD DNP STUDENTS AT ANA MEMBERSHIP ASSEMBLY 2019

Steven G. Pochop Jr., BSN, RN, CPN, DNP
Student, University of San Diego
Olivia J. Kearnes, BSN, RN, DNP
Student, University of San Diego
Janelle A. Bird, BSN, RN, DNP
Student, University of San Diego

What began as an assignment for three doctoral students attending the University of San Diego in their health policy course, culminated in a journey that led enduring empowerment resident within the American Nurses Association (ANA). Group projects, a crux of nursing academia and mainstay of team dynamics, are widely frowned upon by those who must endure such assignments. We found ourselves in this situation as we hurriedly glanced down a list of topics from which to choose and subsequently draft a policy revision recommendation to the ANA. Our combined nursing specialties read like the precursor to a poorly written joke. "What do you get when you cross a palliative care nurse, a mental health nurse, and a pediatric nurse?" Humor aside, our group membership and nursing experiences lent themselves to a unique, collaboration paradigm, seemingly perfectly designed yet assigned randomly. Intent on the submission of an expertly crafted proposal, we chose immunizations as our topic for revision. Its social relevance, coupled with the opportunity to make a significant impact on public welfare, made it an obvious choice.

The challenge of the accomplishment to renovate a vaccine-hesitant culture motivated our efforts. However, we were aware that our endeavor would likely end with an academic grade and no policy change. The grade earned would solidify our second-place effort—a trophy for participation. Students do not change policy nor do they influence the most expansive nursing organization in America to change its policy statement. At least, they did not.

We submitted our proposal to the ANA website and our policy revision recommendation, designing our presentation to sound like a popular trivia game show syndication. The nearly insurmountable task of choosing answers that elicited only one possible correct response (in the form of a question), envigored our desire for vaccination knowledge and to affect change. After we presented the project and submitted our proposal, it was anticlimactically, over. We received our grade, a consolation prize, and a symbol of our unsuccessful attempt in becoming impactful nurse change-makers. Resignedly, we disbanded the group and focused individual efforts towards the preparation needed for our looming pharmacotherapeutics exam. We never expected to receive a callback from the ANA!

When the invitation to present our proposed policy revision to the ANA Voting Assembly arrived, the only word descriptive enough to articulate our collective emotion was fear. Not the crippling fear experienced whilst running for our lives away from a rabid mountain lion (that came later), but rather the type of fear that commanded action and activated the sympathetic nervous system to "fight and respond"—like hearing a code blue alarm sound. Although reasonably well-versed

students, the terms inherent to the ANA organization were foreign to us yet, demanded our attention. "Develop a background document to present to the members of the assembly to stimulate dialogue." The anticipation of additional requirements had not occurred to us. If successful, we were content to receive notification of our success from the ANA without further action.

Ignorant of ANA operations and culture, it was an unknown entity—a roomful of angry, old nurses frustrated that we could not calculate drip rates with the nonexistent second hand of our smart watches. The invitation informed us that a robust discussion was expected and did little to alleviate our concerns. "Robust," defined by Merriam-Webster as "capable of performing without failure under a wide range of conditions" (Merriam-Webster, 2019). We almost respectfully declined in those preliminary moments, without failure, under a wide range of conditions. This assembly of nurses, it appeared, had fixed their gazes upon us.

Understated, the production of a background document to prepare the assembly for 30 minutes of dialogue and discussion was an intimidation. What if we received a question for which we were unprepared? Surely, examples of this phantom background document existed on the web; we would then download one as a template and quickly transpose our research. Six days and three gallons of coffee later, we reached the end of the internet and surrendered to the realization that we had to create and submit an original, group-authored manuscript.

Email and subsequent teleconferences informed us of our instructions and presentation parameters. We would be afforded ten minutes to present our proposal, followed by 30 additional minutes to allow discussion. We preferred the time allotment of presentation and discussion reversed because the term "discussion" was interpreted to politely indicate the delicate flame spray that would erupt over us from the nursing matriarchs perched on their lofty thrones intent upon devouring us upon falter; we desired less time for their mission accomplishment. Next, we began researching and developing our background document with one unitary goal: we had to anticipate every question asked of us because not knowing the answer was unacceptable and would result in annihilation.

Long hours and late nights intertwined with pages of statistics and data validation became commonplace. Spring break began and ended; personalities clashed and mended, and answers to every conceivable question regarding immunizations and vaccine-preventable illnesses was thoroughly researched. To state that our group harmony and cohesiveness remained intact or, that our five-month journey was seamless, without argument or turmoil would be an untruth. Charged emotions and, heated conversations, hallmark traits inherent in-group work, pervaded our dynamics on many occasions. However, the paramountcy of our goal to reinforce nursing efforts waged against the hesitant culture of vaccinations transcended our differences. We completed and compiled our research into a 20-page document, submitting it to the ANA.

Janelle Bird, Steven Pochop Jr., Olivia Kearnes

Upon arrival at the assembly, the previously unreachable and intangible ANA borne of our imaginations disappeared. The foreboding embodiment of staunch angry nurses, an illusion conceived of ignorance; vanished. Before us, an institution representative of the compassion, and spirit resident within all nurses appeared. The mecca of nursing, this organization teemed with welcoming, compassionate peers and brilliant mentors that stood equipped to support us. They coached and encouraged us; they embraced us.

When the time came to lobby and engage congress members and advocate for professional nursing legislation, they joined us, arm in arm. Nearly 400 nurses converged upon the Capitol, our first ANA Hill Day; but only one message was delivered. Experienced, seasoned nurses stood behind us, passing us the torches of their wisdom and understanding as we spoke, not as individuals but with the tongues borne of the collective spirit. The afternoon following, our presentation, fear and trepidation vanished, replaced with the affirmation and accolades of our colleagues. Nurse-after-nurse stood and spoke, lauding our efforts and, strengthening our resolve. There were no ill-spoken remarks, only offerings of support and encouragement. The following day, luggage packed and taxis hailed, our cell phones chirped, alerting the group of a text message that read, "Your policy change was adopted. Congratulations!"

Only a few days prior, three students departed their alma mater, modest and unassuming, yet poised, ready to defend their proposition against a formidable opponent and seemingly insurmountable odds. Returning, were three professionals, emblazoned by the support of the ANA and the platform it provided us to proclaim our work. Our experience with ANA changed us and continues to do so; ANA gave us a gift, the gift of our voices, endowed with humble confidence, and imbued with eloquence. We became empowered nurses.

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Acknowledgements

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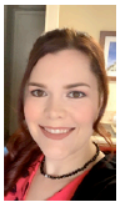
ANA/C Nursing Journal: The Nursing Voice:

Part 2/3: The Education

USD DNP STUDENTS

PART 2/3: THE EDUCATION



Steven G. Pochop Jr., BSN, RN, CPN
Student, University of San Diego

Janelle A. Bird, BSN, RN
Student, University of San Diego

Part I of this vaccination series discussed the experience of three University of San Diego Doctorate in Nursing (DNP) students who proposed a revision of the Vaccination Exemption Policy to the American Nurses Association in Washington, D.C., in June 2019. In Part II of this series, we will illustrate the history and resistance to vaccinations in the United States. We will also examine the lack of education among registered nurses regarding vaccinations and the need for a more structured vaccination educational program.

The History

Understanding the history behind vaccinations is requisite to the development of a refined nursing ethos surrounding the Vaccine Hesitant Culture (VHC). This section discusses the early history of vaccinations from the 18th to the 21st centuries.

Edward Jenner began testing the first cowpox vaccine in the early 1800s, even then, the public resisted his efforts, and the earliest vestiges of the VHC were formed. An inoculation pioneer, he experienced the preliminary glimpses of public vaccination unrest first-hand; his plight was strikingly like that experienced by nurses today. Antiquated by current standards, his practice of scoring the flesh of children to insert the lymph from the blister of the previously vaccinated was cutting edge in the 1700s. The rationale for opposition varied but included criticism due to sanitary, religious, scientific, and political objections (The College of Physicians Philadelphia, 2019).

Remarkably, the public outcry against Jenner remained steadfast even as children recovered from illness. For purposes of civil protection, state legislation established the Vaccination Acts of 1853, which made vaccination mandatory first for infants up to three months old, and increasing later to fourteen years of age in 1867. Public refusal was met with imposed penalties, and in response to perceived injustice and to reclaim control of their bodies, they formed the Anti-Vaccination League and the Anti-Compulsory Vaccination League.

On July 6, 1885, the first human bite victim was treated with a rabies vaccine engineered by Louis Pasteur. Pasteur reluctantly injected nine-year-old Joseph Meister with his new rabies vaccine (RABV) and cured the infirmed child, the alternative of the time was cauterization with a red-hot iron at the portal of entry (Science History Institute, 2016). Where Jenner was eschewed, Pasteur was embraced; the only discernible difference between the two visionaries was public apprehension of disease and death.

Vaccine hesitant positions resurfaced in 1905 when an epidemic of smallpox revitalized public anti-vaccination sentiments after the state of Massachusetts mandated vaccination, which Henning Jacobsen refused based on his family's previous adverse reactions. Despite Jacobsen's "medical contraindication" claims for himself and that of his sons, the Supreme Court determined that the state acted within constitutional constraints. In the 2019 measles outbreak in the United States, the mayor of Williamsburg, Brooklyn declared a public emergency in Rockport County. He mandated that unvaccinated citizens receive the Measles, Mumps, and Rubella (MMR) vaccination or receive an imposed fine of up to $1000.00 (Pager & Mays, 2019). The measles outbreak finally ended on October 3, 2019, but again only after legislative interventions.

The history of vaccination provides a compelling narrative of the public's anti-vaccination sentiment and illustrates, by its longevity alone, that current strategies to change this climate must improve. We are at an impasse, and so shall we remain until the nursing paradigm evolves to include vaccination education and improved modalities to improve vaccination conformity and to counter the VHC.

Current Vaccination Climate

According to the Centers for Disease Control (CDC), several states have experienced disease outbreaks predominantly due to the recent declinate in vaccinations from preventable illnesses (VPI's). Unfortunately, but routinely, patients or parents cite philosophical or religious exemption clauses to avoid inoculation, a tactic steeped in apprehension, resultant from exposure to misinfodemics such as the debunked vaccine/autism correlation, rampant throughout social media platforms. Empowering nurses with the ability to initiate informative and comprehensive discussions is essential to improve the current downward trends in vaccinating.

Educating Our Own

One primary concern regarding the fight against vaccination compliance is relaying the most up-to-date and accurate information to our patients and their families. Since nursing is the most trusted profession and nurses are at the forefront of patient and family teaching, nurses are logically the individuals who can "engage" with their patients during a healthcare visit.

There are programs available that offer education to nurses on how to discuss making healthcare decisions, among other topics. One available educational program is through the Center for Disease Control's (CDC's) online modules that provide information on vaccination to parents and healthcare personnel. The

CDC program also includes an option to request a live speaker; however, this option is not easily obtainable for nurses.

A more intimate approach proposed vaccination educational program utilizes the CDC's current training design in combination with structured role-play scenarios to promote a high level of confidence and comfort discussing this subject. These steps include explanations of the most current vaccinations and their use, best practice guidelines for vaccinations, components and, additives applied in vaccines, and involve major topics currently presented in the media. This will be an opportunity for nurses to actively learn how to approach the topic of vaccination and hold meaningful conversations with hesitant patients and parents, resulting in anticipated positive vaccination outcomes (PVO's).

Utilizing the CDC vaccination education program, nursing training will instill a level of sensitivity to the conversational changes that will develop as they are aware a patient or parent's choice is an emotional and, at times, stressful one. This vaccination educational program provides instruction to nurses on how to respectively recognize these personal beliefs, utilize compassion, and confidently supply patients and parents with re-education to enlighten hesitant patients and parents. The expectation is that there will be patients or parents that will continue in their disbelief of fact-based vaccination information presented to them. Using the knowledge gained during this program, nurses will know how to maneuver the conversation along a positive and compassionate line when confronted with these situations. Employing these educational methods will help to ensure that those that leave successful vaccination encounters then return to a vaccine-hesitant culture imbued with factual education and a heightened sense of enlightenment and empowerment.

Anticipated Result of Program

As the training for this CDC educational program grows, and, with each proposed informative course provided, the hope is that vaccination acceptance will exponentially, positively increase. Breaking down the anti-vaccination hysteresis loop may begin providing a healthier and safer future for our generation and those generations to come.

In conclusion, vaccination education to nurses must continue to be a part of the conversation. If nurses embrace this educational program, they can begin to reach greater patient acceptance, therein providing increased vaccination compliance.

Part II has examined the history of vaccines and the need for a structured nursing educational program to instruct nurses on vaccination. In Part III, we will consider other optimal routes to achieve full vaccination compliance. Nursing implications for our practice, in research, education, and health policy, will also be discussed in Part III.

Acknowledgements

This work was supported by the University of San Diego, Hahn School of Nursing.

ANA/C Nursing Journal: The Nursing Voice:

Part 3/3: Vaccinations: The Effect

USD DNP STUDENTS

PART 3/3: VACCINATIONS: THE EFFECT

Steven G. Pochop Jr., BSN, RN, CPN
Student, University of San Diego
Janelle A. Bird, BSN, RN
Student, University of San Diego

Part I of this vaccination series discussed the shared experience of three Doctor of Nursing Practice (DNP) students attending the University of San Diego (USD) who proposed the removal of the religious exemption endorsement at the ANA Membership Assembly in Washington, D.C. The second installment (Part II) of this vaccination series reviewed the history of and resistance to vaccinations while identifying disparities in vaccination education among registered nurses, which illustrated the necessity of a restructured educational program.

This final installment explores the effects of removing the religious exemption endorsement from the American Nurses Association (ANA) Immunization Position Statement. Deferential contemplation of religious beliefs within the clinical setting is essential as medicine and religion converge, frame, and enlighten choices made by patients and health professionals. Scientists and clinicians confront moral and ethical choices daily and often observe a religious faith that helps guide personal conduct. (Grabenstein, 2013).

ANA Removal of Religious Exemption Endorsement

The endorsement of religious exemptions has been a long-standing staple of ANA policy regarding vaccinations; on July 21, 2015, the ANA approved and issued the following immunization position statement:

"ANA supports exemptions from immunization only for the following reasons:

1. Medical contraindications

2. Religious beliefs" (ANA, 2015)

Annually, the ANA requests proposals for policy revisions to ensure its positional statements remain relevant and to promote the paramountcy of public safety. In 2019, the request for policy revisions occurred amidst one of the worst domestic measles outbreaks in United States history, prompting acceptance of the following revised Immunization Position Statement:

ANA supports exemption from immunizations for the following reason only:

1. Medical Contraindications

Removal of the endorsement must not be construed not as an impingement of civil liberties but rather as a provision of public protection from those claiming religious exemptions without an obligation to a religion or deity, but instead as a red herring to sidestep vaccination. This pretense demonstrates the compulsion for nurses to become proficient in conventional religious doctrines. Nurses should develop both a fundamental knowledge of faith groups and religious objections to vaccination, and a basic familiarity of modifications or denouncements of those objections by organizational leaders.

Religious Beliefs regarding Vaccinations

"Most religions have no prohibition against vaccinations; however, some have considerations, concerns or restrictions regarding vaccination in general, particular reasons for vaccination, or specific vaccine ingredients" (Grabenstein, 2013). Some durable, theologically based, moral convictions toward variolation exist; however, these are cited disproportionately lower within the overall number of religious exemptions claimed nationally; compelling nurses to become conversant in established theology. Issues such as vaccine derivatives obtained from aborted fetus stem cells and those containing porcine-derived components are abhorrent or believed forbidden in many faiths. "Most ostensible objections to immunization attributable to religious belief fell into three categories: (a) violation of prohibitions against taking life, (b) violation of dietary laws, or (c) interference with natural order by not letting events take their course" (Grabenstein, 2013).

Notwithstanding, many faiths concede their spiritual or moral objection to immunizations is secondary to the provision of public welfare. For example, although the Catholic church traditionally objects vaccinations derived from stem cells of aborted fetuses, they have made allowances for vaccinations "... insomuch as is necessary in order to avoid a serious risk not only for one's children but also, and perhaps more specifically, for the health conditions of the population as a whole—especially for pregnant women" (Immunization Action Coalition, 2005). The perception is that religious exemptions claimed are as an escape from vaccination rather than as a genuine faith allegiance as many faiths no longer endorse past objections. "If we are to serve our patients' needs in all their humanity, we should help them gain access to reasoned ethical and theological considerations of clinical issues. When dealing with vaccines, the implications of a personal infectious-disease decision reach beyond the self, to affect neighbors. The decision to immunize or not immunize personal family members changes the likelihood that someone or their family will contract a contagious disease, and vice versa" (Grabenstein, 2013). Table 1 illustrates common faith-based objections to vaccinations.

Table 1. Religious Doctrines Stance on Vaccinations at a Glance

	Amish and Related Communities	Church of Christ, Scientist	Muslims	Judaism	Catholics	Other Christian Faiths	Hinduism	Jainism	Buddhism	Christianity	Multiple Christian Denominations	Dutch Reformed Congregations	Jehovah's Witness	Churches that rely on faith healing	Islam	Nation of Islam
Pork derivatives in vaccines, pork is unclean to ingest				X											X	
Aborted fetuses cell lines utilized to make vaccines					X	X				X	X					
Bovine			X													
Nonviolence towards living things								X								
Disease is a lie from the devil		X														
Immunization may make you less dependent on God												X				
Refuse transfusions of whole blood and certain blood components (e.g., red blood cells, white blood cells, platelets, whole plasma)													X			
Non-violence and respect for life, because divinity is believed to permeate all beings, including plants and non-human animals							X									
Prohibits killing, either humans or animals									X							
Limited access to care, limited disease understanding, higher priority to other activites, and concerns about vaccine safety, with variability among various communities	X															
Avoid all immunizations, based on concern about viral contamination with pathogens that cause "AIDS, Ebola, Hanta, Chronic Fatigue Syndrome, Gulf-War Syndrome, 'mad cow' disease, etc"																X
Focus on healing through faith alone														X		

Table 1: Adapted from Grabenstein, J.D. (2013). What the World's Religions Teach, Applied to Vaccines and Immune Globulins, Volume 31, Issue 16, pages 2011-2023.

Legislative Actions in Select States

Several states have eliminated exemptions altogether as measles characteristically infects the most susceptible residents of a population. The trending data indicates the measles outbreaks that occurred in 2019 were proportional to increased exemption rates, compelling legislators to introduce firmer measures, (Table 2).

Exemplar – California

California removed all but medically contraindicated vaccination exemptions in 2015 and further increased restrictions to obtain medical exemptions when Senate Bill 276 passed in 2019, (Table 2).

Exemplar – New York

Nationally, 1080 cases of measles were reported by June of 2019; however, that year's final six months produced only 184 additional outbreaks. This drastic decline is representative of the states that levied significant countermeasures to curtail disease transmission and the removal of the religious exemption endorsement from ANA policy. New York removed its religious exemption clause, enacted sterner guidelines for following medical exemptions, and mandated a current reconciliation of all school children's immunizations. This enabled state officials to rescind the Emergency Order, which required citizens residing or working in specified ZIP codes to either be vaccinated or prove their immunity to measles. Although the measles crisis in New York was primarily attributed to unvaccinated citizens, ironically, sentiments of backlash and opposition still prevail from those seeking religious and medical exemption leniency.

Exemplar – Mississippi

The state of Mississippi; (considered one of the most challenging states to receive exemptions), has only honored medically contraindicated vaccination exemptions since 1979. As such, Mississippians' rates of vaccination have remained above the 99th percentile for over a decade as reported by the CDC in their annual Vaccination Coverage Among Children in

continues on page 20 »

continued from page 19 »

Kindergarten—United States report. Thomas Dobbs, MD, MPH, of the Mississippi State Department of Health, stated, "We should not have exemptions that are not based in science if someone has a medical exemption, that is science. If someone does not want a vaccine because they saw a scary video online, that is not science. Our main effort must be the proper communication of science, facts, and truth" (Krisberg, 2019).

Conclusion

Part I of this vaccination series illustrated the shared experience of three USD DNP students who affected vaccination policy change at the ANA Membership Assembly in 2019. Discussed in Part II, was the history surrounding vaccinations and requisite immunization education restructure for nurses in today's vaccine-hesitant culture. Lastly, we highlighted the responsibility of nurses to become versed in various religious doctrines regarding immunizations, as well as legislative efforts at the state and national levels, to overcome immunization hesitancy in our society in Part III. Public health, immunization, and ignorant, if not arrogant, attitudes are pawns in the societal struggle of compelled compliance for the greater good versus self-preservation. Nurses must remain cognizant of the responsibility to protect patients with critical acumen regardless of personal preference. Rather than protesting vaccination under the guise of removing religious freedoms, a more pragmatic approach of eliminating all but medically contraindicated exemptions granted by the proper medical authorities is long overdue.

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The coming together of public health and religion is not a collision; rather, it involves repeated intersections. We can advance both healthcare and our condition by discussing them openly more often.

J.D. Grabenstein

Table 2. Vaccination Legislation in 2019

New Legislation		
State		
California	**SB276**	Revoked a physician's ability to grant a medical exemption without meeting strict parameters; limited exemption issuance to only those that are genuinely qualified by a medical contraindication. The new law, effective January 1, 2020, states that by the year 2021, physicians who authorize medical exemptions must submit their recommendations for review by the California Department of Public Health.
Washington	**HB1638**	Removed the personal belief exemption for the MMR vaccine requirement for public and private schools and daycare centers.
New York	**SB2994**	Removed the religious exemption for public school immunization requirements.
Maine	**HB586**	Removed personal and religious belief exemptions for public school immunization requirements.
Federal		
H.Res. 2527: Vaccinate All Children Act of 2019	Introduced a federal requirement on states: no state could offer vaccine exemptions for anything but medical reasons. In other words, no more religious nor personal exemptions, in any state.	

University of San Diego Newsletter

USD Nursing Students' Policy Revision Recommendation Accepted by ANA

MONDAY, NOVEMBER 18, 2019

SHARE THIS POST

Olivia Kearnes, Janelle Bird and Alexandra Pochop (standing in for her husband Steven Pochop) were present to receive the letter of appreciation at the ANACA membership assembly on Nov. 9.

In the spring of 2019, during a health policy course, three second year Doctor of Nursing Practice (DNP) students Janelle Bird, Olivia Kearnes, and Steven Pochop proposed a change in the American Nurses Association (ANA) statement on vaccinations. Their proposed changes were adopted at the national ANA meeting in Washington, D.C. last June. On Nov. 9, 2019 these students were recognized by ANA/California with a letter of appreciation for their policy work and advocacy on vaccinations. The meeting was held at the San Diego Hilton.

For more information about the proposed changes and their story, please see ANA's Nursing Voice at http://associationpublications.com/flipbooks/anaca/2019/Fall/18/

Letter of Appreciation from ANA/C

AMERICAN NURSES ASSOCIATION
CALIFORNIA

Steven G. Pochop Jr. BSN, RN, CPN
University of San Diego DNP program

November 9, 2019

Dear Mr. Pochop,

The purpose of this letter is to recognize your hard work and dedication to the profession of nursing, to this professional nursing organization, and to the advancement of nursing education. Your team podium presentation during the ANA Membership Assembly 2019 in Washington, D.C. was exemplary, and we could not be any prouder. Your policy analysis and recommendations to update the existing ANA's vaccination policy was evidence-based, well researched, and well delivered. Your presentation made an impact on all the 200+ nursing colleagues in the audience and assured that needed policy updates will be made.

As the largest professional nursing organization in the United States representing the interests of 4 million registered nurses, ANA strives for excellence in professional development, advancement of the profession of nursing, and in policy development arena. These are fundamental pillars for both, the ANA and ANA\California. The importance of nursing involvement in policy development and advocacy is paramount in advancing the health and well-being of all Californians and the profession of nursing (ANA\C Mission).

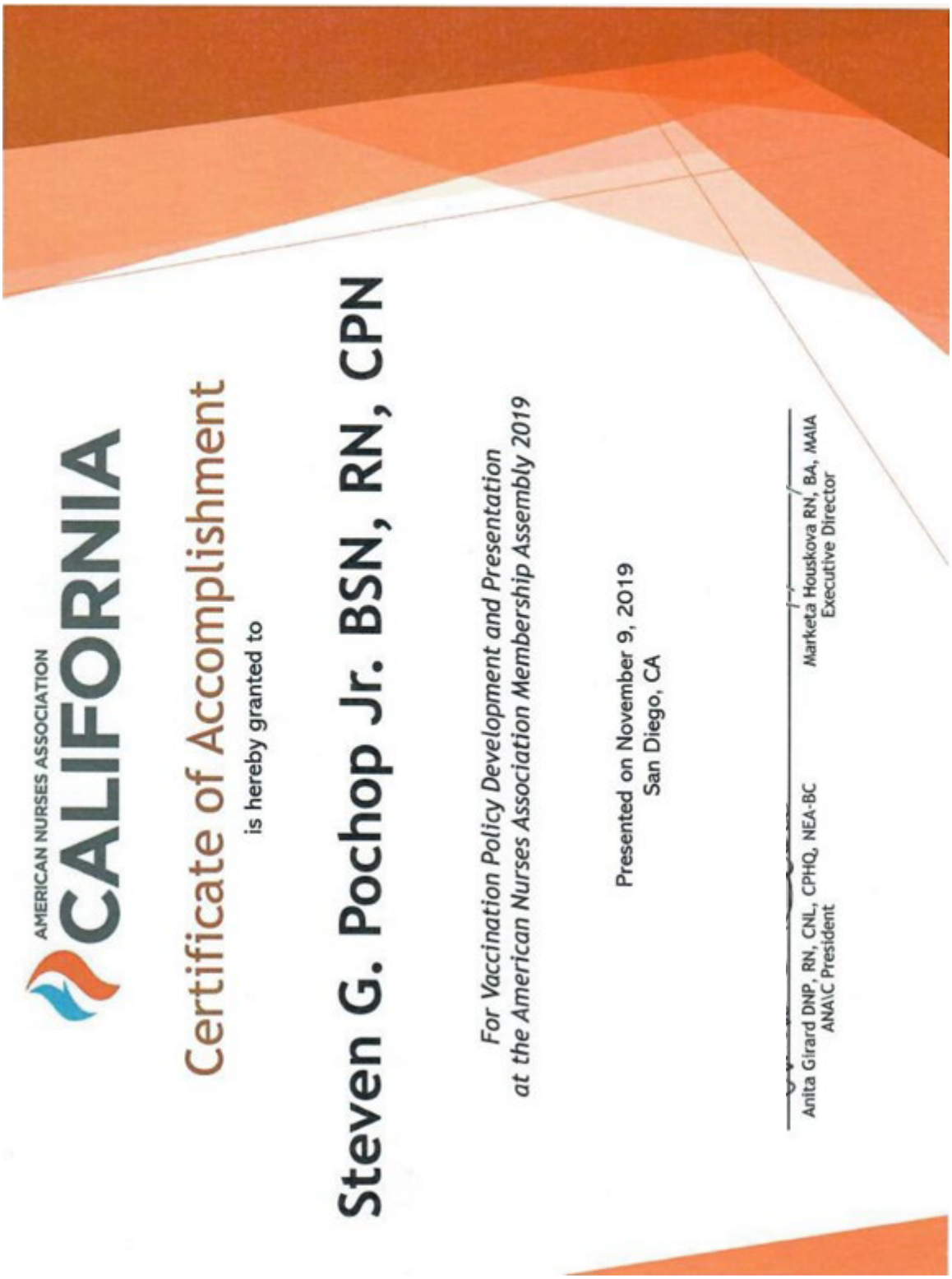
Having University of San Diego DNP students analyze ANA's existing policies, travel to our nation's capital and recommend needed changes to ANA is at the heart of professional development, nursing excellence, and professional leadership. We are very proud of your achievement and would like to thank you for your time, expertise, and enthusiasm for policy development. We look forward to welcoming you and your team at the ANA\C Policy Conference on April 21, 2020 in Sacramento, CA. On behalf of the ANA\C Board of Directors and staff, it is my pleasure to congratulate you on your accomplishment and wish you continued success on your professional journey.

Respectfully,

Marketa Houskova, DNP(c), MAIA, BA, RN
Executive Director

1121 L Street, Suite 406 Sacramento, CA 95814 O: (916) 346-4590 ED@anacalifornia.org

Certificate of Accomplishment from ANA/C



Appointment to the Professional Policy Committee First Alternate Seat

September 24, 2019

Steven Glen Pochop Jr., BSN, (DNP Student PNP/FNP), RN, CPN
1330 Paraiso Avenue
Spring Valley, CA 91977-4340

Dear Lt. Pochop:

On behalf of the American Nurses Association (ANA) Board of Directors, it is my pleasure to inform you that you have been appointed First Alternate to the **Professional Policy Committee** for a period commencing January 1, 2020 and ending December 31, 2020.

Per the *ANA Guide to the Appointments Process*, alternates are designated to serve if 1) another appointee declines or is unable to fulfill the responsibilities of the position; or 2) a vacancy otherwise occurs on the committee before the next appointments cycle. Some committees may engage alternates to participate actively in a non-voting capacity due to the nature of the committee's work. The committee's staff liaison will contact you with additional information.

ANA is served well by members who commit their time and energies to volunteering. Your willingness to serve is a testament to your commitment to ANA and the nursing profession.

Thank you and congratulations!

Sincerely,

Ernest Grant, PhD, RN, FAAN
President

cc: Ann O'Sullivan, MSN, EN, CNE, NE-BC, ANEF, Chair, Professional Policy Committee
Loressa Cole, DNP, MBA, RN, FACHE, NEA-BC, Chief Executive Officer
Debbie Hatmaker, PhD, RN, FAAN, Chief Nursing Officer/Executive Vice President
Cheryl Peterson, MSN, RN, Vice President, Nursing Programs, Staff Liaison
Maureen Thompson, MA, CAE, Vice President, Governance & Planning

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

Letter from Senator Kamala D. Harris

KAMALA D. HARRIS
CALIFORNIA
WWW.HARRIS.SENATE.GOV

United States Senate

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
COMMITTEE ON THE JUDICIARY
SELECT COMMITTEE ON INTELLIGENCE
COMMITTEE ON THE BUDGET

September 18, 2019

Dear Mr. Pochop,

Thank you for contacting me with your thoughts on the state of our health care system and the well-being of the American people.

When children and families are healthy, our communities thrive and our economy flourishes. As a senator representing the largest and one of the most diverse states in our nation, I believe every person—regardless of income, gender, sexual orientation, or race—has the right to health care. To that end, I am committed to working toward solutions that increase access, improve quality, and reduce costs of health care for all Californians, especially for those most in need.

In the Senate, I will continue to fight to protect and improve the Affordable Care Act (ACA). The law has helped millions of Californians obtain health insurance coverage, protected patients from discrimination based on pre-existing conditions, and prohibited insurance companies from imposing annual or lifetime limits on coverage. I have partnered with Senator Feinstein to introduce the Affordable Health Insurance for the Middle Class Act, legislation that would make health insurance more affordable for many middle class families – to show the type of improvements to the ACA that everyone should be able to get behind.

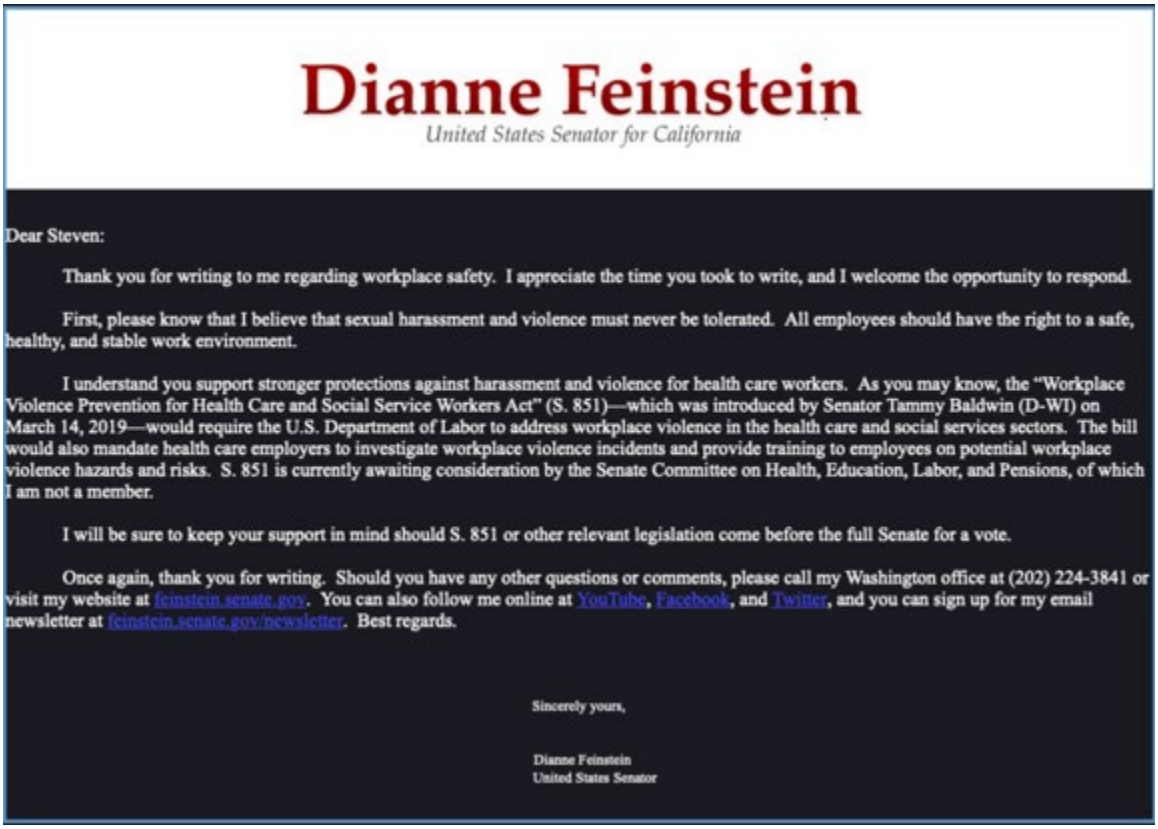
Beyond protecting the vital coverage provisions in the ACA, we must continue to find ways to improve our health care system for all patients. In the Senate, I have supported measures to lower the often prohibitive prices of prescription drugs and to increase funding for community health centers. I'll also continue to fight for robust federal funding of scientific research to cure our rarest and most complex diseases. Together, we can ensure the dream of equal, accessible, affordable health care is realized for all Americans.

Again, thank you for sharing your thoughts with me. If you have any additional questions or concerns, please don't hesitate to contact my Washington, D.C. office at (202) 224-3553.

Sincerely,

Kamala D. Harris
United States Senator

Letter from Senator Dianne Feinstein



Dianne Feinstein

United States Senator for California

Dear Steven:

Thank you for writing to me regarding workplace safety. I appreciate the time you took to write, and I welcome the opportunity to respond.

First, please know that I believe that sexual harassment and violence must never be tolerated. All employees should have the right to a safe, healthy, and stable work environment.

I understand you support stronger protections against harassment and violence for health care workers. As you may know, the "Workplace Violence Prevention for Health Care and Social Service Workers Act" (S. 851)—which was introduced by Senator Tammy Baldwin (D-WI) on March 14, 2019—would require the U.S. Department of Labor to address workplace violence in the health care and social services sectors. The bill would also mandate health care employers to investigate workplace violence incidents and provide training to employees on potential workplace violence hazards and risks. S. 851 is currently awaiting consideration by the Senate Committee on Health, Education, Labor, and Pensions, of which I am not a member.

I will be sure to keep your support in mind should S. 851 or other relevant legislation come before the full Senate for a vote.

Once again, thank you for writing. Should you have any other questions or comments, please call my Washington office at (202) 224-3841 or visit my website at feinstein.senate.gov. You can also follow me online at YouTube, Facebook, and Twitter, and you can sign up for my email newsletter at feinstein.senate.gov/newsletter. Best regards.

Sincerely yours,

Dianne Feinstein
United States Senator

Letter from Senator Kamala D. Harris

KAMALA D. HARRIS
CALIFORNIA
WWW.HARRIS.SENATE.GOV

United States Senate

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
COMMITTEE ON THE JUDICIARY
SELECT COMMITTEE ON INTELLIGENCE
COMMITTEE ON THE BUDGET

July 19, 2019

Dear Mr. Pochop,

Thank you for contacting me to share your thoughts on labor standards. The challenges and opportunities facing working people are a priority for me as well, so I welcome the chance to respond on this important issue.

California is the fifth largest economy in the world, and our industries drive progress across the country—from the cutting-edge technology of Silicon Valley to the farm work of Central Valley that feeds much of America. I strive to meet the diverse needs of our state's workers while supporting the principles of fair, just, and rewarding labor that uplifts people and communities.

To that end, as your senator I have prioritized the development of pathways to good, middle-class jobs in the face of a changing economy. I have visited sites all around California, from the Fowler Packing Plant to the Inland Empire Economic Partnership, to study effective workforce programs that partner labor, education, and industry to meet evolving demands and train a ready, steady, and qualified workforce. I have enjoyed the input of major labor leaders including the UFW, SEIU, AFL-CIO, Teamsters, and AFSCME, alongside incredible grassroots groups like organized farmworker women advocating for overtime pay and community healthcare workers advocating for their patients over profits.

In the Senate, I am proud to support bills that will strengthen labor protections for working people—to make it easier for workers to join unions and bargain collectively with the Workplace Democracy Act and the Workers' Freedom to Negotiate Act; to raise the federal minimum wage with the Raise the Wage Act; to provide overtime protections for farm workers with the Fairness for Farm Workers Act; to prevent wage theft with the Wage Theft Prevention and Wage Recovery Act; to provide comprehensive, national family and medical leave with the Family and Medical Insurance Leave (FAMILY) Act; to remedy sex discrimination in wages with the Paycheck Fairness Act; and to support pension funds with the Miners Protection Act of and the Preserve Rights Of States and Political subdivisions to Encourage Retirement Savings (PROSPERS) Act.

Once again, I appreciate you sharing your thoughts and concerns. If you have additional questions, please do not hesitate to contact my Washington, D.C. office at (202) 224-3553.

Sincerely,

Kamala D. Harris
United States Senator

University of San Diego Newsletter

Hahn School of Nursing Celebrates Military Nurses

FRIDAY, MAY 10, 2019 | Alumni, Catholic Social Thought, Faculty and Staff, Academics, Community Engagement

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The University of San Diego's Hahn School of Nursing and Health Science hosted a Military Nurses celebration in the Beyster Institute for Nursing Research (BINR) Plaza on Thursday afternoon.

Album — **Nursing School Honors Military Nurses** by **usandiego**

University of San Diego flickr

The program, coming during a National Appreciation Week for Nurses, offered a wonderful opportunity to say thank you to nurses who also served in the United States military.

Nursing Dean Jane Georges, PhD, RN welcomed the audience and promptly, with the presence of the USD Naval Reserve Officers Training Corps Color Guard, both the National Anthem and the Pledge of Allegiance were recited.

A blessing and dedication were next, given by Father Robert Capone, a USD alumnus and the university's chaplain. The blessing and dedication were for a new fountain within the BINR Plaza area that USD Nursing Professor Dr. Joseph Francis Burkard, DNSc, CRNA and his wife, donated to USD. Burkard is also a retired Commander in the Nurse Corps of the U.S. Navy.

Todd Uhlman, LCDR, NC, USN, MHA, RN, BSN, CNML, was then on hand to present two Naval Officers with Duty Under Instruction (DUINS) Awards. The awardees were Steven G. Pochop, LT, NC, USN, RN, BSN, CPN and Dehussa Urbieta, LTJG, NC, USN, RN, BSN, CPN.