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National Academy of Nursing (Governing Council Lunch), November 16, 1993

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American Academy of Nursing

600 Maryland Avenue, SW

Suite 100 West

Washington, DC 20024-2571

BALLOTS

THE WHITE HOUSE
WASHINGTON

November 11, 1993

Nola J. Pender, President
American Academy of Nursing
600 Maryland Avenue S.W.
Washington, DC 20024-2571

Dear Dr. Pender:

This letter confirms the appearance of Kristine M. Gebbie, National AIDS Policy Coordinator, at the Governing Council of the American Academy of Nursing luncheon for IOM/Academy members on Tuesday, November 16, 1993 in the Cabinet Room of the Washington Hilton. I also must send regrets that Ms. Gebbie will not be able to attend the annual banquet on November 16, 1993.

Ms. Gebbie plans to arrive at 12:30 and will not make a formal presentation.

Please call me at (202) 632-1090 with any questions or for further clarification.

Best wishes with your event.

Sincerely,



W. Steve Lee, Executive Assistant to
National AIDS Policy Coordinator

Enclosure

NATIONAL AIDS POLICY OFFICE
OFFICE OF THE COORDINATOR

ROUTING SLIP

DATE: 11/3

TO: KG

FROM: ☒ W. STEVE LEE

☐ For your information

☐ For your action

☐ Review and comment by (date)

☐ Prepare reply for Coordinator's signature

☐ Reply directly and blind copy Coordinator

☐ Circulate/forward to:

☐ File

COMMENTS: This is possible but
you are speaking at the dinner
the night before.

It is rather go to
be lunch than the
dinner that night (6/6)



American Academy of Nursing

Established 1973 Under the Aegis of the American Nurses' Association

November 1, 1993

Kristine M. Gebbie, MN, RN, FAAN
The National AIDS Program Officer
Executive Office of the President
750 17th Street, NW
Washington, DC 20500

Dear Dr. Gebbie:

On behalf of the Governing Council of the American Academy of Nursing, I am pleased to invite you to join us for a luncheon of IOM/Academy members on Tuesday, November 16 from 12:30 pm to 1:30 pm in the Cabinet Room of the Washington Hilton and Towers Hotel, Washington, DC. The luncheon will precede the Annual Business Meeting of the Academy.

A draft agenda for the luncheon is enclosed for your information. Please advise us of your availability to attend by completing the enclosed form and FAXing it to Leslie Zeck at 202-554-2262. If you have any questions, please feel free to contact a member of the Academy staff at 202-554-4444, ext. 150 or ext. 152. Jan

We look forward to seeing you in Washington next month.

Sincerely,

Nola J. Pender, PhD, RN, FAAN
President

cc: American Academy of Nursing Governing Council

NJP:lz\conf93\iomlunch.inv
11/1/93

AMERICAN ACADEMY OF NURSING
INSTITUTE OF MEDICINE/AAN GOVERNING COUNCIL MEETING

AGENDA

Tuesday, November 16, 1993
12:30 p.m. - 1:30 p.m.
Cabinet Room
Washington Hilton and Towers Hotel
Washington, DC

- | | |
|---|---|
| 1. Call to Order | Nola J. Pender, PhD, RN, FAAN
President |
| 2. Reports from IOM Members on IOM
Activities | All IOM Members |
| 3. Review of AAN Perspective Goals
in Relation to IOM Program Plan | Nola Pender |
| 4. Review of Upcoming IOM Activities
That are High Priority for Nurses | Elaine Larson |
| 5. Report on Expert Panel Activities | Angela McBride, PhD, RN, FAAN
President-elect |
| 6. Report on IOM/AAN/ANF Senior
Scholars Program | Janet Heinrich
Connie Curron
✓ Marion Ein Lewin |

CONFIRMATION FORM FOR ATTENDANCE AT IOM/AAN LUNCHEON

MAIL TO:

DEADLINE FOR SUBMISSION:

Leslie Zeck
American Academy of Nursing
600 Maryland Avenue, SW
Suite 100 West
Washington, DC 20024-2571
OR
FAX: 202-554-2262

November 11, 1993

I confirm my attendance at the IOM/AAN Luncheon to be held on Tuesday, November 16 at 12:30 p.m. in the *Cabinet Room* at the Washington Hilton and Towers Hotel.

Name: _____

Place of Employment: _____

Street Address: _____

City: _____ State and ZIP: _____

Phone: _____ FAX: _____

Please contact Leslie Zeck at 202-554-4444, ext. 152 if you have any questions.

HEALTH CARE REFORM SPEECH ANA 1993

At the top of the national health care agenda, of course, is health care reform. We all have been reading and talking about health care reform for several years now.

Now that President Clinton has released his Health Security Plan, I want to talk with you from three perspectives:

- First, why health care reform is needed at all, and why we nurses should support;
- Second, why the broad principles being set forth -- for universal access, costs controls and maintenance of quality -- also warrant our enthusiastic support;
- And third, why we believe that the nursing community should support the health care reform program set forth by President Clinton.

Let me address the first point, why health care reform is needed, and why we nurses should support the concept.

Just a few numbers tell the most persuasive story:

- 37 million Americans are without health care coverage.
- Americans spend 14 percent of our gross national product on health care. We are the only nation in double digits except Canada.
- projections are that our spending will increase to 20 percent of our gross national product by the year 2000, if we do nothing about reforming the system.
- a quarter of our health care dollar goes toward administrative costs, filling out and processing forms. In fact, nurses fill out an average of 19 forms per patient.

But we need to go beyond the numbers.

- we all have seen emergency rooms used as primary care facilities because people don't have easy access to basic health care.
- we see a system focused on treating illnesses rather than preventing them.
- we see the waste in over-testing just to protect against medical malpractice.
- we see inequities in how health care is delivered to the poor and in rural areas.

From the perspective of the nursing profession, we are all aware of the secondary role that many registered nurses play in health care, when in fact we can do more and should be better recognized for what we do.

- we see federal training money being spent to develop more specialist physicians rather than nurses who can provide primary care.
- we see hospital emergency rooms overloaded with patients who have nowhere else to go for basic health services.
- we see barriers in most states that deny advanced practice nurses admissions rights at hospitals and the ability to be reimbursed for services without practicing under a physician's supervision.
- we see limited use of schools and community settings to deliver health care services more efficiently.

The lists could go on. We all know the health care system well enough to know that it's not working properly. I would hope that we are in agreement that health care reform is an idea whose time has come. President Clinton's Plan, while not perfect, is the best

opportunity that we have ever had toward reaching our goals and advancing our profession.

My second point has to do with the principles that underlay reform. I would hope that we can agree with the following principles, all of which are contained in Nursing's Agenda for Health Care Reform:

- there should be universal access by all Americans to health care regardless of age and income.
- there should be a basic set of benefits to which everyone is entitled.
- there should be a maintenance of high quality health care for all, with nurses part of the team that decides on and regulates quality.
- there should be programs for the underserved.
- there should be broad-based immunization programs.

- there should be more health care and better school programs.
- there should be access to mental health care.
- there should be coverage for prescription drugs.
- there should be reform of the insurance industry, particularly the elimination of pre-existing conditions as a barrier to insurance, and a ceiling on how much individuals have to pay for a catastrophic illness or injury.
- there should be better care provided in rural and inner-city areas, and incentives for nurses to practice in these areas.
- there should be expansion of public health services at the state level, particularly returning to the original mission of community

prevention, data collection, surveillance and monitoring and disease control.

- there should be more support for nurses in baccalaureate and master's level programs. There should be more money for nursing education.
- there should be the elimination of barriers to permit consumers to have more access to services provided by nurses, especially by advanced practice nurses.

This rather long list represents just a few of the principles that I believe we all can support. They are all reforms that are needed. They are all reforms that are included in the Clinton Plan.

This list leads me to the third point, dealing with the health care reform plan being advocated by President Clinton.

You all may remember that the American Nurses Association formally endorsed Bill Clinton for president before the election.

We were the only professional organization to endorse Mr. Clinton before the election.

We endorsed him not because nurses are Democrats rather than Republicans, but because he promised to make changes in our health care system. Changes that nurses agreed with.

Now he has fulfilled at least the initial phase of that commitment. He has proposed a far-reaching program that would indeed change how health care is delivered and financed. His program will also dramatically change the role and stature of the nurse in the health care system. Every major news organization is listing "nurses" as being in the winner's column.

The features of President Clinton's plan conform to those in Nursing's Agenda for Health Care Reform, a set of principles adopted in 1990 and supported by virtually every nursing organization. As the President's plan was developed in the spring and summer of 1993, nursing had a powerful voice.

We found that we not only had access to the White House, but we had clout. We were one of only a few organizations that had 3

face-to-face meetings with Ira Magaziner in the week before the President released his plan. That is clout.

In our 25 meetings with the White House, we emphasized that our support for the plan was contingent on inclusion of all of the provisions that we wanted -- provisions ranging from the very large concern over universal access and quality, to issues that affect only our own profession. They have given nurses nearly all that we have asked for.

We were pleased that the plan, as offered by President Clinton, did meet our needs, for the most part.

It recognizes that primary and preventive health care across the life span is central to any restructuring of health care. The Clinton plan acknowledges that a health care system that continues to focus on illness and cure, without an appropriate balance of prevention and care, will not work. The proposal clearly says that problems of inadequate access, cost and quality must be addressed comprehensively and simultaneously.

The President's proposed package of basic benefits includes such important preventive and primary care services as immunizations, screening, dental and vision coverage, mental health and substance abuse, and prenatal care. It places new emphasis on primary care and prevention services delivered not only by physicians, but by nurses and other qualified providers in convenient, accessible settings.

Nurses should be pleased that the plan's guaranteed package of benefits emphasizes a broad scope of health services, not just medical services for treatment of illness. It supports nursing's call for school-based clinics, enhanced services for underserved populations, and health education. The services of advanced practice nurses are specifically recognized as covered.

The question that is on everyone's mind is what impact this plan will have on the everyday lives of nurses.

Certainly, as consumers of health care, we will be much better off. The public believes that because we are nurses we have access to better health care than everyone else. We know that is not true.

Under the President's plan, all of us are covered -- whether we are employed or not, whether we have pre-existing conditions, whether we work full-time or not. This has to be a welcome benefit to us and our families.

As providers of health care, our professional lives may stay the same, but also may change. There is no question but that the roles of some nurses may change if the President's health care plan, or any health care plan, is passed. There may be fewer job opportunities in hospitals, for example. But I want to emphasize that the majority of nurses will remain in hospitals where patients will be more acutely ill and require more intensive nursing services.

But offsetting the staff reduction in hospitals will be much greater opportunities in schools and community settings and in managed care institutions. Advanced practice nurses will be able to enter into their own practices and be reimbursed for it.

For the first time ever, advanced practice nurses will be recognized and reimbursed as qualified health care providers in all provisions of The American Health Security Act of 1993 and the Medicare

Act. This will require federal preemptive legislation to remove restrictions on nursing practice. This is a major victory.

There will be a lot more money for nursing education. New entitlement funds for nursing education will prepare and train nurses in a similar fashion to how resident physicians are trained.

I believe that the plan will greatly benefit nurses in the long run. But let's not kid ourselves. Many nurses will need to be retrained to fulfill the needs of a changing health care system. Many of us will find ourselves practicing in new settings. The reform plan is expected to create 750,000 new jobs in the home health field alone -- a tremendous opportunity for nurses.

I am pleased that the President's plan provides funds for retraining and redeployment. It recognizes that during a transitional period, there needs to be financial support for nurses. Our voice has been heard, loud and clear, on this point, and the President's proposal reflects our concerns.

We also are concerned that the training opportunities for low-skilled workers, such as clerical and administrative workers, may

inadvertently increase the pool of nurses aides, nursing technicians and nursing assistants. The plan recognizes that increasing the numbers of these low skilled workers, while essential, does not serve the healthcare needs of the nation.

As we look over the horizon at the next few months of debate, one thing is clear: the health care reform plan that eventually passes the Congress will be a combination of all the plans now being discussed. The Congress will hold hearings on each and every element of the plan. They have heard from every constituency and the voices from around the country will get louder and louder as the debate marches forward.

Washington experts expect this debate to go on for many months, perhaps into next fall, before legislation is enacted. During this time, we nurses, through our representative groups, will continue to be at the table -- whether it's the public hearing table, or the back-room table where decisions often are made.

I believe that all of us can be proud of the efforts made by our representatives in Washington to advance Nursing's Agenda for

Health Care Reform and for successfully encouraging the White House to include our provisions in the initial proposal. Even the Washington Post, in a front page article, acknowledged the new-found power of the nursing lobby. Good for us.

Our lobbyists in Washington are heard only because the White House and the Congressmen know that they speak for 2.2. million nurses across the country. They know that one in every 44 registered women voters in this country is a nurse. They know that we are committed, individually and as a group, to the principles of health care reform. And they know that we will watch carefully what they are doing.

The American Nurses Association is organizing a grass roots program known as N-Stat to help get us organized and to make our voices even more influential. The N-Stat program will enable nurses to lobby more effectively with the Congress and White House, and also to express our views more pointedly through the media. The grassroots program depends on participation from individuals like us, and I urge you all to become a part of this growing network.

Whether you are a part of N-Stat or not, I urge you all to study the Clinton health care plan and learn more about it.

- Think about its overwhelming benefits for the country.
- Think about how it will deal with the inequities and spiralling costs that we are all concerned about.
- Think about how it will change the nursing profession, and how it will affect your own practice.

I think you will agree that we, as the nation's largest single group of health care providers, need to make our voices heard, and need to express our support for the principles in the plan, and for the provisions that will enhance the practice and study of nursing. And in the short term, where change will occur and fear of it will abound, we must reassure and lead our nurse colleagues into the future. It will be brighter and more promising than ever before. But we have more battles ahead . . . in Congress and in the

individual states. Nursing is unified. Let's show them that we are ready to move forward and let nothing stand in our way!

Thank you.

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9/22/93

THE HEALTH SECURITY ACT OF 1993

Health Care That's Always There

Every American citizen will receive a Health Security Card that guarantees you a comprehensive package of benefits that can never be taken away.

Guaranteeing comprehensive benefits that can never be taken away. Controlling health care costs for consumers, business and our nation. Improving the quality of American health care. Increasing choices for consumers. Reducing paperwork and simplifying the system. Making everyone responsible for health care. These are the principles of the Health Security Act of 1993 and they are not negotiable.

In America, rights and responsibilities go hand-in-hand. We will ask everybody to pay something, even if your contribution is small. Everyone must assume responsibility. No one should get a free ride.

Most important, we're going to offer new opportunities and new incentives for people to stay healthy – and to treat small problems before they become big ones. Our goal should be to keep people healthy, not treat them after they become sick.

What's Wrong With the Current System

The things that are wrong with our health care system are threatening everything that's right with American health care.

- Over the next two years, one out of four of us will be without health coverage at some point. Change jobs, lose your job, or move – and your insurance company is currently allowed to drop you.
- Today's system is rigged against families and small businesses. Insurance companies pick and choose whom they cover. Then they drop you when you get sick. If you have a pre-existing condition, you usually can't get any insurance at all.
- Insurance companies charge small businesses as much as 35% more than the big guys.
- Only 3 of every 10 employers with fewer than 500 employees offer any choice of health plan. Millions of Americans have almost no choice today.
- Twenty-five cents out of every dollar on a hospital bill goes to bureaucracy and paperwork – not patient care.
- Fraud and abuse are exploding, costing us at least \$80 billion a year. That's a dime of every dollar we spend on health care.
- Our nation's health costs have nearly quadrupled since 1980. Without reform, by the year 2000, one of every five dollars we spend will go to health care.

The Health Security Plan

Every American citizen and legal resident will receive a Health Security Card. Once you get your card, you can never lose your health coverage -- no matter what. If you get sick, you're covered. If you change jobs, you're covered. If you lose your job, you're covered. If you move, you're covered. If you have the courage to start a small business, you're covered.

Your Health Security card guarantees you a comprehensive package of benefits that can never be taken away. The package is as comprehensive as the ones that many Fortune 500 companies offer their employees. And in critical ways -- like paying for preventive care and prescription drugs -- the package gives you more than big companies provide today.

You will be able to choose your doctor. Everyone will have a choice of health plans. You'll be able to follow your doctors and nurses into a traditional fee-for-service plan, join a network of doctors and hospitals, or join an HMO. Your boss or insurance company won't decide how or where or from whom you get your care -- you will.

Almost everybody will be able to sign up for a health plan at work, like you do today. You'll get brochures that give you easy-to-understand information on several health plans -- which doctors and hospitals are included, an evaluation of the quality of care, a consumer satisfaction survey, and prices. If you're self-employed or unemployed, you can sign up at your area health alliance, which will be run by consumers and businesses and bargain for affordable health care for you.

The federal government will set up a national health board -- a board of directors to set standards and make sure you get the comprehensive benefits and quality care you deserve. State governments will set up health alliances give consumers and small businesses the power to buy affordable care; and the businesses with 5,000 or more employees will be allowed to operate as "corporate alliances."

Insurance companies will be required to use a single claim form to replace the thousands of different forms they have today. So when you get sick, you won't be buried in forms -- and neither will your nurse, your doctor or your hospital.

- **Security for you and your family.**
- **A comprehensive package of benefits.**
- **Health care costs that are under control.**
- **Improved quality of care.**
- **Increased choices for consumers.**
- **Less paperwork and a simpler system.**

That's what the Health Security Act is all about.

Principle #1:

Security: Giving you health care that's always there.

Over the next two years, one of every four of us will lose health coverage for some time. The Clinton plan guarantees that you will never lose your insurance – no matter what. Here's how the plan guarantees security:

- **Makes it illegal for insurance companies to deny you coverage because of "pre-existing conditions."** The Health Security Act also makes it illegal for insurers to raise your premiums or drop you because you get sick. All health plans will be required to accept anyone who applies – healthy or sick, young or old.
- **Guarantees coverage if you lose your job.** The proposal guarantees that you will keep your health coverage even if you lose your job, with the employer portion picked up by Federal revenues and savings. Under the current system, if you lose your job, you lose your health insurance.
- **Guarantees coverage if you switch jobs, move or start a small business.** You will always be protected – no matter what. Today, if you switch jobs, move or start a small business, you can find yourself without health insurance – and risk bankruptcy.
- **Provides coverage for early retirees.** The health security plan guarantees coverage for early retirees, so they don't have to worry about being without coverage after they retire and before they are covered by Medicare. Today many early retirees are losing their health benefits.

Principle #2:

Comprehensive benefits: Keeping you healthy.

All Americans will receive a Health Security card that guarantees you a benefits package that is as comprehensive as those offered by most Fortune 500 companies...and then some.

Emphasizes preventive care. The comprehensive benefits package goes beyond virtually all current insurance plans by covering a wide range of preventive services, including mammograms, Pap smears, and immunizations, **at no charge to you.** It puts a new emphasis on helping you stay healthy, rather than waiting until they get sick. Prevention saves money and improves people's health.

Includes prescription drugs. Many insurance companies and Medicare have failed to cover prescription drugs. But drug costs are breaking family budgets, forcing many older Americans to choose between food and medicine. Health insurance should cover prescription drugs. The Health Security plan does.

All Americans will be guaranteed coverage of :

- Preventive Care (i.e., screenings, physicals, immunizations, mammograms, prenatal Care; at no cost)
- Doctor Visits
- Prescription Drugs
- Hospital Services
- Emergency/Ambulance Services
- Laboratory and Diagnostic Services
- Mental Health and Substance Abuse Treatment
- Expanded Home Health Care
- Hospice Care/Outpatient Rehabilitation
- Vision and Hearing Care
- Children's Preventive Dental Care

Principle #3:

Savings: Controlling health care costs.

Here's how the Health Security Act will control health care costs:

Limits how much insurance companies can raise your premium. Insurance companies will no longer be able to raise your premiums as they please. Today, insurance companies hike your premiums – sometimes at several times the rate of inflation – if you get sick, if someone in your family gets sick, and for any other reason.

Introduces competition to the health care marketplace. The Health Security plan will release the chokehold that in today's system, insurance companies have on all of us – consumers, nurses, doctors, and businesses. Reform will encourage competition – forcing costs down as health plans compete by offering high-quality care at an affordable price.

Cracks down on fraud. The health security proposal makes health-care fraud a crime and imposes stiff penalties on those who cheat the system. It prohibits doctors from referring patients to outside facilities, like labs, which they own a piece of. It stops the kickbacks that some laboratories give doctors in an effort to get their business.

Asks the drug companies to hold down prescription drug prices. The Health Security plan asks drug companies to take responsibility for keeping prices down, without setting prices. In today's system, overcharging runs rampant –certain prescription drugs cost Americans three times more than people pay in other industrialized countries.

Reduces paperwork. All health plans will adopt a single, standard claims form by Jan. 1, 1995. Along with other measures to streamline the system and free nurses and doctors from excess bureaucracy, this will reduce paperwork, cut red tape, and save money.

Squeezes the waste out of Medicare and Medicaid. By slowing the growth of these government programs, the proposal uses funds that have been wasted on excessive charges and funnels them into comprehensive benefits. Under reform, Medicare will be expanded to

cover prescription drugs, and there will be a new long-term care program to help cover home- and community-based care. Today, Medicare and Medicaid spending keeps going up and up. But the elderly and poor aren't getting any extra benefits. Health security will change that.

Principle #4:

Quality: Making the world's best care better.

Emphasizes preventive care. The Health Security plan puts a new emphasis on preventing illness before it becomes a medical crisis. Prevention will improve the quality of care by helping people stay healthy rather than treating them after they get sick. The benefits package fully pays for a wide range of preventive services; the vast majority of today's insurance plans don't cover a penny.

Gives consumers the power to judge the quality of care. Consumers will receive quality "report cards" that provide information on the performance of health care plans and patient satisfaction. These report cards will hold health plans accountable for meeting high standards. The National Quality Program will help states share information on health plan performance.

Reforms malpractice. The President's proposal will limit lawyers' fees in order to discourage frivolous medical malpractice lawsuits. It will also encourage patients and doctors to use alternative forms of dispute resolution before they end up in court. This will help eliminate the "defensive medicine" that drives up costs and hurts quality — doctors ordering extra tests because they fear lawyers looking over their shoulders.

Encourages cooperation in rural and urban areas. Rural residents will have access to the latest technology and emergency services through telecommunications links set up between local doctors and advanced networks of specialists and hospitals. In urban areas, the plan will increase investment in public hospitals and community health centers.

Provides incentives for more family doctors to practice in rural and urban areas. The health security plan will give financial breaks to doctors and nurses who work in underserved rural and urban areas. It will expand the National Health Service Corps. Two of three rural counties today do not have enough doctors and 111 rural counties have no physician at all.

Increases funding for prevention research. The National Institutes of Health (NIH) will expand research in areas like children's health, and health and wellness promotion. Preventive care keeps people healthier and saves money at the same time.

Promotes research on the effectiveness of treatments. Today, a lack of information about the most cost-effective methods of treatment often leads to expensive defensive medicine and wide variation in treatments and costs. The plan's investments in research into what treatments really work will help improve the quality of care.

Principle #5:

Choice: Preserving and increasing what you have today.

Preserves your right to choose your doctor. The proposal ensures that you can follow your doctor and his or her team to any plan they might join. Today, more and more employers are forcing their employees into plans that restrict your choice of doctor. After reform, your boss or insurance company won't choose your doctor or health plan – you will.

Increases your choice of health plan. You will be able to choose from among all the health plans offered in your area – no matter where you work. Only one of every three companies with fewer than 500 employees offer any choice of health plan. After reform, every employee will be able to choose a health plan.

Puts consumers in the driver's seat. The Health Security Act brings competition to health care – unleashing the market forces that will lower costs and improve quality. Giving small businesses and consumers the power to band together in alliances will level the playing field and give them the same bargaining strength as big businesses.

Increases options for long-term care. The President's proposal will make it possible for more Americans to continue to live in their homes and communities while receiving care. Today too many families are split apart when insurance or federal programs only pay for hospital coverage. The plan will help put an end to this situation and give families the options they deserve.

Principle #6:

Simplicity: Reducing paperwork and cutting red tape.

Gives everyone a Health Security Card. The card – with full protection for privacy and confidentiality – will allow for electronic billing and the creation of health care information networks. This will reduce paperwork and simplify the system.

Requires insurance companies to use a single claim form. The Health Security Act will reduce the insurance company red tape that forces doctors and patients to spend their time filling out forms and fighting bureaucrats. All health plans will adopt a single, standard claims form by Jan. 1, 1995. It will enable doctors and nurses to spend more time taking care of you – and less time wrestling with paper.

Eliminates fine print. Everyone will get a comprehensive benefits package – and what you get will be spelled out in easy-to-understand language. If you get sick, insurance companies won't be able to point to fine print and deny you the coverage you've paid for.

Streamlines billing reimbursement for doctors, nurses and hospitals. The comprehensive benefits package, a standard rules and codes for payment, and elimination of excessive government regulations will reduce confusion. Doctors, nurses, and hospitals will have more time to care for patients; and all of us will benefit.

Removes the burden on business of negotiating insurance. Groups of businesses and consumers – regional health alliances – will negotiate for high-quality care at affordable prices. This will simplify today's system, where hundreds of thousands of businesses negotiate with more than 1500 insurance companies. The burden of finding insurance will be lifted – and so will administrative costs – which can run as high as 40% of total health costs for small business.

HOW THE SYSTEM IS FINANCED

The financing proposal was developed under the most rigorous and conservative forecasting standards. For the first time, representatives from every federal agency involved in fiscal accounting and financial projections have been brought together to work out the numbers. Then teams of actuaries, health economists and other financial analysts from outside the government served as auditors and consultants, checking and rechecking.

The system is financed from five major sources:

- 1) Employer and employee contributions – Everyone will pay a portion of health insurance premiums, even if your contribution is small, because everyone must assume responsibility. Today, the overwhelming majority of employers cover their employees, and they'll continue to do so. But the businesses that provide insurance are paying for those who don't. No one should get a free ride.
- 2) Medicare and Medicaid savings – Specific savings can be achieved by slowing the rate of growth of these programs. Every penny of these savings will be channeled back into benefits – prescription drugs and long-term care – for the people which these programs serve.
- 3) "Uncompensated care." – Savings can be achieved from money now paid to hospitals and doctors who care for people who can't afford care but receive it anyway and the uninsured.
- 4) Sin taxes and other federal revenues – There will be some new "sin taxes," and other revenues will be added as health care costs slow, less money is spent, and the difference is no longer tax-deductible.
- 5) Other savings – Reducing paperwork and administration – estimated to cost \$100 billion or more a year – will cut bureaucracy and save money. Cracking down on health care fraud – estimated to be at least \$80 billion annually – and imposing new stiff penalties will also yield savings.

PAYMENT SCENARIOS

As a rule, most individuals and families in which at least one person works will pay a maximum of 20% of the average health plan premium in their area. Those who choose a lower cost plan – from among those offered in the area – will pay a little less than the

20% average. Those who choose a more expensive plan will pay a little more, as they do today. Employers who currently pay 100% of health benefits may continue to do so.

Two parent family with children: Two parent families with children – whether one or both parents work – pay a maximum of 20% of the family premium offered by the average plan in their area. If both parents work, they choose how to pay their family's share. They can have the share deducted monthly out of either paycheck or write a check to the local alliance.

Couple: Working married couples – whether one or both spouses work – pay a maximum of 20 percent of the average plan premium. They can have the share deducted monthly from either paycheck or write a check to the local alliance.

Single-parent family: Working single parents with children pay a maximum of 20 % of the average plan premium for a single parent policy.

Individual: Working single people pay a maximum of 20% of the average premium for an individual policy in their area.

Part-time worker with no unearned income: Part-time workers pay a maximum of 20% of the average plan premium for their policy type in their area.

EXCEPTIONS

Exceptions are provided for: (1) the self-employed and independent contractors; (2) part-time workers who have unearned income; (3) families with incomes below 150% of the poverty level; and (4) seasonal workers.

Self-employed/independent contractors: The self-employed and individual contractors can deduct from their taxes 100% of their health care costs. As with any small business, they pay the employer share. They also pay an individual share. If a firm earns less than \$24,000 a year, it is eligible for subsidies.

Part-time workers with unearned income: Part-time workers with unearned income pay a maximum of 20% of the average plan premium for their policy type – individual, couple, two parent, or single parent family.

The number of hours someone works determines how much of the premium is paid by the employer and how much by the individual. For example, an employer would pay 40% of the premium for someone who works half-time. Payment of the remaining 40% of the premium depends on how much a person makes in unearned income, with subsidies provided on a sliding scale for those whose incomes are below 250% of the poverty level.

Families with incomes below 150% of the poverty level: Families at this level are eligible for discounted premiums and pay a maximum of 20% of the employee's share of

the average plan premium. This applies to individuals making \$10,455 annually; couples with incomes of \$14,145; families of three earning \$17,835; and families of four with incomes of \$21,525.

Seasonal workers: Seasonal workers pay a maximum of 20% of the average plan premium in the area where they reside.. Those whose incomes are 150% of the poverty level or below are eligible for discounted premiums. If they have unearned income and are not working, seasonal workers are treated the same as part-time workers.

Unemployed and non-working: Unemployed individuals and heads of household who make less than 150% of the poverty level are eligible for individual subsidies on a sliding scale. Those with unearned income pay all or part of what would normally be the employer's share of the premium.

Those whose incomes are 250% of the poverty level or less – pensioners, for example – are eligible for discounts on what would be the employer's share. They are not eligible for individual subsidies, and pay the normal individual share of the health premium.

SAVINGS

Highlights:

We know this can work. There's no reason why our international competitors spend so much less than we do on health care - - yet they insure all of their people and they provide richer benefits. There's evidence out there in places that have gone to competition, that providers can and will cut their costs substantially and quickly.

California hospitals have kept their growth rates well below the national average - - 9% versus 30% over 1983-1990.

The State of Minnesota has kept its annual rates of increase 2% below statewide trends for the last two years - - primarily as individuals have chosen lower-cost plans.

Germany and Japan have been able to keep the growth in their health care costs down to GDP while ours have been growing at 9% and 10%.

The Mayo Clinic has kept its growth down to 3.9%.

Health care spending can be reined in to meet the budget caps through cutting out the waste in the current system - - streamlining administrative overhead and increasing the productivity of doctors, nurses and other health care workers.

The major cost containment mechanisms under reform come from increased efficiencies through competition. Budgeting the rate of growth in the health care premium acts as a backstop to the competition - - a commitment to downward pressure on costs that can further bolster competitive savings.

Washington State and Minnesota have recently passed health reform legislation that combine principles of managed competition with strict cost containment measures. In Minnesota, the rate of growth in health care spending must decline by at least ten percent a year for five years, beginning in 1993.

Giving incentives to providers to deliver more cost-effective care and reducing administrative costs can free up dollars to both insure all Americans and make their health care more affordable.

The reform proposal first takes cost out of the system by:

- **Changing the incentives in the insurance market to compete on**

quality and efficiency rather than avoiding high-cost patients

- **Prepaying health plans, changing the incentive from "doing more" to "doing it better"**

Under today's system, doctors get paid for each test and procedure they perform. That means, the more they do, the more they get paid. Under reform, health plans work under a fixed prepayment - - a budget that provides discipline - - changing the incentive from doing more to competing on quality and efficiency.

In Northern California, Kaiser Permanente members have 25% fewer hospital days per capita than other residents.

- **Reducing variation in practice patterns within and between communities through research and better information exchange**

Boston residents get twice as much care (costing \$300 million more annually) than residents in New Haven, Connecticut. The difference in spending is not due to a difference in the quality of care patients receive.

Open-heart surgery that costs \$21,000 in one Pennsylvania hospital costs as much as \$84,000 in another hospital in the same state. And, the lower-cost hospital had better outcomes.

- **Streamlining administration**

Under today's system, as much as 30-40% of the premiums paid by small firms support the overhead of brokers, insurance agents and underwriters. Large firms pay significantly less for administration - - closer to 5-7% of premiums. Under reform, firms with 5,000 or fewer employees join health alliance where administrative and purchasing functions are consolidated. Economies of scale result in a lower administrative burden for the system as a whole.

A growing share of the health care dollar pays for processing paper and complying with regulations. For every one doctor hired at a hospital, there are four administrators. Under reform, a single claims form replaces the hundreds of different forms. A standardized benefits package, and standardized reimbursement rules, procedures and regulations scale back administrative overhead.

- **Making consumers cost conscious**

Under today's system, consumers often do not know how much health care costs. Employers pay their premiums; insurers pay the tab. Under

reform, consumers, not their employers, decide among health plans based on price and quality. Choosing higher-cost plans means consumers have to pay more out-of-pocket. Choosing lower-cost plans drives providers to find ways to become more efficient.

In 1988, the state of Minnesota changed its contribution from 100% of the state fee-for-service plan to 100% of the low-cost plan serving a given county. Due in large part to consumer switching, annual rates of increase have been at least 2% below statewide trends for the last two years. Estimated system savings are \$23 million over the last three years, and \$12 million in 1993 alone.

- **Strengthening consumer bargaining leverage**

The Health Insurance Plan of California (HIPC) received bids that were as much as 55% lower than the same plan offered by the FEHBP.

In Orlando, the 78-member Central Florida Health Care Coalition succeeded in negotiating better prices with regional hospitals that enabled the Orange County School Board to keep 20 teaching jobs it had planned to cut. The coalition persuaded hospitals to analyze why costs and quality of care differed for patients with the same illnesses. With this information, costs per hospital discharge fell 2%.

An Enforceable Budget - the Back-up Engine for Cost Control

While there is ample evidence that lower cost growth will be driven by competition and increased efficiency, the health security proposal builds in a back-up measure to cost control: an enforceable budget.

The budget is met through capping the growth in premiums individuals and businesses pay for the comprehensive benefits package, similar to the caps proposed by Kassebaum, Danforth and enacted in the State of Washington.

Health Security Plan

"If you like your insurance today..."

Summary

People who like their health insurance today have a lot to gain from the health security plan. First -- and most important -- they'll get something that no amount of money can buy in today's insurance market: security. Lose your job? You're covered. Want to change jobs? You're covered. Your child gets sick? You're covered. You just can't guarantee that today.

People who like their health insurance today will also get increased choices, the chance to stop trading wage increases for the same health benefits, and preventive care benefits that will keep them healthy. Even those Americans who are satisfied with what they've got now have plenty to gain. And they'll probably pay less for better care.

Today

Millions of Americans have worked hard to get the solid health benefits that they enjoy today. Almost all of us have been forced to trade increases in our wages in order to maintain the same health benefits we had the year before. Or worse. And millions are locked into their jobs; they want to find better jobs but can't leave because they fear losing health insurance and not being able to get a new policy.

Even those with excellent health insurance packages live in constant fear of losing that protection. Insurance companies hold all the cards: they can drop you for almost any reason. If you move, change jobs, or get sick, your insurance can disappear overnight and, if someone gets seriously ill, bankrupt your family.

Health Security

The Health Security plan gives every American -- even those who like their health insurance today -- something no amount of money can buy today: guaranteed security. All Americans will receive a Health Security Card that guarantees a comprehensive package of benefits that can never be taken away. No ifs, ands, buts or fine print. No longer will American families be asked to make significant decisions -- about where to live, work or how to care for a sick relative -- based on discriminatory insurance rules.

The plan also:

- **Protects you if you lose your job.** Let's say your company offers you a Cadillac health plan today. That's great. But what happens if the company has to cut back and you lose your job? You lose that Cadillac plan and end up naked in the middle of the road.

- **Increases your choices.** Today only one of every three companies that employ fewer than 500 people offers employees a choice of plan. And rising health care costs and the bottom line are putting choice out of the reach of more people everyday. The Health Security plan guarantees you a choice of at least three plans in every area: a traditional fee-for-service plan like many people have today, a network of doctors and hospitals, and an HMO-type plan. You -- not your boss or a benefits manager -- choose from whom and how you'll get care.

- **Helps restore lost wage increases.** The Health Security plan will give millions of American workers their first real chance for wage increases in years. For two decades rising health care costs have robbed American workers of wage increases they need and deserve. If we do nothing, health costs for an insured worker will rise from 1 in 5 to 1 in 4 dollars in just seven years. By giving business the bargaining power it needs to get affordable health care and helping provide for retirees -- whose health costs are killing some big manufacturers -- the Health Security plan helps workers.

- **Guarantees preventive care.** By providing a full range of free preventive care benefits, the Health Security plan offers all but a few Americans something new: care to keep them healthy, rather than coverage for after they get sick. Preventive care benefits include such things as physicals, immunizations, mammograms and Pap smears.

THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript

September 10, 1993

REMARKS BY THE FIRST LADY
AT STATE LEGISLATIVE CONFERENCE

George Washington University
Washington, D.C.

MRS. CLINTON: Thank you very much. Those of you who have not previously been acquainted with President Bolger, I hope now you know why he is the longest-serving President of the Senate of the Commonwealth of Massachusetts.

I am grateful for this invitation from the University and the Foundation, and particularly pleased to see not only legislative leaders from all over the country, but students and others associated with this university which has a particular emphasis on health care reform and whose faculty has been very helpful to us in the process of the last months in working our way through the many difficult challenges posed by the requirement the President imposed upon us, which is to come forward with a plan that could serve as the basis for making it possible to say in this country that we did provide health care to every American in an affordable way that guaranteed quality now and into the future.

This has been an extraordinary process. And it has involved literally thousands of people, not only those here in Washington, but from throughout the country -- those who minister on the front lines of health care, in our hospitals, our hospices, doctors and nurses and technicians; those are who the recipients of care, the patients, with all of the myriad of problems that we have come to recognize; those who have preexisting conditions for whom insurance is either impossible or out of reach financially; those who want to take more responsibility for themselves, but find it very difficult to figure out how in a system that doesn't stress or even require responsibility from all of its citizens.

We have talked with legislative leaders and governors in every state through your representatives and in person. We have

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talked with businesses, those who provide insurance; those who are worried that they will no longer be able to do so because of the costs imposed; those who have had to drop it; those who see their employees suffering under the extraordinary financial and psychological burdens of facing health care problems without any financial security.

I have traveled throughout our country. I have sat and talked with men and women who have worked hard for a living for years and years often for the same company, and yet cannot find their way into the insurance market. I have talked with physicians who treat our most vulnerable populations and who tell me repeatedly that a sensible health care policy would not only be humane and moral, but economically significant because we could prevent problems before they deteriorated.

You all know the stories that are legion that have brought us to this point. And what I hope we will do as a nation in the next months is not just to continue talking and wringing our hands, sharing the anecdotes, worrying over the future, but to roll up our sleeves and together solve the problems posed by a country that spends more money on health care than any other in the world yet does not provide quality, affordable health care easily accessible to all of its citizens. That is the framework into which I hope we will move the debate.

I have been gratified by the outpouring of involvement from people in all walks of life and all political persuasions. In my consultations that have gone on repeatedly since last February on the Hill, I have found an extraordinary range of interest and support from both Democrats and Republicans. And I am particularly grateful for those members of Congress in both parties who have moved beyond rhetoric on this issue, who have been willing to get into the very difficult detailed analysis necessary for us to make the right choices.

Let me start today by outlining for you what we view as those principles that we wish to retain and stand upon as we move forward into the final details of the blueprint that the President will be presenting and what will be guiding the administration in its continuing negotiation with members of Congress and others who are dedicated to achieving the kind of result that I think all of us would like knowing how difficult that will be to do.

We intend to stand by six basic principles. First, security. Every American should have health security regardless of where he or she works, whether or not he or she has ever been sick before. Regardless of any circumstance, that person should know that they are entitled to having their health care needs met. That

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requires that we achieve universal coverage in America, not just universal access with continuing financial barriers, but coverage that actually will result in access being realistically available to every American.

Now when I talk about health security, I am not merely talking about those nearly 40 million Americans who currently are uninsured. That is a significant issue that has to be addressed. Most of those Americans who are currently uninsured, 85 to 90 percent are workers and their families. Those are the people that I met in places like New Orleans, who had worked often 15, 18, 25 years for a firm; and at the end of that length of employment were making \$15,000, \$18,000 a year; could not afford in the current marketplace health insurance and yet had health problems that were often then either unaddressed until they deteriorated or which left us paying the bill because services would be delivered, but there was no insurance and the people were not eligible for public financing so the costs were shifted onto us.

In addition to those nearly 40 million uninsured, there is a significant portion of the population that is underinsured -- insurance policies that don't pay for primary and preventive health care -- a very pennywise and pound foolish approach to health care. Why don't we pay for the well child physical exam, for the mammogram, for the pap smear instead of paying for the operation or the chronic debilitating condition? If we can shift our focus to primary and preventive health care while we provide security, we will not only be taking care of health problems earlier, we will be saving money.

I will never forget sitting down, talking to a woman who was a bookkeeper for this company in New Orleans, who said, "I try to be a responsible person. I go every year for a physical exam. I pay for it out of my own pocket. This past year I was told by my doctor that he found a lump. I paid for the mammogram. I was referred to a surgeon. The surgeon said to me, if you had insurance, I would biopsy it; but since you don't, we will watch it.

Imagine how you would feel if that happened to you or someone in your family. But imagine further what will happen when that woman, if she does, God forbid, develop cancer, does get the treatment that even the uninsured get, and we pay for it instead of paying for something easier for her psychologically and physically that will save us all money.

But security is also not just about the uninsured and the underinsured. Security really is about all of us. Any one of us who is currently insured cannot predict how much that insurance will cost next year. We cannot predict if we are employed and the employer pays some or all of our insurance, even whether that

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employer will continue to do so; whether that employer will be in business; whether I will be laid off. There is no security even for the insured in this system. So when we talk about security, we are talking about making sure we provide health care that is always there for every American. That has to be a bedrock principle. And the sooner we can achieve that, the more we will be able to control the costs in the entire system.

Now security also means that every American should have access to a guaranteed benefits package that sets forth what they are entitled to with respect to health care. And it is our very strong belief that benefits package should emphasize primary and preventive health care. We are very committed to that. We want people to seek care earlier to get problems taken care of more cheaply. We want more physicians and nurses and others providing primary care instead of taking care of conditions that can only be treated by more expensive specialty care.

Second, we want a simpler system. You know, I have heard many discussions about how complex reform will be. I sat down a few months ago and tried to write out what our current system is. Try that sometime. Sit down and try to write out what is America's health care system right now. Describe who gets what benefits under what circumstances and what insurance markets according to what underwriting practices, who gets financial help from the government and who doesn't. Just write it out. And if you can write it out and think you've totally described our system, please send it to me, because our current system is a nonsystem. We do not have one that can be described in any simple term to anybody. We have a patchwork that has grown up kind of willy-nilly over the decades and which has gotten increasingly more difficult for people to understand.

I won't embarrass anybody by doing this, except myself, to say how many of you have every actually sat down and read every word in your insurance policy when you signed up for health care? Very few people do. This is a system that has gotten out of control for the average American. We want a simpler system that people can understand. And it is not only going to be simpler to understand, it must be simpler to administer. There is no reason why this country should be spending the amount of money we currently do on administering a system that not one of us can adequately describe.

If we take seriously simplicity, then what we want to do is to take our existing system, which does provide health care now for most Americans, although without the security that I think should be there, and we want to begin to take away from it the complexity and the insecurity, but to keep what is good about it, the best health care in the world, if you can get there and pay for it. We all know that. But what we want to be able to say to Americans is,

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this system is an American solution to an American problem.

We intend for you to continue to pay premiums for insurance and we intend for you to choose your health plan, but we will make you better informed consumers in this simpler system. And we will cut from it the kind of administrative costs that only add to our financial burdens in providing health care.

Third, we want choice for consumers. We want individuals to be able to choose, to make an informed choice about the health plan they intend to be part of. What we currently have in this non-system that we are all laboring with is an increasing trend toward limiting choice. Employers make the choice for most individuals in insurance plans that are employer/employee based. Employers are being driven more and more into making those choices based on bottom line considerations. Individuals, whether they have first dollar coverage or make some contribution, have no stake in making cost-conscience informed choices.

In the system that we are proposing, there will be large purchasing units that will be available for the premiums to be paid into. Health plans will be bidding for the right to sell their health services to individuals. Each individual, not the employer, but the individual, each year, will choose from among the health plans in his or her region. So I, as a consumer, will be able each year to decide do I want the HMO. Granted, it will be cheaper for me. They can deliver health care more cheaply in this model. Or do I want a PPO, or do I want the fee for service network that will be mandated to be available in every region. Or maybe an as-yet undeveloped form of delivering health care because we want the market to help create new and efficient ways of delivering health care.

And then the next year, suppose I enrolled in one group, and I decide that for whatever reason I'm not satisfied, then I, not the employer, not the government, I make the choice to move elsewhere. There will be some financial considerations that I will take into account, that I will decide whether I wish to spend more of my share of the 20 percent premium on the cheaper, the average, the more expensive form, but that will not be a choice dictated by anybody else. It will be made by the individual on his or her experience. And over years we will begin to have consumers who know about health care and take responsibility for it because of choice being theirs to make.

Fourth, there will be and will have to be savings in this system that can be better utilized. This is one of the most misunderstood aspects of health care in America right now. We are currently spending around \$900-plus billion. That translates, for all you policy wonks, into about 14 percent of our Gross Domestic

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Product. There isn't any other country even close. The closest is Canada with about nine percent. Most of our other industrialized competitors are between eight and nine percent. They deal with cost pressures. They deal with technology and demands from populations. But they have a better base from which to make those decisions because they are not already spending so much money in such a disorganized way.

If we do nothing, if we just throw up our hands and say oh my gosh, good try, but just like Franklin Roosevelt and Harry Truman and Lyndon Johnson and Richard Nixon and everybody else, we just can't deal with this problem, it's just too much for us, then we can look forward to spending increasing amounts of our out of pocket wages on health care. We can look forward to having 20 percent of our Gross Domestic Product by around the year 2000 being spent on health care without insuring one more person, without assuring security, without changing the system toward primary and preventive health care. The status quo in this instance is not static.

Now what do we do with the amount of money that we currently spend? Well, we spend some of it from state and federal government revenues for Medicaid and Medicare and additional services that the government provides. We spend some from the employer/employee contributions that make up the bulk of the financing. But much of that money goes to propping up an inefficient system. We believe that there is the capacity to reallocate the money in both the public and the private sector in efficient ways that will enable us to reach universal coverage and do so more cost effectively.

Now many of you have read in the newspaper in the last few days that we believe there are additional savings to be realized in both the public and the private sector. We do believe that. In both the Medicaid and the Medicare systems; even after budget reconciliation, the rate of growth in both of those systems was 16 and 11 percent, respectively.

Now if you are continuing to grow a public program at 11 percent, when your population, particularly your elderly population, is not growing that fast on an annual basis; when it is far above our current rate of inflation; and even allowing for differentials and the cost of delivering services, that is an enormous amount of money on a very large base. We think in both the public systems, you can reduce the rate of growth. We are not talking about cuts. We are talking about reducing the rate of growth to inflation plus, population, plus some give.

But even cutting that in half, from 11 to 5.5. percent to 6 percent, when we are also in the benefits package we are

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proposing, adding prescription drugs for the population, including the Medicare population; adding a long term care commitment, so that we can begin to build up a home-based and community-based infrastructure that will roughly relate to the amount of money by which we are reducing the rate in the growth of those programs, that seems to us to be a more efficient way and frankly a better deal for the recipients of those programs because there is savings to be realized in there.

You've heard a lot of talk, a lot of loose talk frankly, about capping entitlements for deficit reduction. But if all one did were to cap entitlements in Medicaid and Medicare for deficit reduction without doing something about the whole system, particularly what happens in the private sector, you would have an explosion of cost shifting in the private sector put on the backs of the states, local governments, and employers, which will further increase in security because those costs cannot be handled. So what we are advocating is reducing the rate of growth using most of that to provide new benefits and at the same time beginning to provide some budgetary framework for the private sector as well.

Now those are not easy concepts, I grant you that. But stop and think about how much money we are already spending, about our public system's growing at 11 and 16 percent a year with very little understanding of how we can better utilize that money.

I was home in Arkansas a few weeks ago and a friend of mine who is an ophthalmologist came to see me and he brought with him two bills. And he said, you know, I've been following what you've been doing and I'm very committed to it because I have become more cost conscious; and I understand now what the President has been saying all these years about the need to get savings out of the current system that can be better utilized. Those two bills were for the same procedure that he performed on two different patients, using his nurses, at two different hospitals in Arkansas, 10 miles apart, neither of them a teaching hospital, neither of them having any particularly special needs for larger reimbursements than others. But even saying that one did, the difference in the hospital bill to his two patients was \$1,400. One patient was billed about \$900, the other was billed \$2,300.

He laid those bills in front of me and he said, "I performed the surgery; I brought my nurses; I prescribed the same kind of surgical supplies; I had the same procedures run. He said, I've looked closely; there might be a little difference -- maybe \$100 or so difference -- but there is no way to account for this discrepancy in the service that was given to the patient. Medicare and the secondary carrier paid both without a question.

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Now, in the public and private systems there has to be some budgetary framework. But we cannot -- and let me repeat -- we cannot just reduce the rate of growth in Medicaid and Medicare and expect to have a system that will perform efficiently. What we are proposing is that we set a capitated rate in states and regions within states, and we permit the private sector, through the market, to bid on these health plans. There may be some variation between plans because the cost starting out may be higher in one region than another. And what we do then is to have a budget as a cap or a discipline over the private sector that will not have to even be invoked or enforced if the market works the way we all believe it should.

Those of you from Florida know that in the recent bidding in the health care plans that are being set up in Florida on regional basis, the bids came in considerably below what the prognosticators had predicted. We think that is the way to keep these two systems in balance. So the savings that will be realized from budgeting both systems and from beginning to squeeze out the administrative costs, being much tougher on waste and fraud and abuse, being able to find that out -- right now there are so few incentives for providers to turn in what they consider to be practices that should be stopped. Now, in a budgeted system there will be every incentive to be more efficient and to keep an eye on what the bills are, because it will all come out of the same pool. And people will have to make more realistic allocations of how they deliver health care.

Fifth quality: You cannot have a reform system that does not not only provide for but require quality standards and quality outcomes. That is a statement that I think everybody would agree with, but we need better ways of making it happen. We need better information.

I have been particularly impressed by what some of the states have done in collecting information about quality outcomes. A couple of states have for the last several years gone into their hospitals and collected information about procedures and then compared outcomes.

And the most striking conclusion to me from several of those states is that if you take a procedure, take a coronary bypass, it will be charged to the patient, and therefore either to the insurer or to the public sector, at a range that is literally thousands and tens of thousands of dollars. You might have a coronary bypass in one hospital in a state costing \$20,000, and a hospital down the road or across the state costing \$60,000.

And when outcomes have been carefully compared, the more

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expensive operation doesn't necessarily have the better outcome. But if there is no budget, if there is no incentive to make good decisions about how procedures like that can be performed at high quality with good outcomes, more cost effectively, why should the second hospital worry whether they charge \$60,000? Or in the case that my friend in Arkansas, \$2,300.

Quality has to be the key to everything we do. We have to ask ourselves, will this be good for patients? Will this be good for physicians, nurses? Will this make quality better? I will not want a health plan that you can't answer that question in affirmatively. The federal government and the state government will have to take more responsibility for collecting information about quality and for disseminating it, so that both physicians, hospitals, providers, patients, all of us know so we can make more informed choices.

I'm very excited about some of the proposals that we will have for quality because the kind of quality we're talking about will change the way we practice medicine and how we take responsibility for ourselves.

And that is the sixth principle: responsibility. We want everybody to take responsibility for their own health. That means we want everybody in the system contributing to it. We have looked at a number of ways of financing this system. There aren't any real secrets, there are only a couple of different ways of going about doing it. We could move toward a single payer system where the government would raise taxes to replace the private sector investments and take over the financing of health care. There are a lot of qualities about single payer systems that are important: universal coverage, administrative simplification, provable savings, that we think we can get in our plan, as well.

But it seems both substantively and politically hard to imagine that we would replace all the money that's currently in the system and create a government funded one. And so for a number of reasons, that is not the way the President chooses to go.

There are also variations on individual responsibility, where individuals are required to buy health insurance, whether it's through a Medisave or an IRA or some other approach. And we've had a lot of very constructive conversations with those members of Congress who believe that that is the route to go. We have some differences in how that would work, and we are continuing to discuss and consult with them. But our fear is that if we only had an individual mandate, like auto insurance in some of your states, there would be two adverse consequences that we can't figure out how to get around.

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The first would be that for many people for whom insurance is currently unaffordable, the fact that they would be individually mandated to do so will not make them go out and do it. And even with subsidies, which is part of, at least, one of the plans that is proposing this, it's difficult to know exactly how we would get the subsidy level at the right point in order to support that kind of individual requirement.

The second problem, and one that deeply troubles me, is that in an individual mandate, all those employers who are currently providing insurance would no longer feel compelled to do so. So at what level would we see an increase in the uninsured? Because if you're out there providing insurance now and we pass an individual mandate, how do we prevent people from shedding employees off of their health insurance or never offering it in the first place? And then how do we subsidize increasing numbers of people who would be thrown into the marketplace?

Those are difficulties we have that we don't quite see how to get around in order to get to universal coverage, which we think is essential.

The third way, in general, is to build on the system that we have, an employer-employee based system in which everyone is responsible for contributing. Right now we have a lot of free riders. You can walk down the main street in any town in any of your states, and you can go to the business that is providing insurance in whatever degree it's providing it, and next door, the one that isn't. But when the employees of the second store get sick the ambulance comes for them, the hospital takes them in, the doctor comes to their bedside, the nurse provides the therapy that's required, and then they walk out of the hospital. And maybe they can pay something, and maybe they leave a big bill that they get sued over. But the bottom line is that there is more uncompensated care in that hospital, which then gets shifted to the rest of us who pay, and then gets picked up by the public sector in some way as well.

It's just fundamentally unfair that some businesses have borne the burden for the health care system and others haven't. Now having said that, we need a system that is fair. We need a system in which everybody takes responsibility, everybody makes a contribution, but they do it in an affordable way. And what we believe should be done is that low wage workers and small firms should be subsidized so that they are able to purchase insurance in a reformed insurance market. You can't put them out there in the market as it is now and say, go get it; they couldn't afford it. But where we have large purchasing alliances, they will be able to afford it. And they will therefore make their contribution.

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We also believe people on Medicaid and Medicare who work should make a contribution. We think everybody needs to know that their health care is their responsibility. But if we establish a system in which we protect small business you will see two things happen. For most large businesses who have borne the cost of health insurance in many regions of the country, their costs will drop dramatically because we will cap the amount of money that any business has to pay for health care. And we will cap it significantly below what the average employer pays now.

So imagine, if you will -- and go back and talk to employers who provide insurance -- how much they are currently paying and how we will lower their costs. We think that will be an economic stimulus, because if you no longer have to pay as some do, 19 or 20 percent; as most do, 13 to 14 percent; as many do, 10 to 12 percent; and instead have to pay no more than 8 percent, that's a lot of money that can go into wages, profits, investments in this country if we get the burden of health care off the necks of the employers who are currently paying.

And if we say to small businesses who have been paying, you will get the same break, and then we say to all of those businesses who have not paid and all of those employees who have not contributed, we expect you to make a contribution but we will cap how much you have to pay and subsidize you so that it is not financially burdensome to you. And we will say to the self employed, we will give you a 100 percent tax deductibility for health insurance. And we will further say to business, we will roll in the health care part of worker's compensation into this health plan; we will roll in the health care part of auto insurance into this health care plan, I don't think there are many businesses -- if they get beyond their ideological opposition to having to do it, who if they look at the bottom line and project costs into the future in the auto insurance, worker's comp and health care systems in this country -- will not find that this is a good deal.

Now, there may be exceptions, but we're talking about making a plan for the vast majority of people and businesses in America that will be affordable and will give them the chance to have a health care system that works.

Now none of this comes without controversy; none of this will be easy. But we are very excited by the level of cooperation and assistance that many of you, through your organizations, have already given us. We intend to continue that. We do not believe we have all the answers. We do not believe that we have the tablets that we have brought down and here they are. We believe the President will present a blueprint with these basic principles. If there are better, more efficient, less costly, quality driven ways of

MORE

doing any of this that we haven't thought about or have overlooked, we are open to that.

But what we are not open to is a stand pat negative, nay-saying opposition that will not recognize the reality of the problem facing this country, both in human and economic terms. We have to get beyond politics as usual. There is no Republican or Democrat or liberal or conservative answer to this. This is a moment in history which we have to seize in order to take care of ourselves. Who would have thought a month ago -- certainly who would have thought a year ago -- that on Monday the President would host the Israeli government and the PLO? Who would have even dreamed that were possible?

Some people did. Some people never gave up. Some people knew, no matter how dangerous and difficult and politically explosive it was, that that kind of sustained effort to solve what could be one of the most difficult problems in the history of the world was worth going after day after day after day.

Our problems pale in comparison. But we have the same opportunity if we don't lose heart, and if we don't turn our ears off and listen to propaganda, but instead keep working toward a solution
(End of side one, begin side two of tape)

-- control. And that is certainly what the American people want. And those of us who have any responsibility for health care whatsoever need to keep trying day after day until we finally have a signing ceremony at the White House and put this country on the right track to take care of itself, to live up to its potential, and to deal with this problem.

Thank you all very much. (Applause.)

END

MORE

9-21-93

NURSES AND OTHER HEALTH CARE PROFESSIONALS

Health care reform will increase the role of nurses, nurse midwives, and other health care professionals in primary and preventative care. It will reduce professional barriers for these health care providers and cut the paperwork that forces them to spend as much time at a desk as at a bedside.

- Health care reform will reinforce the role of nurses as health care providers for primary, preventive, mental health, and long term care services. Advanced practice nurses -- registered nurses who have met advanced educational and clinical practice requirements -- will play a crucial role in guaranteeing that every American receives high-quality care.
- To remove inappropriate barriers to practice, model professional practices statutes for advanced practice nurses and physician assistants will be developed. Nurses will be able to contribute on the basis of their skills and work to the full scope of their training. They will work in partnership with physicians and other health providers to ensure high-quality care.
- Funding for training of nurse practitioners and other health care providers will be increased to double the number of graduates annually and to expand existing programs.
- Paperwork will be reduced so that nurses can concentrate on providing care to patients -- not filling out forms.
- Incentives will be provided for nurses and other health care providers to work in underserved rural and urban areas.
- Nurses will provide home-based and community care for older Americans, persons with disabilities, the chronically ill, and other vulnerable populations such as the mentally ill and children with special needs.
- Racial and ethnic diversity among nurses will be increased so that patients will be served by nurses and health care providers with community roots.

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THE CLINTON PLAN AND SMALL BUSINESS

Small businesses are hardest hit by today's insurance system, and stand to gain the most from the Clinton reform plan.

62% of small businesses already provide insurance for their employees, but it isn't easy. Small firms pay the highest premiums, and their rates are going up much faster than rates at big firms. Current insurance practices discriminate against them and they drown in red tape and high administration costs. Most small business owners who do not currently cover themselves or their employees would like to, but simply can't afford it.

The President's plan will actually lower costs for most small businesses that now provide insurance.

■ First, it will outlaw insurance company practices that discriminate against them. Such as:

- **experience rating** — insurers jack up costs if one employee becomes ill or injured
- **medical underwriting** — basing premiums on medical history, which tilts the field against small risk pools
- **price baiting** — jacking up rates after the first year of coverage, when pre-existing condition bans expire
- **occupational redlining** — insurers sometimes refuse to cover entire industries perceived to be at risk

■ Second, it will eliminate the paperwork that small businesses have to deal with, creating a single insurance form and a simple, easy-to-understand set of rules for all plans.

■ Third, it will pool small businesses and individuals to give them the same bargaining power in buying insurance that big companies have.

■ Fourth, it will fold in the costs of worker's compensation, cutting costs and guaranteeing that companies don't pay twice for health care.

■ Fifth, for the first time ever, the plan will provide 100% tax deductibility for the self-employed.

The plan will be gradually phased in, with government assistance, to ensure that small businesses that don't currently provide insurance can afford to cover their employees.

It already works in Hawaii. Hawaii's plan — passed in 1974 — requires all businesses to contribute to the cost of their employees' health insurance. But small businesses have continued to thrive. In 1991, Hawaii was the nation's third fastest-growing state for small businesses, and Hawaii's unemployment rates are consistently among the lowest in the country.

See pages 33-42 of *Health Care Update: The Need for Reform* for the details.

THE HEALTH SECURITY PROPOSAL

HOW IT WILL AFFECT DOCTORS

Preserving the Doctor - Patient Relationship

The personal relationship between doctor and patient is the cornerstone of patient care. Yet under the present system, that relationship is undermined by insurance regulations that force employees to quit their family doctor when their insurance, through a job loss or change, is altered. The Health Security proposal protects the right of Americans to choose their doctor and stay with that person, regardless. Doctors will be able to order for their patients the tests they need and the medications they require, without fear that they are causing economic hardship.

An End to the Paperwork 'Hassle Factor':

Filling out confusing forms and picking through the details of varying benefit packages can be a frustrating and overwhelming experience for doctors' clerical staffs. The Health Security Act of 1993 will reduce the "hassle factor." With the institution of standard benefit packages, doctors will no longer have to wade through fine print to find out if a procedure is covered. Under reform, a standard form for all payers and common coding system will replace the bureaucratic nightmare of multiple claims forms and codes.

Malpractice Reform:

The Health Security proposal is a bold attempt to finally overhaul the medical malpractice system. Attorneys' fees will be limited, and patients wishing to file claims will be required to first make their case in an out-of-court setting before going to court (alternative dispute resolution).

Streamlining Regulation:

Quality assurance programs run by the government have relied too often on external checks, forms and process manuals, and on the punishment of providers. Through reform, these programs will be retooled to set and enforce performance standards, not detailed process standards.

Doctors' Incomes:

Historically, doctors have been well paid and this will not change under health reform. What is likely to occur is a closing of the gap between the incomes of specialists and primary care physicians -- as the demand for primary care physicians grows.

WHAT IS WRONG WITH THE CURRENT SYSTEM?

- **LACK OF SECURITY**
- **SKYROCKETING COSTS**
- **GROWING COMPLEXITY**
- **DECLINING CHOICES**
- **DIMINISHING QUALITY**

THE HEALTH SECURITY PLAN

SECURITY: GUARANTEES A COMPREHENSIVE
PACKAGE OF BENEFITS THAT CAN NEVER BE
TAKE AWAY.

RESPONSIBILITY: ALL AMERICANS PAY
THEIR FAIR SHARE.

WHAT DOES THE HEALTH SECURITY PLAN GUARANTEE?

- **A COMPREHENSIVE BENEFITS PACKAGE,
INCLUDING PREVENTIVE CARE, THAT CAN
NEVER BE TAKE AWAY**
- **CONTROLLED HEALTH CARE COSTS**
- **IMPROVED QUALITY OF CARE**
- **INCREASED CHOICE FOR CONSUMERS**
- **REDUCED PAPERWORK AND SIMPLIFIED
SYSTEM**

WHAT DO EMPLOYERS AND EMPLOYEES PAY FOR COVERAGE?

- **PREMIUM BASED SYSTEM**
- **EMPLOYER RESPONSIBILITY**
- **EMPLOYEE RESPONSIBILITY**
- **UNEMPLOYED**
- **MEDICAID/CASH ASSISTANCE**

SPENDERS AND SAVERS

AMONG THOSE CURRENTLY INSURED:

- **67% WILL PAY LESS FOR THE SAME OR SIMILAR BENEFITS**
- **20% WILL PAY SAME OR MORE BUT WILL GET COMPREHENSIVE BENEFITS**
- **13% WILL PAY SOME MORE FOR SIMILAR BENEFITS**

Worker Premium Contributions

Preliminary Estimates Based on National Averages

Scenario	Income	Today	Reform (Yearly)	Reform (Monthly)
Family of Four	\$40,000	\$1,080	\$840	\$70
Couple	\$40,000	\$950	\$720	\$60
Single Parent Family	\$25,000	\$920	\$740	\$62
Individual	\$25,000	\$330	\$360	\$40
Uninsured Family	\$25,000		\$840	\$70



Elements of the American Health Security Act of 1993 Supported by the Nursing Profession

September 20, 1993

The proposal clearly states that problems of inadequate access, cost, and quality must be addressed comprehensively and simultaneously. Access will be greatly improved with an eye not only to controlling costs but to retaining and improving the quality of health care services.

Access

The plan guarantees Americans and legal residents access to health care by ensuring a comprehensive package of benefits with no lifetime limits.

Access to care would be rapidly phased in by the states under the President's plan.

Access to health care would be improved in rural and urban areas that currently are underserved. There are financial incentives to attract nurses and other health care professionals to areas with inadequate care.

Access to primary care services is greatly enhanced in the President's plan. No longer will people have to come to the hospital in an advanced stage of disease, or suffering from a problem that could have been treated in a less costly setting or avoided altogether by prevention or early detection and treatment.

The consumer will have greater access to a range of qualified health providers under the President's proposal. The proposal recognizes that people currently cannot always choose from a range of qualified, accessible providers because of restrictive regulatory and payment practices, and takes steps to rectify this inequity to providers and consumers alike.

Quality

Quality management will be a key factor in health care delivery under the President's proposal. Registered nurses are a key component to maintaining quality in hospitals and other delivery settings.

Nurses are pleased that the plan's guaranteed package of benefits (Chapter IV) emphasizes a broad scope of quality health services, not just treatment of illness. It supports nursing's call for school-based clinics, enhanced services for underserved populations, and health education. It includes critical elements such as home-based care, public health initiatives, and opens the door to addressing our growing need for better long-term care services.

The President's proposed package of essential benefits includes such important preventive and primary care services as immunizations, screening, dental and vision coverage, mental health and substance abuse, and prenatal care. It places new emphasis on primary care and prevention services delivered not only by physicians, but by nurses and other qualified health providers in convenient accessible settings.

Advanced practice nurses are recognized as fully qualified providers throughout the American Health Security Act, whether specifically referring to primary and preventive health care or in other areas such as ambulatory care, hospital services, hospice services, or home health care. The proposal calls for federal preemption of artificial barriers to nursing

practice. The plan includes antidiscriminatory language to assure that nurse providers are included in covered services. States may not use licensure requirements to discriminate against the appropriate practice of health professionals as defined by nationally recognized professional standards. This language will help to ensure a greater use of nurses to meet the nation's current and future health care needs.

Cost

We support the greater use of community rating, eliminating pre-existing conditions as a way for insurance companies to reject higher-risk individuals, and limiting an individual's out-of-pocket expenses following a catastrophic health event.

Administrative simplification will result in cost-savings, not only in direct dollars for time spent in administrative tasks, but in reduced frustration for nurses and others whose administrative tasks rob them of necessary time for quality patient care.

Focus on Primary Health Care

The nursing profession is pleased that the President's plan recognizes that primary and preventive health care across the life span is central to any restructuring of health care delivery. The proposal acknowledges that a health care plan that continues to focus on illness and cure, without an appropriate balance of prevention and care, will not work.

Education, Cultural Diversity, Minority Recruitment

The support for students in baccalaureate and master's level nursing programs has been well received by the nursing community. We also endorse loan forgiveness for primary care providers.

Nursing strongly endorses the President's stated intention to increase the cultural diversity of the health care workforce by supporting programs aimed at under-represented ethnic, minority and/or disadvantaged persons. The proposal supports efforts to recruit and retain students to nursing and other professions, and to increase the number of minority faculty and researchers in the health professions.

Public Health

Increased funding for public health programs at the state level is critical to the future health and well-being of a diverse U.S. population. The plan coordinates the delivery of personal health care services through regional alliances with the delivery of public health services in order to reach the common goal of improving the health of the American population.

Nursing endorses the plan's aim to repair, strengthen and consolidate essential federal, state, and local public health services. The plan's focus would help to restore the original mission of public health programs to engage in community prevention rather than direct delivery of health services. The plan would support such core public health activities as data collection; surveillance and monitoring; protection of the environment, housing, food, and water; and disease investigation and control.

A strong public information and education component is called for to mobilize communities and motivate individuals to reduce risks to health. Nursing stands ready to lead community and individual efforts to reduce some of our deadliest and costliest health risks — tobacco use, drug and alcohol abuse, sexual practices that increase the prevalence of HIV infection and other sexually transmitted diseases, inadequate or poor nutrition, physical inactivity, and lack of childhood immunizations.

TOUGH QUESTIONS AND ANSWERS FROM MOCK INTERVIEW WITH VIRGINIA TROTTER BETTS, ANA PRESIDENT, AT MEDIA TRAINING SESSION:

(Feel free to refer to these questions/answers when giving media interviews)

1. What does the plan mean for the individual nurse?

THERE WILL BE A SHIFT IN JOBS, BUT OVERALL THE OUTLOOK IS VERY OPTIMISTIC. THERE WILL BE A NEED FOR MORE HEALTH CARE PROVIDERS AS MORE PEOPLE COME INTO THE HEALTH CARE SYSTEM. NURSES ARE CAPABLE TO FILL THOSE ROLES.

DUE TO THE FACT THAT 37 MILLION PEOPLE ARE CURRENTLY UNINSURED, THERE WILL BE NEW OPPORTUNITIES FOR NURSES IN A VARIETY OF SETTINGS.

2. From the standpoint of the individual RN, what will the plan mean to them in terms of job, money, flexibility?

IT WILL MEAN DIFFERENT THINGS. NOT ONLY ARE THERE 2.2 MILLION NURSES THE PROVIDERS OF HEALTH CARE, BUT WE ARE ALSO THE CONSUMERS OF HEALTH CARE. IT IS VERY IMPORTANT TO HAVE THE SAFETY NET WE PROVIDE, TO BE ABLE TO MOVE FROM JOB TO JOB WITHOUT PRE-EXISTING CONDITIONS. IN MANY WAYS, IT MEETS THE NEEDS OF A NURSE AS A CONSUMER OF THESE SERVICES. AS A PROVIDER OF THESE SERVICES, IT HAS THE POTENTIAL TO RESTRUCTURE WHERE THE NURSE WORKS. ABOUT 68% WORK IN HOSPITALS AND I BELIEVE AT SOME POINT, FEWER NURSES WILL WORK IN HOSPITALS AND MORE IN THE COMMUNITY. WE, IN THE PROFESSION, WILL HAVE TO WORK ON THAT WORKFORCE TRANSITION PLAN.

3. Will there be more jobs for nurses?

A BASIC PREMISE OF THE PLAN WILL BE MORE JOBS FOR PEOPLE PROVIDING CARE AND FEWER JOBS FOR PEOPLE WHO ARE FILLING OUT FORMS FOR CARE. WHEREVER YOU ARE PROVIDING CARE, THERE WILL BE MORE JOBS FOR NURSES. DIFFERENT JOBS. NURSES WILL BE INTERESTED IN THE CHALLENGE AND WILL LOOK FORWARD TO WORKING IN THE PUBLIC HEALTH SYSTEM. WE EXPECT TO BE LEADERS IN THE PUBLIC HEALTH MOVEMENT.

4. Are you getting any static from those working in hospitals who might lose their jobs and will have to be retrained for other jobs. Fear the change?

THERE IS AN ELEMENT OF CONCERN BY ALL PROVIDERS RIGHT NOW. BUT, I DON'T THINK THERE IS AN OUTCRY FROM PRACTICING NURSES AS MUCH AS FROM THE MEDICAL COMMUNITY WHO ARE CONCERNED ABOUT HEALTH CARE REFORM. NURSES ARE BASICALLY FOR HEALTH CARE REFORM AND WE WILL HELP ON A STATE BY STATE POSITION TO MAKE THAT TRANSITION.

5. How much will ANA spend on lobbying?

1. IT IS HARD TO ISOLATE A NUMBER BECAUSE ANA'S EFFORTS ARE INTEGRATED INTO OTHER PROGRAMS AS WELL.
2. WE HAVE BEEN INVOLVED IN HEALTH CARE REFORM FOR OVER A DECADE SO THERE IS NO DRAMATIC INCREMENT THAT IS NECESSARY.
3. A LOT OF WHAT WILL BE DONE WILL BE DONE ON A VOLUNTEER BASIS. THERE ARE 2.2 MILLION NURSES OUT THERE WHO ARE WILLING TO HELP. WE ALREADY HAVE A LOT OF CALLS ALL OVER THE COUNTRY FROM NURSES WHO WANT TO VOLUNTEER.

6. How do you describe ANA's lobbying efforts and objectives?

THERE WILL BE DUAL EFFORT ON FEDERAL AND STATE LEVELS.

ANA WILL INTENSIFY OUR DISCUSSIONS WITH EACH MEMBER OF CONGRESS WHO WILL BE VOTING ON THE PLAN.

ONE OF THE THINGS NURSES HAVE THE OPPORTUNITY TO DO AT THE STATE LEVEL IS TO IMPACT THE HEALTH CARE REFORM PLAN. WE WILL HAVE NURSES PARTICIPATING AS QUALIFIED PROVIDERS OF CARE.

AT THE NATIONAL LEVEL, WE WILL HIGHLIGHT THEIR SUCCESSES AND HOW THEY HAVE BEEN ABLE TO HAVE STATES MEET THEIR GOALS.

7. What is your relationship with the AMA?

WE HAVE SOME COMMON POINTS WITH THE AMA, INCLUDING UNIVERSAL ACCESS, WHICH IS THE NUMBER ONE PRIORITY OF HEALTH CARE REFORM, HOWEVER WE ALSO HAVE SOME POINTS OF DISAGREEMENT.

THIS IS NOT A TURF BATTLE. THE AMA HAS PUT THEMSELVES IN OPPOSITION TO ANA NOT VICE-VERSA.

THE THING TO REMEMBER IS THAT THIS IS NOT A WIN OR LOSE SITUATION. WE ARE ALL IN IT FOR THE CONSUMER.

8. The AMA has criticized your research findings that claim that advanced practice nurses perform as well as or better than physicians in delivering primary care. The AMA claims that the nurses in these studies were supervised by a physician and that the physician was ultimately responsible for the patients' care. How do you respond?

THAT DOES NOT SURPRISE ME. PHYSICIANS WANT TO KEEP THE MEDICAL MODEL WHERE THE PHYSICIAN IS ALWAYS THE CAPTAIN OF THE SHIP AND THE COACH OF THE TEAM.

9. Nursing is actively promoting a larger role for advanced practice nurses as independent providers of everyday health care services that today patients must go to a physician for, yet you also oppose the use of lesser skilled, assistive personnel substituting for nurses in hospitals. Are you really looking at ways to contain costs or are you only interested in preserving jobs for nurses?

WE ARE VERY INTERESTED IN COST CONTAINMENT. BUT QUALITY IS ALSO IMPORTANT. ANA DOES NOT HAVE ANY PROBLEM WITH UNLICENSED ASSISTIVE PERSONNEL ASSISTING A NURSE APPROPRIATELY IN A NURSE SETTING. WE ARE ALL FOR THAT. IT IS THE FACT THAT THERE IS A STAFF NURSING SHORTAGE. IT IS NOT A GOOD IDEA TO HAVE NURSING POSITIONS THAT ARE NEEDED, TO BE REPLACED BY INDIVIDUALS WHO ARE NOT LICENSED AND WHO HAVE NOT BEEN TRAINED TO CARE FOR THESE PEOPLE. IN SOME CASES, NURSES IN HOSPITALS ARE DOING TRANSPORTATION, RUNNING DOWN TO PHARMACIES TO PICK UP DRUGS, BATHS, AMBULATION. THEY ARE DOING VERY IMPORTANT ASSESSMENT DIAGNOSIS AND CARE AND AT THE SAME TIME DOING CUSTODIAL CARE. WE WOULD FAVOR NURSES APPROPRIATE ASSISTANCE IN PATIENT CARE SO THAT THE NURSE CAN PROVIDE THE CARE THAT IS NEEDED TO THE PATIENT. WHAT IS INAPPROPRIATE IS WHERE THE OBSERVATION OF A CRITICALLY ILL PATIENT HAS BEEN TAKEN OVER BY UNLICENSED ASSISTIVE PERSONNEL IN THE NAME OF WORKPLACE REDESIGN. WE WANT THE APPROPRIATE STAFF MIX FOR ACUITY. HOSPITALS SHOULD KEEP IN MIND WHILE TRYING TO "MANAGE THEIR ECONOMICS," THAT STUDIES SHOW THAT IF YOU WANT TO HAVE A GOOD PREDICTION OF AVOIDING MORTALITY, DECREASING MORBIDITY, INCREASING PATIENT SATISFACTION, YOU NEED TO HAVE A GOOD MIX OF NURSES TO PATIENTS. NONE ARE ACHIEVED WITH UNLICENSED ASSISTIVE PERSONNEL. ONE OF THE THINGS WITH MANAGED COMPETITION IS THE LENGTH OF STAY. SEVERAL STUDIES THAT SHOW THAT IF THE NURSE/PATIENT RATIO IS GOOD THE LENGTH OF STAY DECREASES AND GETS THE PATIENT AT HOME QUICKER AND SAVES THE ORGANIZED DELIVERY SYSTEM MONEY.

10. You claim that 60-80 percent of primary and preventive care can be provided by a nurse. What's the 20-40 percent that can't be provided by a nurse? How does the nurse know what he/she can't handle? How does the patient know?

AN APN OR A PRIMARY CARE PHYSICIAN SHOULD BE THE TRIAGE PERSON--FIRST POINT OF CONTACT. I.E. AS A PRIMARY CARE PROVIDER OF MENTAL HEALTH SERVICES, I WAS A TRIAGE PERSON IN A MENTAL HEALTH CENTER. WE WERE ON A ROTATING BASIS AND I SAW THE NEXT PERSON THAT WALKED IN THE DOOR. THIS PATIENT HAD A LONG HISTORY OF PHYSIOLOGICAL AND PSYCHOLOGICAL PROBLEMS, A LONG STANDING PSYCHIATRIC HISTORY AND NOT A CLEAR UNDERSTANDING OF WHAT MEDICATIONS HE HAD BEEN TAKING. I TRY TO GET A VERY GOOD HISTORY DOWN ON PAPER, BUT I IMMEDIATELY GO TO THE CONSULTING PSYCHIATRIST AND FEEL THAT HE IS MUCH MORE APPROPRIATE TO DEAL WITH THIS PATIENT THAN ME, RATHER THAN TRY TO CHANGE THE MEDICATION.

11. What are the malpractice implications in relation to removing the barriers against advanced practice nurses?

AS IN ALL HEALTH CARE PROVIDERS, ADVANCED PRACTICE NURSES ARE ACCOUNTABLE FOR THE CARE THEY PROVIDE AND THEY DO HAVE MALPRACTICE INSURANCE THAT COVERS THEIR SCOPE OF PRACTICE.

AN ADVANCED PRACTICE NURSE HAS 2 TO 4 YEARS OF TRAINING BEYOND THE BASIC NURSING EDUCATION TRAINING(4 YEARS).

THE RATES OF MALPRACTICE OF ADVANCED PRACTICE NURSES IS LOW. THE REASON BEING IS THAT THERE IS A HIGH LEVEL OF SATISFACTION FROM THEIR PATIENTS. THE CARE NURSES SUPPLY IS QUALITY CARE. NURSES SPEND TIME WITH THEIR PATIENTS, WITH THE PATIENT'S FAMILIES, THEY EMPHASIZE EDUCATION AND WHEN NEEDED, APPROPRIATELY REFER TO OTHER HEALTH CARE PROVIDERS.

THE NURSING COMMUNITY HAS EXCELLENT EXPERIENCE IN PROVIDING THE DIRECT CARE TO LOTS OF CLIENTS. NURSES SPEND MORE TIME WITH CLIENTS, LISTEN TO THEM AND MEETS THEIR NEEDS AS COMPARED TO PHYSICIANS. NURSES PROVIDE BETTER CARE THAN PHYSICIANS AND THEY PROVIDE CARE IN A MANNER THAT DOES NOT CAUSE ADVERSARY RELATIONSHIPS THAT GET STARTED WHEN AN INDIVIDUAL SUES A HEALTH CARE PROVIDER.

12. Why does ANA advocate a four-year BSN degree when there are so many associate degree programs graduating nurses? Is there any difference in what the two can do? They both earn the same, don't they? Aren't two-year programs the quickest way to produce more nurses? and less expensive?

WE ARE NOT TRYING TO MAKE THAT A BARRIER. WE ARE TRYING TO LOOK INTO THE FUTURE AND THE KIND OF CARE THAT IS NEEDED TO GO ON IN THIS COUNTRY AND TRY TO HAVE THE EDUCATION BASIS TO FIT WITH THAT. AS CARE MOVES INTO THE COMMUNITY, THE EXPANDED SCOPE OF PRACTICE NEEDS TO BE TAUGHT IN NURSING SCHOOL. THEY ARE TEACHING EVERYTHING THEY CAN IN ASSOCIATE PROGRAMS, WHICH, BY THE WAY, WERE STARTED TO QUALIFY NURSES TO WORK IN HOSPITALS. IF LESS CARE IS GOING TO BE GIVEN IN HOSPITALS IN THE FUTURE, IT ONLY MAKES SENSE THAT NURSING EDUCATION WILL HAVE TO READJUST TO THAT. I WOULD HOPE THAT THOSE ENTERING THE NURSING WORKFORCE WOULD TEND TO HAVE GOTTEN A BACCALAUREATE DEGREE. 4-YEAR DEGREES HAVE GREATER FOCUS ON COMMUNITY, IMPACT ON COST AND QUALITY ON DELIVERY OF SERVICES. THAT IS THE KIND OF NURSE WE WILL NEED IN FUTURE. THE CURRENT MAKEUP OF THE NURSING COMMUNITY NEEDS TO RECEIVE ALOT OF ATTENTION. EMPLOYERS NEED TO PAY ATTENTION TO AN RN AS AN ASSET TO THE SYSTEM AND NOT A LIABILITY. ANA AND SNA WILL WORK WITH ALL THOSE SYSTEMS AT THE LOCAL LEVEL TO BE AS SUCCESSFUL AS POSSIBLE.

THE DIFFERENCE BETWEEN 4-YR AND 2-YR? FOR CAREER ENHANCEMENT ONE WOULD GO THROUGH 4-YEAR DEGREE. IT WILL BE MUCH HARDER FOR 2-YEAR. ANA/SNA WILL BE THERE AND WE WANT THEIR EMPLOYERS TO HELP THEM ALSO. I MEET NURSES EVERYDAY WHO ARE AFRAID OF THE CHANGE. WE ARE ALL FEARFUL FOR CHANGE. BUT THIS IS NOT ONLY GOOD FOR THE CONSUMER BUT ALSO FOR NURSING.

13. What coalitions are you going to be in?

WE WILL MAINTAIN THE SAME WE HAVE HAD ALL ALONG. CERTAINLY THE NURSING COMMUNITY IS SPEAKING IN ONE STRONG VOICE ON THIS ISSUE. WE ARE INVOLVED IN SEVERAL COALITIONS WITH CONSUMER GROUPS WHO ARE ALSO CONCERNED THAT UNIVERSAL ACCESS WITHOUT THE PROVIDERS TO DO IT WILL BE A PROBLEM, AND WE HAVE BEEN MAJOR PLAYERS WITH LEADERSHIP COALITIONS FOR HEALTH REFORM. WE WILL STAY WITH THOSE GROUPS.

14. How are nurses doing financially these days? Shortage?

IT IS VERY GEOGRAPHIC AND VARIABLE BY REGIONS AND WORKSITES. THERE IS IN THE TRANSITION AN ATTEMPT TO DOWNSIZE HOSPITALS. THEY WILL HAVE TO UPSIZE COMMUNITY CARE. THEY ARE DOING WELL FINANCIALLY, BUT NOT WELL AS COMPARED TO PHYSICIANS. I THINK WE ARE VERSATILE AND THE BEST VALUE IN THE HEALTH CARE SYSTEM.

15. What do you like most about the plan?

UNIVERSAL ACCESS. THIS IS CLEARLY THE TOP ISSUE IN THIS COUNTRY. ONE OF THE NEGATIVE OUTCOMES ISSUES ABOUT THE QUALITY OF LIFE HAS TO DO WITH THE FACT THAT ALL AMERICANS DO NOT HAVE ACCESS. WE VERY MUCH WANTED THAT AND WE ARE EXCITED IT IS THERE.



AMERICAN NURSES ASSOCIATION

ANTITRUST

Under the new health system, the antitrust laws will be strengthened to ensure that health providers are treated equitably within the health system. Artificial barriers of practice will be removed by clearly articulating inappropriate barriers to practice via rulemaking, regulation, agency advisory opinions, and concerted enforcement of antitrust laws.

The new health system will compel all business entities to treat all health providers in accordance with the legal scope of their practice and will review all actions taken by corporations working within the plan carefully, especially when they adversely impact upon one class of health professionals. Such remedies to prohibit anticompetitive behaviors used to limit provider practice include

- Use of practice arrangements that prohibit [nurses] from performing patient care activities within the scope of state nursing practice acts.
- Use of practice arrangements that limit the activities of [nurses] recognized as advanced practitioners.
- Imposition of insurer limits on the availability and accessibility of liability coverage for [nurses], or the requirement for physician supervision as a prerequisite for coverage.
- Use of insurance surcharges to increase malpractice premium coverage, and other insurance-related impediments to physician -nurse collaboration.
- Subjective or arbitrary insurance reimbursement policies, such as denial of reimbursement for services performed within the scope of any licensed provider's practice if there is coverage of the service provided by the physician.
- Denial of staff privileges at health care facilities including prescriptive authority for those authorized by state law to prescribe.



AMERICAN NURSES ASSOCIATION

TRANSITION PHASE HEALTH CARE REFORM

HOSPITAL REFORM

ANA has data that hospitals are dramatically changing their level and mix of staff for patient care in what is claimed to be a response to impending health care reform and presumed changes in institutional reimbursement. This is a process we have every reason to expect will be accelerated once the health care plan is released. We are convinced that interim measures are absolutely essential in order to protect patients from a significant and dangerous downgrading of nursing care in hospitals and nursing homes.

Therefore, ANA recommends that several actions be taken to prevent diminished quality of care and loss of registered nurses in health care institutions which receive medicare payment.

Hospital Reform

To reduce the potential for disruption in the hospital industry during the transition to the new health care system, the American Health Security Act imposes interim hospital regulations.

To avoid premature, reactive hospital closures, dislocation of personnel, and potentially serious threats to the safety and quality of hospital services, a transition plan is essential. The transition plan needs to put into place a series of interim quality protections that safeguard patient care and provide for a retraining and re-deployment plan for personnel.

The decisions of hospitals and other institutions to significantly alter staffing levels, mix, or re-employ personnel should be guided by several basic principles: advanced public disclosure of the intention to merge, close, or significantly redeploy personnel, involvement of consumers and affected professional personnel in development and implementation of via educational programs and other means for re-deployment, evaluation and reporting to consumers, certifying bodies and professional providers the impact of re-deployment on patient outcomes and other quality of care indicators, and assurance that re-deployment plans use professional personnel in accord with licensure laws, educational preparation and assessed competence.

A national transition plan should contain at a minimum:

- Retraining and Relocation Programs to prepare personnel to assume positions in primary health care, public health, and critical care across a variety of settings..

- Use of conversion boards to assess the opportunity for the hospital to be converted to some other use thereby keep jobs in the community.
- Training programs on "How to Start a Business" and access to small business loans.
- Pre-notification of hospital closure or merger.
- Continuation of health and pension benefits.
- Continuation of HIV disability coverage.
- Limits on discounting health care services to prevent cost shafting.
- Annual public reports about the impact of major institutional changes in staffing levels, mix or deployment on the quality of care delivered.

Should there be significant changes in morbidity or mortality rates or increases in adverse occurrences (such as falls, nosocomial infections, medication errors) or other indicators of change in the quality of care in hospitals, then more aggressive steps will need to be taken, such as,

- Wage pass through for providers of direct care.
- De-certification or fines of hospitals.
- Protection of hospitals that are sold providers or provide a high percentage of uncompensated care by establishing uncompensated care pools until all citizens have universal access.



AMERICAN NURSES ASSOCIATION

EDUCATION OF NURSES

Determination of Nurse Workforce

The Secretary of the Department of Health and Human Service will determine the estimated need of nurse workforce and advanced practice nurses needed to meet the health care demands of the nation. This will be based on the workforce estimates of the National Council on Nurse Education, and its allocated regional councils. Regional councils identify needs in facilities and communities within the area of the country it serves.

The Secretary appoints the National Council on Nurse Workforce, which includes nurse educators, practicing nurses, advanced practice nurses, student nurses, consumers, hospital administrators, a practicing physician and a member of the state public health department.

The Council recommends the total number of needed positions for primary and tertiary care, based on the national need for nurses. The National Council on Nurse Education will:

- * Collect and evaluate data related to workforce surveillance, including shortage areas, recruitment and retention strategies and needed nurse education programs.
- * Current regional distribution and baccalaureate and masters education programs.
- * The need to maintain a range of primary care positions for members of under-represented minority groups.
- * The current state legislation which allows expanded practice for advanced practice nurses.
- * Other factors relating to specific nurse workforce needs, such as recruitment of new providers, training for nurses leaving tertiary care settings for community and public health positions, education for advanced practice roles.
- * The need for the development of innovative demonstration programs to enhance the cost effectiveness of the delivery of nursing care and the development of educational programs to prepare

nurses to meet the workforce needs.

- * Communication linkages will be established with the National Council on Graduate Medical Education that responds to the needs created by the reduction in medical specialty training by providing an adequate pool of advanced practice nurses to meet the continuing demand for these tertiary care services.

In developing its recommendations, the Council seeks the views of professional nursing, hospital, public health and educational associations and other appropriate organizations. Recommendations relating to workforce needs will be reported to the Secretary of Health and Human Services annually and take into account the differences among training programs and variable turn over in facilities.

Funding for Nurse Education

Legislative authority to establish a new system to increase and manage the supply of education and training for nurses.

It is estimated that many of the (66% of the 1.8 million) nurses current employed in hospitals will need to shift their current work skills to meet the demands of the new health care system. Among these nurses, advanced practice nurses are essential to the delivery of primary care and hence, an increased number of providers will be needed to provide increased these services under a reformed health care system. Entitlement funds (such as those used in the graduate medical education program) must be allocated to support education and training of these providers by a mechanism similar to that for resident physicians. This mechanism would enable hospitals to maintain quality service and cost effectiveness within the constraints of the new health care system. This new entitlement program would be funded by a combination of Medicare contributions and a surcharge on health premiums to a newly created direct nurse education and training trust fund. Because of the importance of advanced practice nurses to the delivery of care, a constant stream of dollars is needed to be support the education and training of these providers on a basis similar and equal to resident physicians.

The Nurse Education and Training Trust Fund would be managed by the Secretary of Health and Human Services in order to assure that sufficient numbers of nurses and advanced practice nurses are available to meet the needs of the health care consumer. These funds would be used toward the goal of increasing the number of overall primary care providers in the United States through both education (i.e., scholarships, loans) and training programs. Included among the programs to be established are:

Funding for Nurse Education:

- * Develop retraining opportunities for nurses who are forced to leave the tertiary care workforce for community, primary and preventive care practice areas. Included among these opportunities will be programs for continuing education, faculty development, incentives for linkages of diploma schools with baccalaureate and masters nursing programs as well as incentives for these facilities to develop linkages with primary care, schools and public health networks.**
- * Collect and evaluate data related to workforce surveillance, including shortage areas, recruitment and retention strategies and needed nurse education programs as well as current regional distribution of baccalaureate and masters nurse education programs.**
- * Development innovative demonstration programs to enhance the cost effectiveness of the delivery of nursing care and the development of educational programs to prepare nurses to meet those workforce needs. In addition, technical assistance will be provided to states for the enhancement of state utilization of nurse providers.**

Funds for advanced practice nurse and primary care nurse education and training will come from changes in the Social Security Act to entitle nursing education programs to GME funds:

- * Ten percent of GME funds pooled from all insurers will be available for reimbursement to providers for the costs of academically based, advanced practice, primary care, nurse education programs according to the following formula**
 - A formula should be determined by the Secretary to provide a prorated annual stipend for each full time, graduate nursing resident-student who provides patient care at the provider site;**
 - The costs of clinical nursing faculty supervision at the provider site based on the average annual salary for clinical faculty; and**
 - Other related teaching expenses.**

MEMORANDUM

TO: SNA Presidents
SNA Executive Directors

FROM: Virginia Trotter Betts, JD, MSN, RN
President

DATE: September 21, 1993

RE: Clinton's Plan for Health Care Reform

The ANA Board of Directors today voted unanimously to support the American Health Security Act of 1993. Attached is the press release announcing our position. Tomorrow ANA will send you a packet containing talking points from the White House and from us. You'll be pleased to know that the White House talking points have been modified to acknowledge nurses as qualified providers.

We have made major strides in the last two weeks in shaping the Plan that will become the specifications for the President's legislative initiative.

The major items that were the fundamental issues addressed at the Nursing Summit have all been included in the President's Plan. This is a major victory for ANA and nursing. Please spread the word and take credit!!

You will find on careful analysis that the President's Plan remains, (or, should I say is "reshaped") very much like "Nursing's Agenda for Health Reform." It is good for patients, for the country and ultimately for nurses.

Clearly, there are short run problems as we speak and we are working vigorously on resolving them. This must not minimize our enthusiastic support and continuing participation in the health care reform debate.

ANA will be present for the President's White House Ceremony on Thursday, September 23, 1993 to celebrate the Administration's commitment to health care reform. Watch "Cross Fire" (CNN) on Wednesday featuring ANA President Virginia Trotter Betts. Ginna will appear on the *McNeil-Lehr News Hour* next week, and a nurse from Tennessee will be on the *Today Show* on Thursday. We're also expecting a major story in *USA Today*.

Our work has just begun. We appreciate your help. Be a player. Stay a player.

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MEMORANDUM

TO: Tri Council Members
Endorsing Organizations

FROM: Virginia Trotter Betts, JD, MSN, RN
President

DATE: September 21, 1993

RE: American Health Security Act of 1993

As you know, ANA representatives met today with Ira Magaziner, senior White House advisor to President Clinton. We reviewed our concerns about:

1. Phase in of Health Care Reform; and
impact of quality of care in Hospitals
2. Antitrust protections that includes nurses
3. Medicare Reimbursement of Advanced Practice Nurses
4. Concerns re: funds for nursing education

We have agreed with Mr. Magaziner to insert language in the following areas:

1. **Phase In**

The Department of Labor has prepared a document dealing with work force development in the health care industry which will become a part of the plan. This results from non-stop meetings with ANA since Friday. The document now speaks to retraining, career mobility and innovative work force practices for professional nurses.

2. **AntiTrust**

We anticipate language will be included in the plan that speaks to strengthening the nation's antitrust laws; although this is a matter that remains outstanding.

3. **Medicare**

Language is to be added to support reimbursement of Advanced Practice Nurses.

4. **Nursing Education**

Upon receiving a report that the nursing education community was in agreement, the language that secures ten percent (10%) of GME dollars for nursing education will go forward.

The plan as currently negotiated is one of specifications and the language is conceptual. Actual legislative language will be worked out over the next three weeks. We will be monitoring these developments closely.

The ANA Board of Directors has voted to enthusiastically support the Clinton plan. Attached is a copy of the press release ANA is releasing tonight. Tomorrow, a packet will be sent to each of you that includes talking points from the White House and ANA. We look forward to hearing how each of your organization's plans to proceed. Please fax this information to me as you decide. We would appreciate hearing about your organization's response to the Plan notwithstanding your decision. Please call us for White House contacts to communicate your response. [At ANA HQ, Donna Richardson, Director of Government Affairs (x440) or Jocelyn Coffey, Sr. Admin. Assistant (x442).] We hope that we can all be visible and proactive in the weeks ahead.

We appreciate your many calls and know you will understand that I cannot respond to each personally. We will make every effort to return calls through staff or provide information requested.

Thank you all for your help, perseverance and good will.

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M E M O R A N D U M

TO: Deborah Arrindell
American Nurses Association

FROM: Rob Portman

CC: Tom Glynn
Kitty Higgins

RE: Revised Workforce Proposal

DATE: September 21, 1993

Enclosed please find a revised draft of the health care workforce development proposal that we have been discussing. As you will see, we tried to incorporate as many of your comments as we could without seeking specific guidance from the White House. The shading represents additions to our previous draft, and the strikeouts reflect deletions. I believe this draft represents a strong effort to accommodate your concerns and reach consensus on the principle issues.

We are still open to discussing any issues that were not included in this draft. However, given the time constraints and your separate discussions with Ira, a better alternative might be for us to submit this (or a slightly revised) draft to the White House along with an attachment listing those additional issues that you feel should be included in the document or in some other part of the plan (e.g., transition or quality).

I want to thank all of you for your patience and consideration in this matter. I look forward to continuing what I feel have been extremely productive and cooperative discussions.

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WORKFORCE PROPOSAL FOR INCLUSION IN THE COMPREHENSIVE HEALTH CARE REFORM LEGISLATION

INTRODUCTION

Legislation as comprehensive and far-reaching as the proposed health care reforms will clearly have major implications for the American workforce. The health care industry accounts for 1/7 of the nation's economy, is the third largest employer, and has been the largest creator of new jobs since 1980. Any changes affecting an industry this large will necessarily spill over into other areas of the economy. Furthermore, several aspects of the legislation will disproportionately affect particular kinds of employers, such as health insurance companies and small businesses that do not currently offer coverage to their workers.

The critical workforce issue raised by the health care reform plan is its effect on employment. Within the health care industry, there will be differential impacts based on the type of jobs individuals hold. "Front-line" providers of health care services such as nurses, physician's assistants, allied health professionals, and long-term care providers are expected to experience an increase in the demand for their services as universal coverage extends access to all citizens and as the population continues to age. ~~The reform plan is expected to create as many as 750,000 new jobs in the home health care field alone (check number).~~ Incentives to control costs may slow the projected increases in ~~job~~ the growth of health care provider jobs for these occupations, but little long-term dislocation is expected. ~~There may, however, in the short run, however, there may be some significant relocation of jobs for various groups of providers, such as nurses, as resources continue to shift away from hospitals and small physicians' offices to out-patient and managed care settings.~~

Occupations that are associated with, but ancillary to, the direct provision of health care services will experience more significant employment effects. New administrative efficiencies will eliminate the need for many clerical and administrative positions, both within health care institutions and in the health insurance industry. Cost-control incentives may also cause layoffs in support services such as housekeeping, security, food services, etc. The creation of the health alliance system will likely force insurance firms to consolidate operations and may result in severe levels of unemployment among employees of health insurance companies.

~~Restructuring the delivery of health care services will particularly affect workers in hospitals and other high-cost institutions as competition forces them to reorganize and/or emphasize lower-cost ambulatory and community-based care. Mergers and acquisitions among these institutions will bring further changes to the workforce. The competitive disadvantages facing financially distressed public hospitals, and the potential integration of public health services with private sector providers in the mental health/mental retardation fields, may cause dislocation of public employees.~~

~~Finally, employees of companies not currently offering health benefits to their employees, particularly low wage workers, will also be vulnerable to job loss. As these employers face new requirements to pay for a substantial portion of workers' health benefits, the effective cost of their low wage workers will increase significantly. While gradual phase in of universal~~

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~~coverage and short-term subsidization of small employers will mitigate these effects, some job loss can be expected, particularly in the short run.~~

The differential effects of health care reform on employment present a unique opportunity to improve the long-term career prospects for workers whose jobs are imperiled by the adoption of the new system. Our specific challenge is to provide enhanced employment opportunities for low-wage, lower-skilled administrative/clerical workers in the health care and insurance fields and ~~appropriate redeployment assistance to health care professionals;~~ through ~~We~~ must improve ~~better~~ access to training, establishment of career mobility programs, ~~educational opportunities,~~ and enhanced employment services. At the same time, we must ensure an adequate supply of well-trained ~~and appropriately educated~~ health care providers to meet the increased demand for health care created by the reform plan.

The lack of well-developed career ladders is a particular problem in the health care industry. Although this industry has been an important source of job creation for over a decade, a significant number of these positions pay relatively low wages and offer little potential for skills development and career mobility. At a time when shortages are predicted for many of the skilled health care professions, a new system offering enhanced employee development is needed, *particularly for those employed in the industry who hold lower-skilled positions* and are more vulnerable to layoffs as a result of pressures to minimize costs. ~~We must also ensure the quality and safety of the care delivered to the public by avoiding the creation of a pool of low skilled workers who might be inappropriately used as an inexpensive labor force to replace higher skilled workers.~~

~~The cost containment policies adopted as part of health care reform will strongly influence both short-term employment effects and future workforce development. Cost containment strategies may tempt health care facilities to decrease labor costs by reducing real wages and de-skilling jobs. Such strategies may also lead to reduced incentives to invest in the workforce and ultimately lower the quality of patient care. Rather than encouraging employers to take the low-wage path, the Federal government's cost-containment strategy should protect basic labor standards and provide incentives to reorganize work and invest in upgrading the skills of front-line health care workers.~~

~~The ultimate success of the new managed competition framework in delivering continuous quality improvement and lower costs will depend upon its ability to encourage new ways for workers and managers to work together in a cooperative, productive relationship. As the manufacturing experience demonstrates, innovative long-term solutions to cost and quality issues will require the participation of the entire workforce in quality management -- front-line employees as well as managerial personnel.~~

This proposal suggests several actions to address the workforce issues relevant to comprehensive health care reform. The first goal of these actions is to confront workforce issues in a proactive manner, avoiding layoffs where possible and handling them effectively when they occur. It is essential that structures be created to handle the unemployment and dislocation effects of health care reform *before they occur*. The significant lead-in time required to fully implement health reform makes this task possible. A second, related goal is to ensure an adequate and efficient supply of qualified health care providers to meet the anticipated increase in the demand for health care services during the transition to the new

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system.

ACTION 1: *Establish a National Institute for Health Care Workforce Development.*

The National Institute for Health Care Workforce Development (the Institute) will facilitate the nation's transition to a new health care delivery system by analyzing the workforce development needs of the new system and helping to meet those needs during the transition. The Institute will serve as an important resource for policy makers, health care institutions, educators, professional associations, and health care unions. This entity, jointly administered by the Departments of Labor and Health and Human Services, [or, operating as a subsidiary to the National Health Board] will fulfill a unique role in that it will focus on *workplace issues* relevant to the health care workforce.

Rather than taking a purely academic approach, the Institute will incorporate the unique insights of a variety of organizations with practical expertise in these issues. The Institute will focus on 1) the changing human resource needs of health care employers caused by the reform plan, 2) the educational, training, and career development needs of health care employees, and 3) effective programs for addressing the needs of both groups in an innovative and constructive fashion.

- o **Functions.** The Institute will analyze and develop recommendations on a range of issues of importance to the development and utilization of the health care workforce. Specifically, it will be charged with:
 - Examining the effect of the new health care system on the occupational mix of service providers;
 - Studying the service delivery needs of health care institutions and the educational curricula and occupational training needs of the non-physician workforce caused by the shift to the new system;
 - Analyzing the empirical evidence demonstrating current and projected future areas of labor shortages in the health care delivery system, highlighting areas of critical shortages and developing strategies to alleviate them;
 - Identifying and addressing unmet data collection needs necessary for effective policy formulation;
 - ~~Studying and reporting on employment and mobility trends for non-physician health providers, including but not limited to analysis of changes in skill requirements, compensation, recruitment (including minority recruitment), and mobility trends;~~
 - Studying the requirements for organizing various health care settings according to principles of high performance work, initiating demonstration projects for

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model practices that extend beyond the health care industry's traditional "top-down" total quality management approach, and addressing the implications of such actions for new worker skill requirements, employee empowerment, and safety and quality outcomes;

- Studying and, where appropriate, encouraging increased utilization of interdisciplinary and other innovative approaches to the delivery of health care services and the development of multi-skilled health service providers;
 - Developing, evaluating, and disseminating models for training, career development, redeployment, and work restructuring programs in the health care field.
- o **Administration.** The Institute will have a 12-15 member board of directors (Board) committed to active involvement and providing strong policy guidance. The Board will represent a partnership among health care institutions, government, labor, professional organization, and educators. Accordingly, membership to the Institute's Board will be drawn as follows:
- Co-chaired by the Secretary of Labor and the Secretary of Health and Human Services;
 - Three representatives of health care institutions. These should include one individual designated by each of the following organizations: the American Hospital Association, the Group Health Association of America, and the American Healthcare Association (long-term care facilities);
 - Three representatives of health care employees. Organizations represented may include the American Nurses Association, the American Federation of State, County, and Municipal Employees, and the Service Employees International Union;
 - Three representatives from organizations of health care education. Suggested organizations include the National Network for Health Career Programs in Two-Year Colleges, the Association of Schools of Allied Health, and the National League for Nursing;
 - One representative each from the National Health Board and the Department of Education's Office of Adult and Vocational Education;

~~Two representatives from consumer organizations.~~

The Institute's staffing level should be adequate to fulfill the organization's objectives. At a minimum, it should include three executive staff -- a director, an assistant director, and a fiscal manager -- and a professional staff of functional specialists. Collectively, the professional staff should possess expertise in health care education and

occupational training, certification and licensure requirements, work-based learning, human resource management, and health economics.

- o **Sunset Clause.** To ensure the Institute serves as a meaningful entity with the clearly defined mission of guiding the nation's *transition* to a new health care system, the reform legislation should include a sunset provision terminating the Institute's ~~operations~~ in the year 2000, ~~unless evidence can be presented demonstrating the need to extend its operations.~~

ACTION 2: *Provide transitional funding for "health care workforce development grants" to support programs for skills up-grading, occupational retraining, and career ladders, and quality improvement in the health care setting.*

The new competitive environment created by health care reform will result in increased vulnerability of lower-skilled workers within the industry to layoffs driven by cost-containment pressures. The most effective means of ensuring the continued employability of these individuals is to prepare them for the higher ~~value-added skilled~~ health care jobs that are experiencing strong rates of growth. At present, however, only a small number of health care organizations are experimenting with measures to train non-professional employees for higher-skilled jobs, or to implement structured career ladder programs. The result is that most of these workers – who are currently employed, but at-risk of dislocation – have limited access to the training and educational opportunities necessary to prepare them for high ~~value-added jobs available career options.~~

Although it is not routine practice for the Federal government to provide for the training and development needs of employed workers, ~~at least two unique circumstances combine to make a compelling case for temporary action in this instance. First, comprehensive health reform is a Federally initiated action which will produce a period of instability and some dislocations in the health care labor market, particularly among lower skilled workers. Second, factors such as the rapid increase in demand for services caused by implementation of universal coverage and the aging of the baby-boom cohort will likely exacerbate existing and projected shortages in many health care occupations. Ensuring adequate numbers of well-trained care providers will be critical to the success of the reform effort. On a more general level, the Federal government has an important stake in encouraging high performance workplaces through participatory programs in the health industry; for the success of the reform effort will also depend, in large measure, on its ability to ensure quality improvement at lower cost. The success of the reform effort will depend, in large measure, on its ability to ensure the presence of adequate numbers of well-trained care providers.~~

~~Transitional~~ Health care workforce development grants can help offset the ~~potential~~ temporary adverse employment effects of health care reform and improve the quality of patient care by helping to overcome skill bottlenecks and shortages. By providing health care employers (and other appropriate entities) with assistance in preparing ~~non-professional~~ employees for new roles within the organization, the grants can address potential dislocations *before they occur*. Development grants will provide lower skill employees with opportunities to upgrade

their skills and prepare for more challenging and meaningful careers, with correspondingly higher wages. Professional employees will be able to obtain the continuing education and training necessary to adjust to changes in practice patterns caused by health care reform. ~~Finally, these~~ Finally, these grants can enable health care institutions to develop measures for utilizing their human resources in the most effective manner possible, which will encourage both higher quality and lower cost services.

Major elements of program design are discussed below.

- o **Essential Criteria.** Successful applicants for grant funds must be able to demonstrate the potential to *significantly* augment employee skills, ~~to and~~ address shortages resulting from the transition to the new system; ~~and to adopt innovative workplace principles (e.g., employee participation and empowerment, labor-management cooperation, provision of training, employment security, etc).~~ Additionally, proposed projects must be designed to accomplish one or more of the following objectives:
 - Obviate or significantly reduce reform-related lay-offs;
 - Prepare employees for new occupations, ~~practice models, and skill requirements~~ within the organization or ~~new institutional settings~~;
 - Facilitate a restructuring of the work process in order to improve both the quality and efficiency of care;
 - ~~Foster a high level of employee participation in decision-making, e.g., self-managed teams, employee participation committees, etc;~~
 - Address serious local or regional shortages in one or more health care occupations caused by or related to the reform plan;
 - ~~Provide experienced health care workers with specific skills necessary to work in primary care, or home care settings;~~
 - Establish and implement structures for a system of career ladders and career mobility within the organization.
- o **Project Administration.** The workforce development grants should be administered through the National Institute for Health Care Workforce Development. This is a logical extension of the Institute's proposed role as the primary organization addressing issues of development and utilization of workers in the health care industry during the reform transition.
- o **Eligible Applicants.** Entities eligible to apply should include hospitals; health maintenance organizations (HMOs); long-term care facilities; labor unions representing individuals employed in the health care industry; ~~consortia of small providers pooling~~

~~resources and expertise; or consortia of any combination of providers, labor unions, institutions of higher education; or consortia of these groups, which may also include as partners institutions of higher education or community groups.~~ Projects proposed for funding should also include on-going activities of an entity mentioned above. However, proposals to fund on-going activities should be required to demonstrate that Federal assistance would result in *new* individuals being served.

- o **Use of Funds.** Permissible use of grant funds should include:
 - Classroom training, including academic instruction at an institution of higher education, for ~~non-supervisory managerial~~ employees;
 - Expenses associated with the provision of on-the-job training or classroom education for ~~non-supervisory managerial~~ employees learning new occupational skills; ~~moving to new health care settings; or shifting from specialized to primary care services;~~
 - Developmental costs of career ladder or other occupational mobility programs;
 - Developmental costs associated with designing or restructuring degree curricula to meet the needs of non-traditional students such as working adults and career-changers;
 - ~~Developmental costs of training workers to participate in continuous quality improvement programs;~~
 - Provision of support services such as modest stipends, supplemental child care expenditures, textbooks or training materials, student travel costs, etc.
- o **Sunset Provision.** In order to ensure the workforce development grants function to meet the *changing needs* of the health care service delivery system during the period of transition, rather than subsidizing the on-going operations of health care providers, the reform legislation should include a sunset provision paralleling that of the Institute - ending the program in the year 2000, unless otherwise extended.

ACTION 3: *Develop measures to promote wide-spread implementation of career ladders for non-supervisory employees in the health care industry.*

Well-designed occupational mobility programs will benefit health care employers, employees, ~~communities;~~ and the broader labor market. Lower-skill employees will gain the opportunity to upgrade their abilities and move into more challenging and rewarding positions. As they become more skilled these employees may be less vulnerable to layoffs, and will be better positioned to find new employment should the need arise. Employers will develop structures that meet their specific staffing needs and ameliorate skilled labor shortages. By encouraging long-term employment relationships and investment in the community, career ladder

programs minimize employers' risk of losing training investments due to turnover. ~~Even unemployed entry level workers may benefit. The process of internal promotion often creates a "vacancy chain" that ultimately results in external hiring at the entry level.~~

The comprehensive reform initiative offers a singular opportunity to promote greater implementation of career ladder programs in health care settings. In considering measures to increase the incidence of such programs, the following elements deserve attention.

- o **Incentives for action.** There are at least two broad approaches one might use to encourage implementation. The strongest approach – and one that virtually assures compliance – would require all providers receiving Federal funds to have implemented (or at least developed) career ladder programs for non-supervisory managerial employees by a specified time. In particular, allied health plans could be required to meet such a requirement as a condition of entering into an agreement with a regional health alliance. Alternatively, non-coercive "rewards" for compliance could be offered such as special tax consideration for training and developmental expenses related to the effort or other forms of preferential treatment.
- o **Applicability.** If institutions receiving Federal funds are *required* to implement such a program, certain exemptions should be made. Small employers have fewer funds to train employees and fewer opportunities for advancement. Therefore, establishments under a certain size, such as 100 employees, ought to be exempted.
- o **Program Design.** Elements of a model career ladder program are described in Attachment #1.

~~**ACTION 4: Establish mechanisms to re-employ displaced clerical or administrative workers in health alliances or other appropriate organizations.**~~

~~Health care reform is expected to generate significant employment effects for clerical and administrative workers in the insurance and health care industries. At the same time, States will be required to create and staff health alliances to administer the managed competition system. New jobs created by the alliances can serve to alleviate some of the displacement effects experienced during the early stages of adaptation to the new system.~~

~~The following measures will assist in the re-employment of dislocated clerical and administrative workers.~~

- o ~~Employers in the insurance and health care industries could be required with worker consent to supply the names and addresses of any permanently laid-off clerical/administrative employees to a designated State agency. When the State begins to staff the alliances, it would then be required to send certain information to the individuals on its list of dislocated employees. This should include:~~
 - ~~• a description of the functions and activities of the alliance;~~

- ~~• a list of the broad occupations the alliance intends to hire;~~
 - ~~• approximate numbers of each occupation to be hired;~~
 - ~~• the skills and requirements for each position;~~
 - ~~• approximate salaries and benefits;~~
 - ~~• whom to contact if interested in pursuing employment at the alliance.~~
- ~~o To strengthen the proposal, alliances could be required to develop selection criteria for hiring new employees. Individuals drawn from the list of dislocated workers could then be given either an absolute preference in hiring or a weighted advantage favoring their selection over other individuals. Under this stronger variant, hiring preferences might be extended only to (formerly) non-supervisory workers and/or (formerly) clerical workers.~~
 - ~~o There is an inevitable amount of turnover and hiring in all industries, even those not experiencing net employment gains. Furthermore, the anticipated expansion of HMOs and other forms of managed care may create some new employment opportunities for clerical and administrative workers in these settings. Therefore, another variation on this option might allow members of the alliance to access this broader list of dislocated workers for the purpose of job recruitment.~~

ACTION 5 4: ~~Include supplemental funding for, and encourage close coordination with, the Administration's Comprehensive Workforce Adjustment Initiative: general dislocated worker assistance programs.~~

The mandate to extend universal coverage to all employees could have serious implications for workers across the entire economy, particularly those not currently receiving health care benefits. Some dislocations will occur within the health care and insurance industries; however, much of the job loss may occur outside these industries among low-wage individuals. Because negative employment effects of health care reform will extend across industries and occupations, so too should the adjustment assistance necessary to facilitate the movement of dislocated workers back into the labor market.

The Administration is currently developing a comprehensive ~~dislocated workers~~ worker adjustment program to serve all workers, regardless of the cause of dislocation. Conceptually, the program will ~~offer enhanced employment services and~~ will be customer-oriented, outcomes-based, and de-centralized at the local level. More specifically, it will offer a variety of services including training, labor market information, re-employment services, in some cases income support, and access to "one-stop" career development centers.

- ~~o Supplemental Funding. Most dislocations caused by health care reform will be addressed by this comprehensive program. However, the health care reform~~

legislation can help alleviate the added stress that will be placed on the dislocation adjustment system by authorizing additional funds for comprehensive adjustment services to be provided to states as they make the transition to the new system:

- o **Coordination:** These worker adjustment mechanisms can work to facilitate a smoother transition to the new health care reform environment. The envisioned national labor market information system and "one-stop" career centers can be particularly useful in this regard.
- **Job matching between health care employers and dislocated health care and insurance workers** could be greatly facilitated by requiring health alliance and allied health plans to list all job openings with the local office of the Employment Service (ES) in the short term; eventually a "health care jobs bank" could be created in the "one-stop career centers" created under the worker adjustment assistance legislation.
- **Health care and insurance providers implementing significant layoffs** could be required to refer newly dislocated workers to the local ES or one-stop center (once it is created), which will have comprehensive listings of all industry-relevant jobs (including but not limited to health care jobs) available in the area or region.
- **Health care employers** could be given incentives, possibly in the form of modest preferential tax treatment or contracting preferences, for significant efforts to recruit and hire through this "jobs bank" system.
- **Regional health alliances** should be required to recruit positions through the "jobs bank."

ACTION 5: *Develop measures to promote wide-spread implementation of innovative work practices and employee involvement in the health care industry.*

The government has the unique opportunity — and given its stewardship over expenditure of taxpayer funds, the obligation — to accelerate the use of innovative work and human resource practices and employee involvement programs in the health care industry. Successful programs offer the possibility of improved service quality, operational efficiency, and more meaningful employment.

o **High Performance Workplace Practices:**

- **The National Institute for Health Care Workforce Development and the Department of Labor** should be charged with studying the application of high performance work principles in the health care industry, including the formation of employee participation committees. Within six months of the effective date of the health care reform legislation, the Institute and DOL, in consultation with

HHS, should be required to make recommendations to the National Health Board on the most appropriate and effective method of encouraging health care providers to adopt such workplace practices. The Institute shall report to the Board within six months of the effective date of the health care reform legislation.

- In the alternative, in choosing among competing allied health plans, alliances could consider, and give preferences to, plans whose providers commit to implementing employee participation committees. The Institute and DOL, in consultation with HHS, would work to identify additional appropriate criteria associated with high performance work. Potential areas might include, but would not be limited to, adoption of continuous quality improvement strategies; increased employee empowerment; efforts to "upskill" the workforce; benchmarking; and self-managed teams.

- o Information and technical assistance on these matters would be supplied to providers by the Department of Labor, the Institute, and the State Quality Management Programs.

- o At a minimum, employee participation committees should operate in accordance with the following principles:

- Employee representation would be drawn in proportion to unionized and non-unionized employees. Where more than one union is present, both (or all) will be represented.
- Committees would have access to quality and cost measurement information and training in quality control and improvement methods.
- As provided under Section 8(a)(2) of the National Labor Relations Act, committees would not have the authority to address salaries, wages or economic fringe benefits.
- Management would be required to hold periodic meetings with committees to discuss ways to improve quality and efficiency.

- o **Consultation on Delivery System Changes:** In unionized settings, when plans for significant service delivery system changes are contemplated – whether by health plans or individual providers – employers must give advance notice to and consult with employees and their representatives about the impact and necessity of such changes. Delivery system changes which would ordinarily necessitate notice and consultation include, but would not be limited to, the following.

- Elimination of categories of jobs;

- Elimination of particular services in a health care facility;
- Shift of health care delivery from one setting to another (such as from institutional to non-institutional settings);
- Change in the governance of facilities or decision-making responsibility for operation or provision of services (State to county, public to private, etc);
- Dislocation of a significant number of employees;
- Changes in supervisory structure and responsibilities of health care teams.

Consultations should concentrate on the impact of the contemplated changes on quality of patient care, disruption of the workforce, and methods for redeploying affected workers into the new delivery system. Alliances should be required to establish grievance procedures by which employees or their representatives could file complaints. Such complaints would be considered as part of a plan's or provider's annual performance review.

Attachment #1:

Key Elements of a Career Mobility Program in the Health Care Setting

Career mobility programs constitute a form of internal labor market (ILM). ILMs may be loosely characterized as an organizational policy of internal promotion, or "hiring from within", to fill job vacancies above the entry level. Because ILMs are associated with long-term employment relationships, they encourage career mobility within the organization and offer several benefits to both employers and employees. By reducing turnover, employers lower costs associated with recruitment, hiring, and orientation. Long-term costs of training and developing the workforce are decreased because there is less risk the employee, once trained, will leave the organization and because the employer has a longer time horizon over which to recover the cost of the investment. From the employee's perspective, ILMs offer the assurance of stable employment, the opportunity to acquire additional skills, and an increased probability of career advancement.

At present, there are few well-established, comprehensive career ladder programs in place in the health care industry. Funding and evaluation of several large-scale demonstration projects may provide useful models for replication throughout the industry.

Program Structure

Important elements to be incorporated into a model career mobility program include the following: are listed below. These elements are applicable to all settings. However, at unionized institutions, it will be necessary to ensure all actions are in accord with terms of relevant collective bargaining agreements.

- o Program implemented and administered *jointly* by management and employees, or in unionized settings, their representatives. This would likely take the form of a joint labor-management committee where labor and management will fully and equally participate in all decisions. At locations where all or part of the workforce is unionized, employee representatives would be drawn in proportion to the number of unionized and non-unionized employees. If more than one union is present in the bargaining unit, both or all should be called upon to participate.
- o Explicit, clearly defined skill requirements developed for all positions within the organization and projections of the number of openings for each position. By documenting the skills, training, education, and experience required for all positions, individuals will be able to determine their training and skill development needs and devise an appropriate plan for meeting these needs. Each occupation's list of skill requirements should be free of ambiguity and *functionally-based* to the greatest extent possible. Projecting the number of job openings likely to become available within a given period of time will also help to inform employees' training decisions.

- o **Opportunities for lateral career movement.** In addition to the development of career ladders – vertical paths to career advancement – organizations should initiate a complementary system of career “lattices” that offer individuals the opportunity to move laterally into other occupations more congruent with their career aspirations, interests, and skills.
- o **Discussions with employees as to training needs for career advancement.** Supervisors and/or members of the human resources/personnel department should be available to periodically discuss with employees what opportunities exist through the organization to upgrade their skills, and which skills will need to be developed for further career progression.
- o **Commitment to a policy of internal hiring and promotion.** While it will not be feasible to hire *solely* from within, the institution must demonstrate that it is committed to filling its staffing needs through the training and promotion of existing employees. All employment opportunities above the entry level must first be posted within the workplace. Hiring from the outside should only occur in the event no internal applicants are qualified for the position and none can be trained in a reasonable period of time.
- o **Opportunities to work while training or completing an educational program.** If lower-skilled employees are to progress more than one or two “rungs” up the career ladder, at some point they will probably need to return to an academic setting to obtain further education. Because these individuals are mature adults, few will be able to quit working to pursue full-time studies. The opportunity to work part-time will provide some degree of income maintenance. Even more effective would be the provision of full-time pay and benefits in exchange for half-time work during the course of studies and an obligation to work at the sponsoring institution full-time thereafter for some specified period of time.
- o **Provision of support services.** The extra time demands associated with career upgrading training during non-work hours can limit participation by those with child-care responsibilities. In the event training can not or will not be scheduled during regular work hours, compensation for the marginal amount of child care (or direct provision of child care services) will help to ensure that such considerations do not prevent full participation in career development opportunities.
- o **Evaluation and dissemination.** The project must contain a strong evaluative component. Factors to be considered in the evaluation should include both individual-level and organization-level outcomes. Individual outcomes consist of factors such as skills development, career advancement, earnings gains, and potential for further advancement. Organizational outcomes include numbers of individuals trained, numbers promoted, employee and management satisfaction as measured by surveys or other instruments, increased quality of care, cost effectiveness, and potential for replicability. Additionally, organizations should commit to participation in outreach and information dissemination activities.

Training Provided

The training opportunities provided may take several forms, as appropriate. These include remedial education instruction; GED; on-the-job and classroom occupational skills training; academic instruction necessary for a certificate, degree, or certification; apprenticeship; and mentoring. Provision of instruction/training on-site is desirable but will not always be feasible.

Training should have a logical and clear link to career advancement. To the extent possible, successful training completion should directly result in increased earnings, career advancement, recognized and portable credentials, or other benefits.

DRAFT

Coalition for Quality Care and Competition

4424 Montgomery Avenue, Suite 102, Bethesda, MD 20814 - (301) 652-5066, Fax: (301) 913-9146

Associations of Health Care Providers

September 16, 1993

Mr. Ira Magaziner
Senior Advisor to the President
for Policy Development
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Mr. Magaziner:

The Coalition for Quality Care and Competition (CQCC), comprised of the undersigned associations representing 400,000 health care practitioners serving health care consumers during 400 million visits/procedures each year, supports the inclusion of non-discriminatory language in any health care reform package. This language is necessary in order to guarantee consumers appropriate access to all health care professionals who are licensed or otherwise regulated in a state to provide health care services.

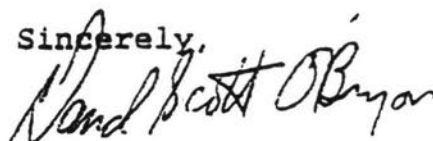
We support the following concepts specifically:

- The proposal should include language which prohibits any entity or plan from discriminating against a class or type of health professional.
- Eliminate restrictions in current law that pose barriers or prohibit health care providers other than medical doctors from practicing in accordance to state licensing acts in those settings recognized under the national plan.
- Hospitals or other facilities may not prohibit licensed health care providers other than medical doctors from being appointed to all categories of staff membership and from being accorded clinical privileges, including patient admission and discharge privileges, as permitted by state law.
- All federal provisions guaranteeing non-discriminatory access to qualified health care providers should be required to apply to all states, entities and plans.
- Throughout the proposed health care reform plan, the term 'physician' should be replaced with 'qualified health professional' as currently defined.

Mr. Ira Magaziner
September 16, 1993
Page Two

We endorse language which defines "health care practitioners" to be any state-licensed or otherwise regulated health care provider. In any health care reform legislation, consumers must be provided protection which will assure their ability to receive treatment from any class of health care provider. Artificial barriers which restrict the consumers' ability to choose among classes of health care providers must be removed; these barriers serve as a detriment to both the consumer and society.

Sincerely,



David Scott O'Bryan
Coordinator

CQCC is composed of ten national associations:

- American Association for Marriage and Family Therapy
- American Association of Nurse Anesthetists
- American Chiropractic Association
- American College of Nurse-Midwives
- American Occupational Therapy Association
- American Optometric Association
- American Physical Therapy Association
- American Podiatric Medical Association
- American Psychological Association
- American Speech-Language-Hearing Association



American Nurses Association

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Virginia Trotter Betts, JD, MSN, RN
President

Barbara K. Redman, PhD, RN, FAAN
Executive Director

TO: Ira Magaziner
Senior Advisor to the President for Policy Development

FROM: Virginia Trotter Betts, JD, MSN, RN
President, American Nurses Association

DATE: September 14, 1993

RE: Interim Protections for Quality of Care in Hospitals

As we discussed during our meeting on Saturday, the American Nurses Association (ANA) is extremely concerned that hospitals are dramatically changing their level and mix of staffing for patient care in what is claimed to be a response to impending health care reform and presumed changes in institutional reimbursement. This is a process we have every reason to expect will be accelerated once the health care plan is released. We are convinced that interim measures are absolutely essential in order to protect patients from a significant and dangerous downgrading of nursing care in hospitals and nursing homes through a short-sighted elimination of large numbers of positions of registered professional nurses in these institutions.

Therefore we recommend that several actions be taken to prevent diminished quality of care and loss of registered nurses in health care institutions.

1. Analyzing data on direct care providers

Data should be analyzed regarding: number of nursing staff performing direct care, percentage of registered professional nurses among this staff, percentage of licensed and unlicensed personnel and average number of patients per registered professional nurse providing direct patient care. Both current and ongoing data and data from January 1, 1992 onward should be analyzed. These can be related to data regarding quality indicators including morbidity and mortality data, patient days, hospital readmission within thirty days, patient falls, medication errors, use of restraints, incidence of nosocomial infections, etc. (See also attached article by Patricia Prescott).

2. Requirements for health care institutions

(a) Hospitals for which data reveals a marked drop or change in numbers of staff providing direct care, a significantly lower percentage of registered nurses providing care and/or a significantly increased percentage of unlicensed personnel should be required to account for these changes to HCFA overseeing that institution. (See discussion of penalties below.)

(b) Hospitals will provide for utilization of sufficient numbers and types of direct care providers based on patient classification systems that account for severity of illness, need for and intensity of patient care services. Each institution's staffing plan must be documented and made available to consumers and federal and state regulatory agencies.

(c) Hospitals will seek to maintain existing levels of staff providing direct patient care, and will create mechanisms to allow participation of consumers, professional providers and hospital staff in decisions regarding hospital reorganization and changes in patient care delivery systems.

3. Penalties

A finding that (1) there have been significant changes in number and/or mix of patient care personnel that can not be attributed to changes in census, patient acuity, etc., or (2) that hospitals have failed to comply with requirements identified in (b) and (c) immediately above should give rise to *a presumption that the hospital is delivering unsafe care*. Specifically, the hospital would be presumed to be out of compliance with Medicare conditions of participation including, but not limited to, 42 CFR Section 405.1024 (b)(1) and (b)(3) (for acute care hospitals) or Section 405.1124(c) (for nursing facilities).

Data that a lower quality of care (based on quality indicators identified above) is being delivered at an institution that has significantly changed its number and/or mix of patient care personnel may be used as further evidence that the institution is out of compliance with Medicare conditions of participation.

4. Further Discussions

This reflects our initial discussion of immediate steps that can be taken now to protect patients from unjustified downgrading of patient care services in claimed anticipation of changes in institutional reimbursement. We look forward to working closely with you on this issue, which will be of increasing importance as the health care reform plan is officially announced.

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FOR IMMEDIATE RELEASE
September 22, 1993

CONTACT: Joan Meehan, ext. 244
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AMERICAN NURSES ASSOCIATION SUPPORTS CLINTON HEALTH PLAN AS BEST VEHICLE FOR REFORM

Pledges Grassroots Support to Bolster Congressional Action

WASHINGTON, DC -- Calling it a bold, visionary plan that addresses the fundamental problems of the nation's health care system, the American Nurses Association (ANA) today announced its strong support of the Clinton Administration's health care reform plan. ANA believes that consumers will benefit from the security of knowing they have access to comprehensive, quality health care services. The plan represents a major victory for registered nurses, who will play a larger role in the delivery of care, particularly preventive and primary health care.

"America's nurses believe that access to appropriate, quality, affordable health care is a right, not a privilege. The reforms proposed by the Clinton Administration are revolutionary in scope and demonstrate a commitment to fix a system that is broken," said ANA President Virginia Trotter Betts, JD, MSN, RN.

ANA, which has actively promoted nursing's reform plan, *Nursing's Agenda for Health Care Reform* since 1990, specifically praised the provisions of universal access, a mandated comprehensive benefits package, insurance reforms and recognition of advanced practice nurses and registered professional nurses as qualified providers for a continuum of health care services.

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NEWS RELEASE

CLINTON HEALTH PLAN/2

"This plan puts a greater emphasis on maintaining health and wellness, concepts that are central to nursing," said Betts. "It means that consumers will have access to a variety of cost-effective providers and will be able to choose an advanced practice nurse for care if they wish. It means that advanced practice nurses will be able to diagnose, treat and prescribe medications for everyday health care needs without unnecessary, costly oversight."

Currently, 100,000 advanced practice nurses provide primary health care services. The Clinton plan is calling for a new funding system to prepare more nurses as primary care providers to meet the demands of the new health care system. This special entitlement could be a mechanism similar to that for resident physicians.

ANA also supports the plan's approach to controlling the increase in health care costs, specifically through paperwork reduction, a crackdown on fraud and abuse, quality assurance initiatives and malpractice reforms. ANA supports provisions in the plan that empower consumers to be more active participants in health care decisions based on cost, quality and outcomes data as well as including consumers on key health care boards.

Overall, ANA believes the plan will greatly benefit consumers, especially children, the underserved, and the elderly. Consumers will have greater access to services that maintain and enhance their health and wellness provided by registered professional nurses in community locations, such as schools.

"This is a bold plan that puts consumers' needs first and foremost," said Betts. "The nation's nurses believe in President Clinton's plan. We support its goals and we will continue to work hard so that health security for all Americans becomes a reality as quickly as possible."

ANA has committed its national grassroots lobbying system, Nurses Strategic Action Team (NSTAT) to promote health care reform at the local and state levels. NSTAT is comprised of thousands of nurse volunteers who work to generate media, political and hometown support as well as lobby their federal senators and representatives.

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The American Nurses Association is the only full-service professional organization representing the nation's 2.2 million Registered Nurses through its 53 constituent associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.



AMERICAN NURSES ASSOCIATION

IMMEDIATE RELEASE
September 13, 1993

CONTACT: Lisa Wyatt, ext. 240

NATIONAL NURSING SUMMIT UNITES LEADERS AND TARGETS KEY ISSUES FOR HEALTH CARE REFORM

Nurses Establish Common Goals and Strategies; Focus on the Big Picture

Washington, DC – The leaders from 63 major nursing organizations, representing nearly one million registered nurses, met in Chicago, Illinois, on August 27 - 28 for a National Nursing Summit to generate and achieve consensus on strategies to position nurses for the future in a reformed health care delivery system.

With respect to *Nursing's Agenda for Health Care Reform*, a general consensus was reached by overwhelming support for the specific mandatory elements of national and state health care reform and strategies to implement reform. The goals and strategies also addressed reform of nursing education, a workforce transition plan, and expansion of advanced nursing practice. Specific goals and strategies were established for five major areas: national health care reform, state health care reform, education funding and reform, advanced practice regulation and payment, and workforce transition and redeployment.

The recurring theme throughout the two-day event was unity among all nursing organizations and increased emphasis on critical issues of interest to the general public and policy makers, such as the delivery of affordable health care services in convenient, familiar sites. Specifically, nurses are zeroing in on issues that are in the best interest of the public and the health of the American people.

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"Nurses are united and are no longer fractionalizing," said Virginia Trotter Betts, JD, MSN, RN, president of the American Nurses Association. "Nurses are powerful because we are a block of 2.2 million health care workers."

Among the 63 organizations in attendance were presidents and executives from many national nursing organizations, including: the American Nurses Association, the National League for Nursing, the American Association of Colleges of Nursing, the American Organization of Nurse Executives, the National Student Nurses Association, the National Council of State Boards of Nursing, the National Federation of Specialty Nursing Organizations, and the National Institute for Nursing Research. A total of 23 nursing groups co-sponsored the two-day event.

Summit speakers included the nation's most distinguished nurse intellectuals and leaders. Other renowned influential persons from related professions included: Carl Volpe, PhD, National Governors Association; Barbara J. Safriet, JD, associate dean, Yale Law School; and Peter Buerhaus, PhD, RN, director of the Harvard Nursing Research Institute.

"There are some wonderful opportunities here for nursing but I don't think that national health care reform is an opportunity to do everything that nursing would like to do," said Linda H. Aiken, PhD, RN, FAAN, trustee and professor of nursing, University of Pennsylvania. She urged her counterparts to focus on the big picture during the health care reform debate, such as the legal, financial, and professional barriers to nursing practice.

"The best single opportunity to make a lasting impact on nursing has to do with using the federal health initiative to remove the barriers to practice, particularly for advanced practice nurses," she emphasized. Four other opportunities for nurses identified by Aiken were: the creation of new and expanded roles for nurses in hospitals; enhanced
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professional opportunities for nurses outside of the hospital sector; expanded educational opportunities and federal subsidies for nursing education; and increased funding for nursing research.

Goals and some strategies for each of the five major issues for which consensus was achieved among the 63 voting nursing organizations included:

National Health Care Reform:

1. Assure universal health care coverage that is portable and unrestricted by pre-existing conditions. Strategies include: mandating inclusion of currently uninsured and underinsured individuals; designing mechanisms to reduce administrative health care costs; seeking new revenue sources, such as "sin" taxes; and assuring access to health care through improved community-based health care systems.
2. Assure involvement of nurses and consumers in health care planning and policy development. Strategies include: mandating equal representation of nurses and other health care providers on all national, regional and state health care policy and regulatory boards and commissions; and mandating consumer representation on all national, regional and state health care policy and regulatory boards and commissions.
3. Remove barriers to nurses to practice to the full extent of their education and receive payment for services. Strategies include: revising Medicare reimbursement policies; requiring that nurses be designated as qualified providers and receive direct

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compensation for services rendered under existing structures and be included in new payment structures; ensuring that payments cover all preventive, primary, acute and long-term services as well as assessment, diagnosis, treatment, teaching, evaluation and coordination of care.

4. Allocate resources to redesign the nursing workforce to deliver services in a restructured health care system. Strategies include: assuring that sufficient numbers of nurses are available to meet the needs of consumers in a restructured health care system; supporting re-education and deployment of current nursing personnel; and raising the numbers of advanced practice nurses.

State Health Care Reform

1. Achieve universal access to cost-effective quality care services for all state residents that addresses prevention, primary care, acute care, long term care, case management and mental health services

delivered by the most appropriate, qualified provider in the most appropriate setting.

Strategies

include: prohibiting discriminatory and anti-competitive language that excludes nurses as providers; and supporting prescriptive authority for advanced practice nurses and fair reimbursement policies for all nurses.

2. Ensure a public health system that is accountable for the health of the community. Strategies include: creating linkages between state health policy entities and the official state health agency responsible for planning, quality, cost and surveillance of community health; developing and monitoring outcome measures for individuals, families and

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communities; and planning and advocating for resources to revitalize and restructure the public health system.

3. Include representation of nurses and informed consumers on state health policy and regulatory bodies. Strategies include: strengthening nursing organizational collaboration at the state level and jointly support qualified registered nurses to policy and regulatory boards; and strengthening collaboration with consumers.

Nursing Education

1. Prepare the nursing workforce to meet the needs of the consumers in a reformed health care system. Strategies include: increasing the community and population-based focus of undergraduate education; preparing faculty to educate students to function in a reformed health care system; and developing transition programs for career mobility and security.

2. Increase the numbers of advanced practice nurses prepared at the graduate level. Strategies include: Allocating new Graduate Medical Education (GME) funds to nursing to support graduate education; allocating majority of new GME funds to educate primary care providers; and obtaining funding support for students who are members of racial and ethnic minority groups and others from underserved areas.

Advanced Nursing Practice

1. Provide consumers with access to cost-effective, quality care. In doing so, advanced

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practice nurses will function autonomously within areas of competency through the removal of regulatory, financial and practice barriers. Strategies include: developing coalitions of advanced practice nurses at the national and state levels; providing information to nursing stakeholders to develop and promote consensus building within the nursing community about advanced practice nursing; ensuring preparation and utilization of advanced practice nurses; educating key decision makers about advanced practice nursing; revising state and federal laws to remove unfair and illegal restrictions on advanced nursing practice; and lobbying for federal and state incentives and changes to reform legislation and regulation to remove barriers to nursing practice.

2. Establish fair and nondiscriminatory payments system that includes payment for nurses' services. Strategies include: ensuring legislative language that specifies payment for services provided by nurses; moving immediately to seek Medicare reimbursement for services provided by advanced practice nurses without regard to geographic boundary; and moving immediately to seek Medicaid reimbursement for services provided by advanced practice nurses.

3. Eliminate the regulatory barriers to advanced nursing practice at federal and state levels. Strategies include: the nursing community will assist in developing federal incentives that eliminate requirements for supervision of nurses by non-nurses; establish plenary prescriptive authority for advanced practice nurses; and assure clinical privileges for advanced practice nurses.

Workforce

1. Redesign the workplace to provide a continuum of care that is accessible, quality-based and effective for all. Strategies include: educating nurses about health care reform (state and national) and implications for their practice; developing innovative

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workplace transition models that prepare nurses for future roles; and developing methods of demonstrating the value of nursing services to the public.

2. Establish an organized redeployment and workforce transition plan. Strategies include: assisting registered nurses to focus on career security vs. job security; securing substantial private education monies to assist nurses in redeployment; developing continuing education for current registered nurses that supports shifting roles; maintaining wage/benefits structure for registered nurses; developing manpower planning models that include deployment projections; and increasing access to RN/BSN programs.

3. Position nurses as essential providers across the care continuum. Strategies include: support federal pre-exemption incentive for uniform prescriptive authority and override physician supervision; design and differentiate nursing roles to support the full range of nursing practice; develop standards by nurses to guide the use of support personnel to maximize the role of professional nurses; form a new partnership among consumers and health care providers; develop action plans to involve nurses in all levels of health care policy; secure third party reimbursement and entitlement for nurses; and establish nurses as gatekeepers for referral of nursing services.

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distribution: nursing, health care

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MEDIA BACKGROUND

TALKING POINTS TO SNAs ON HEALTH CARE REFORM AND THE WORKPLACE

1. ANA is aware that individual nurses and State Nurses Associations are concerned about the current climate in acute care hospitals as work begins on President Clinton's proposal for health care reform. Many nurses fear the impact of health care reform on their jobs. ANA has actively discussed these concerns with Ira Magaziner and the White House staff, the Department of Labor and the Department of Health and Human Services, and will diligently continue to do so as health care reform efforts proceed.
2. ANA is addressing workforce concerns, particularly as they relate to acute care hospitals, in a two-pronged approach - first, advocating directly with the White House for inclusion in the health care legislation of language on staff mix and patient safety; and second, advocating for inclusion of acute care RNs in any retraining and redeployment plan developed by the Labor Department.
3. It is not *reform* that will have adverse effects on nurses' jobs, but *inappropriate actions* by hospital administrators in the coming months as reform is enacted that we are concerned about. ANA wants to assure individual nurses that the President's plan, as we see it, will greatly benefit nurses as providers and as consumers of health care.

Inappropriate Layoffs, Staff Mix, and Patient Safety

4. ANA is dismayed and alarmed at the growing number of inappropriate layoffs and changes in staff mix, particularly in acute care hospitals. Over the past year, ANA has tracked a growing number of reports from nurses, SNAs and the press about changes in workforce patterns in the health care industry. There are increasingly frequent reports about changes in skill mix, abrupt and unannounced layoffs, increasing use of unlicensed assistive personnel to do work previously done by RNs, and hospital restructuring aimed solely at saving money.
5. Why is this happening? ANA sees several reasons:
 - low census in overbedded communities
 - loss of managed care contracts by acute care hospitals
 - general economic issues and recession
 - mergers, acquisitions and closures of hospitals
 - hospital administrators' anticipation of financial implications of cutbacks in Medicare and Medicaid under health care reform.



6. Proactive downsizing by hospitals - without a full assessment of the impact on quality patient care - may seriously jeopardize patient access to care, quality, and safety.
7. ANA is convinced that interim measures are absolutely essential in order to protect patients from a significant and dangerous downgrading of nursing care in hospitals and nursing homes because of a short-sighted elimination of RN positions.
8. We know from well-documented research that higher proportions of RNs (skill-mix) is directly linked to fewer patient deaths, fewer complications, shorter lengths of stay, and increased patient/consumer satisfaction.
9. ANA believes that any hospital's decision to significantly alter staffing levels or mix or to redeploy personnel should include:
 - advanced public disclosure of plans to merge, close, or significantly redeploy personnel,
 - educational programs for professionals to prepare them for redeployment,
 - reporting to consumers, certifying bodies and professionals the impact of redeployment on patient outcomes and quality of care.

Plans for Career Security through Retraining and Redeployment of Workforce

10. ANA is pressing for a health care reform transition plan to ensure that reform can be carried out without premature, reactive hospital closures, massive dislocation of employees, and serious threats to the quality of patient services. ANA has had numerous meetings to advise HHS and DOL what is needed in such a plan.
11. A transition plan must speak to career security through retraining and relocation programs to position acute care hospital RNs for moving into new areas of need such as primary health care, public health, and critical care.
12. ANA believes that over time, higher skilled employees such as RNs will be in great demand in the acute care setting and other health care delivery sites because hospital employers will shift their emphasis from cost containment to quality and effectiveness.
13. A transition plan is essential because the health care industry is the nation's third largest employer, accounts for one-seventh of the nation's economy, and has been the largest creator of new jobs since 1980.
14. DOL says, and ANA agrees, that while long-term dislocation of front-line providers such as nurses will be minimal, there may be significant relocation of jobs over the short term as resources shift away from hospitals and physicians' offices to outpatient and managed care settings.
15. ANA is working with DOL to ensure that retraining efforts focus on increasing the future workforce of professional providers, and do not unintentionally create a large pool of low-skilled health care providers.

16. ANA supports the creation by DOL and HHS of the National Institute for Health Care Workforce Development to facilitate transition to a reformed health care delivery system. The institute would be made up of representatives from health care institutions, labor unions, educators, and consumers.

Other Possible Effects of Health Care Reform on Collective Bargaining

- Tougher negotiations - attempts by employers to take back hard won benefits.
- Reduced incentives for employers to negotiate health care benefits beyond the federally mandated benefits package.
- Increased numbers of mergers, acquisitions and closures if anti-trust regulations are relaxed. ANA will press for language that requires evaluation before a merger is approved of its impact on employee jobs, wages, benefits and collective bargaining rights.
- Greater use by health care institutions of strategies borrowed from the manufacturing industry, such as TQM (total quality management), CQI (continuous quality improvement), or patient-centered care. These programs must be evaluated by nurses for their appropriateness to the delivery of health care services, as well as for whether they **increase** nurse participation in decision-making or **decrease** it by being used as "shams" for management control.
- As employer health care costs become more predictable over time, employees may return their economic focus at the bargaining table to improving wages and other benefits, rather than negotiating for health care benefits.
- There may be new opportunities to include advanced practice nurses into the bargaining unit.
- Internal organizing, servicing contracts, and communication among local bargaining units may become more difficult as more care moves into the community and home.

Some Additional Points

- ANA is working to preserve your **career** in nursing. We are concerned that hasty, inappropriate layoffs of nurses in acute care settings may jeopardize patient safety.
- We know that some nurses will be displaced from jobs as a result of health care reform, but ultimately nurses will fare better in a reformed health care system than all other workers. The White House estimates that 600-700,000 new jobs may be created by the new health care plan. We believe many of those jobs will be filled by nurses.
- Professional nurses are well positioned to be retrained and redeployed into a system that is more community based. Retraining, redeployment programs, increased funding for nursing education--that is what ANA is fighting for--to preserve your **career**.
- Keep in mind what this plan does for you as a consumer of health care and of the security it will bring to your family.
- The nursing community supports several alternative financing approaches - including the employer mandate in the Clinton plan and the single payer mechanism that has worked well for Canada.



OCT 19 1993

American Academy of Nursing

Established 1973 Under the Aegis of the American Nurses' Association

October 13, 1993

Kristine M. Gebbie, MN, RN, FAAN
National AIDS Policy Coordinator
Department of HHS
Executive Office of the President
750 17th Street, NW
Washington, DC 20500

am I available?

Dear Ms. Gebbie:

On behalf of the Governing Council of the American Academy of Nursing, it is my pleasure to invite you to be our guest at the annual banquet and awards and induction ceremony of the American Academy of Nursing. The banquet will be held at 7:00 p.m. in the International Ballroom of the Washington Hilton and Towers Hotel, Washington, DC, on Tuesday, November 16, 1993. Attire for the banquet is formal.

We are enthusiastic about the opportunity for nurses to come together to develop effective treatment approaches and policy recommendations for the prevention of injuries and deaths from violence. We look forward to your participation.

Please respond by using the enclosed form. If you have any questions, please contact Leslie Zeck of the Academy staff at 202-554-4444, ext. 152.

Sincerely,

Nola J. Pender, PhD, RN, FAAN
President

NJP:lz\conf93\banquet.inv
10/13/93

CONFIRMATION FORM FOR BANQUET ATTENDANCE

MAIL TO:

DEADLINE FOR SUBMISSION:

Leslie Zeck
American Academy of Nursing
600 Maryland Avenue, SW
Suite 100 West
Washington, DC 20024-2571

October 29, 1993

1993 AMERICAN ACADEMY OF NURSING CONFERENCE VIOLENCE: NURSING DEBATES THE ISSUES

I confirm my attendance as a guest of the American Academy of Nursing at the annual banquet on November 16, 1993.

Signature _____

Please print the following information:

Name: _____

Educational Credentials: _____

Position Title: _____

Place of Employment: _____

Street Address: _____

City: _____ State and ZIP: _____

Phone: _____ FAX: _____

Please contact Leslie Zeck at 202-554-4444, ext. 152 if you have any questions.



OCT 10 1993

OCT 19 1993

American Academy of Nursing

Established 1973 Under the Aegis of the American Nurses' Association

TO: Fellows of the American Academy of Nursing
FROM: Nola J. Pender, PhD, RN, FAAN, President
DATE: September 30, 1993
RE: Call-To-Meeting

*will attend if no
conflicts*

This notice constitutes the official call to the 1993 Annual Business Meeting of the American Academy of Nursing. The business meeting will be held in the **International Ballroom East** of the Washington Hilton and Towers Hotel in Washington, DC. The meeting will convene at 3:30 p.m. on Tuesday, November 16, 1993 and will adjourn at approximately 5:00 p.m. The annual banquet and induction ceremony will follow the business meeting at 7:00 p.m.

A copy of the minutes of the 1992 meeting are enclosed. Please review the minutes prior to the business meeting and **bring the minutes and the Annual Reports with you to the meeting for reference.** Also enclosed is the agenda for the business meeting, annual reports of committees and expert panels, and important information on the conference.

The Governing Council looks forward to seeing you next month in Washington, DC.

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9/28/93

AAN BUSINESS MEETING AGENDA

**November 16, 1993
3:30 to 5:30 pm**

**Washington Hilton and Towers Hotel
Washington, D.C.**

Call to Order

Review of Standing Rules

Quorum

Minutes of the 1992 AAN Business Meeting

Beverly Malone

Report of the President

Nola J. Pender

Annual Reports:

Nominating Committee

Joyce J. Fitzpatrick

Membership Committee

Peggy L. Chinn

Governing Council

Beverly Malone

Finance Committee

Patricia Forni

Public Relations

Patricia A. Moccia

Nursing Outlook

Carol Anderson

Conference Planning Committee

JoAnn E. Glittenberg

IOM/AAN/ANF Scholars Program

Connie Curran

Unfinished Business

Fellow Selection Process

Peggy L. Chinn

Evaluation of Expert Panels/
Commission

Angela B. McBride

Update on Strategic Planning

Nola J. Pender/Angela Barron
McBride

New Business

Presentation of Certificates of Service

Nola Pender

Report of Teller

Patricia Moritz

Introduction of New Officers and 1993-1994
Governing Council

Remarks of President-elect

Angela McBride

Adjournment

JH:tb:conf93.callmtg.busmtg93.agd
10/6/93

AMERICAN ACADEMY OF NURSING

1992 Business Meeting
Hyatt Regency-Union Station
St. Louis, Missouri

October 10, 1992

CALL TO ORDER:

The Annual Business Meeting of the American Academy of Nursing convened at 1:00 P.M., Saturday October 10, 1992 in the Regency Ballroom A-C of the Hyatt Regency Hotel-Union Station in St. Louis, Missouri. Dr. Nola Pender, PhD, RN, FAAN, president, presided.

Patricia Sloan requested permission to video excerpts of the meeting and so on for 20th year anniversary and for the future 25th year anniversary M. Elizabeth Carnegie Archives

WELCOME AND INTRODUCTIONS:

Dr. Nola Pender, president welcomed Fellows and new Fellows who are to be inducted in the evening. She introduced ANA Officials who were present. Virginia Trotter-Betts, who is president of the American Nurses Association, and Dr. Barbara Redman who is Executive Director of ANA.

ADOPTION OF STANDING RULES:

Dr. Pender reviewed the following rules for the conduct of the Business Meeting:

1. To be admitted to a Business Meeting, a Fellow must present a badge or other identification of fellowship.
2. To obtain the floor, a Fellow should rise, address the chair, and give her/his name.
3. Fellows may not speak and debate more than twice to the same question or longer than three (3) minutes without permission from the body.
4. All motions, except those of a routine nature, shall be in writing and sent to the Chair immediately following presentation.

MEMORIALS:

Dr. Pender memorialized two Fellows who died since the last business meeting: Dr. Dorothy Cornelius and Dr. William E. Field, Jr. Members observed a moment of silence for their departed colleagues.

QUORUM ESTABLISHED:

Dr. Pender reported that in accordance with policy adopted by the membership, a quorum was present. 214 Fellows are present.

MINUTES OF THE 1991 BUSINESS MEETING:

Dr. Anderson presented the motion, which was seconded and carried, that

MOTION: *the minutes of the 1991 American Academy of Nursing Business Meeting be accepted as presented.*

REPORT ON THE ORGANIZATIONAL STRUCTURE AND AFFILIATION OF AAN:

Dr. Pender presented introductory remarks on the "Report of the Governing Council to Fellows of American Academy of Nursing on AAN's Organizational Structure."

ANNUAL REPORTS:

The chairpersons of several of the standing committees were recognized and opportunity was provided for answering questions related to the 1992 Annual Reports that had been distributed to Fellows with their Call to Meeting materials.

More detailed reports to be provided so that budgeting can be more realistic.

A question was raised about the scholarships and endowment funds that were discussed at the Annual Meeting last Year. Dr. Forni responded by stating that \$5,000 and \$10,000 scholarships have been appropriated into the 1993-1994 budget.

Dr. Anderson presented a motion, which was seconded and carried, that

MOTION: *the annual reports of the American Academy of Nursing be accepted as presented.*

MEMBERSHIP COMMITTEE REPORT:

Dr. Pender called Dr. Peggy Chinn to address the "Proposal for Membership Process" report on membership, membership process, and also present some summary comments on the forum on membership that occurred yesterday.

Dr. Chinn acknowledged the report was a result of the efforts and time of the many groups of people within the Academy that preceded this Membership Committee including the Task Force on Diversity in Membership. This report is a combination of work done by the previous year's task force as well as the current committee on membership.

Highlights of the proposal:

- Part 1: Selection Process for Fellowship in the Academy in the final voting stage.
- Part 2: Nomination Process for Fellowship in the Academy. The committee is proposing a change whereby there would no longer be a sponsor and a co-sponsor, but rather two sponsors for every nominee. Both sponsors will be equally responsible for the data that is submitted to the selection committee as well as for two \$25.00 fees that accompanies the nomination with the stipulation that people will only be able to sponsor one nominee per year. The committee is also proposing slight shifts in the wording and presentation of the documents presented for nomination. These are not fundamental changes. This is to alleviate the significant unevenness in the nature of the material for review. This change is to give better guidance for the quality and a more even quality. Further, the committee is proposing to restructure the way in which we conceptualized what counted as evidence in meeting the criteria for membership so as to promote diversity. Finally, the membership committee is proposing a 15 member selection committee that would review the materials and have discussion of qualifications concerning the nominee and make a final selection at the meeting rather than to send out the mail ballot. This change grew out of two concerns. First, the cost to mail ballots. Second, the evidence that members had in front of them regarding their decisions.

MOTION *the membership committee report and recommendations for change in the Fellow selection process for the Fellow selection process be accepted as presented.*

After the President called for discussion of each section of the proposed changes in the Selection Committee formation the motion.

SECTION REGARDING DECISION OF FELLOWS AND THE SELECTION COMMITTEE:

A Fellow expressed concern regarding 2 sponsors for each nominee. Cost and time efficiency were being sacrificed and 2 people were being asked to do the same job. Another Fellow questioned the doubling of the \$25.00 initiation fee to \$50.00. Dr. Forni explained that the bulk of the cost to process applications annually was approximately \$17,000 annually. Another Fellow requested explanation as to how different institutions would create diversity of membership in ethnicity, geography as well as expertise. Further, concern was expressed as to what model of diversity is planned to be followed. Another Fellow asked the timeline for implementation of the new Fellow Selection Process. Dr. Pender said that it would be for the next group of nominees. This Fellow expressed support of the new Fellow Selection Process. Extended discussion in both support and opposition to the proposed changes was offered. A number of Fellows expressed concern over the lack of information regarding the costs of both selection processes and how they compared and that there was insufficient information to make an informed vote. The issue of appointment was questioned. Another fellow expressed the need to consider the electronic availability of voting by computers and discs. This would reduce the exorbitant costs of paper mail out ballots. Another Fellow expressed the possibility of using a Bio-Sketch rather than the involved application that is currently in use.

POINT OF ORDER

The narrative form of the report did not allow sufficient latitude for amendments and that it should be sent back to committee and put in the form so that it could be more easily voted on. Dr. Pender noted that this report could in fact be amended without a motion to table for revision and amendment.

Another Fellow raised the question as to who is actually making the vote on the new Fellows to be admitted. Are the members just rubber stamping yes and the membership committee is in fact making the actual decision. Dr Chinn responded by stating that this is clearly the problem.

MOTION

To refer this entire proposal back to committee and put it in a format that is more easily amendable for voting purposes.

A Fellow summarized the discussion very briefly in the following points:

1. Mailing is costly
2. More information needs to be provided to the voters
3. Questions on the role of the committee
4. Need for diversity of on the committee on membership
5. Improve the quality of the candidates via sponsors

Concern was expressed by this that taking the vote away from the members was disenfranchising them. Fellows need to be involved in the organization and voting is a positive way to do that.

When the motion is referred back to committee it will not be discussed for another year.

MOTION: *The motion currently on the floor was amended to exclude the Criteria for Fellowship and the material supporting the nomination be left on the floor for action and refer the rest of the report back to committee.*

POINT OF ORDER: Clarification of the portions of the report that are being voted on. In response, Dr. Pender noted that the Fellowship was voting on the Section beginning with Criteria for Fellowship through the Materials Supporting the Nomination.

The motion to amend the original motion was made, seconded and carried.

MOTION: *To refer the rest of the proposal back to committee.*

The motion was made, seconded and carried by a standing vote.

CRITERIA FOR FELLOWSHIP:

Dr. McCarthy, who acted as teller, expressed concern regarding the issue of voting. If members wish to continue to have the privilege of voting, then they need to exercise that right when given the opportunity. Not everyone takes this very seriously. In the last vote, roughly a little over 50% of the members actually voted. Of those who did vote, not all voted for all the positions and fellows presented for voting.

In referral back to committee, a fellow noted for the concern of costs to be considered and that the fees be related to the cost of this process.

MATERIALS SUPPORTING THE NOMINATION PROVIDED BY THE NOMINEE:

A fellow expressed concern that there is no way to provide for corroborating evidence of the accomplishments of candidates. These are from the nominees' words in their applications. Dr. Chinn responded by stating that this was the reason for the use of two sponsors rather than one for verification of the nominees' accomplishments.

MOTION: *To accept the criteria for fellowship and materials supporting the nomination provided by the nominee.*

The motion was seconded and carried.

Because the proposal is referred back to committee is not necessary to process the proposed by-laws changes that were to be discussed at this point in time.

SPECIAL REPORT OF ORGANIZATIONAL ARRANGEMENT THAT WAS REQUESTED AT THE 1991 ANNUAL MEETING:

The Governing Council was authorized to develop options to maintain but revise the structural relationship with ANA to enable AAN to carry out fully the promise of its mission and to present their findings to the membership at this meeting.

A forum was held on this proposal prior to this business meeting. Items were included in the packets regarding the movement of ANA and AAN as they discussed this issue and the AAN and ANA officials are recommending that the non-corporate affiliate as proposed, be adopted.

Numerous exchanges have transpired between AAN and ANA and the following options are available.

1. An incorporated organization.
2. Non-corporate affiliate (recommended).

A question was raised regarding a mail ballot on this vote. All of the members are present and why can't the vote be taken with those at present. In response, Dr. McBride noted that due to the amount of information and the seriousness of the issue, the committee preferred the mail ballot.

MOTION: *Acceptance of the memo of understanding which is in support of the non-corporate affiliate for submission to the Fellows in a mail ballot. Seconded*

MOTION: *Amend the motion the striking the mail ballot from the motion. Seconded*

Opposition was expressed to the amendment to strike the mail ballot due to insufficient information and legal counsel regarding the changes in the structure.

Support of the amendment was expressed that sufficient discussion has occurred and the issues have been raised and we have more of our members here than any other group does when a decision of this magnitude is raised.

MOTION: *I move acceptance of the memorandum of understanding for non-corporate affiliate for submission to the Fellows.*

All of the suggestions from the forum were taken into consideration.

The Motion is carried.

NEW BUSINESS:

Dr. McBride presented a report on the activities of long range planning for commissions and expert panels. Remarkable work has been done with the expert panels and one commission, despite so many other considerations of the organization. The first policy paper that has emerge out of Nursing Outlook is exciting. This will be presented after this meeting. The commission has served two purposes. One was to respond to all of the papers developed by the various expert panels to in fact help tease out the policy implications and to provide feedback. They also put together a document that talks about how to develop papers and how to be sensitive to talking about policy issues. They have worked as an expert panel with regard to the document to be presented regarding health care policy. The new AAN staff with Dr. McBride will be doing evaluations of how things have gone so far. It is time for reflection on what has worked and what hasn't worked. Principles to be considered are the resources attainable when new expert panels are created. Directions have been proposed to develop skills regarding policy and to have a conference regarding policy development. Long range planning goals include improvement in describing the expertise of the fellowship. Expert panels imply that a group is coming together for a common purpose. This could be carried out by refining the membership directory to include expertise as well as names and addresses. This would help promote the membership to other organizations and institutions who would like the expertise and who need the expertise. Dr. McBride encouraged the use of the new executive director, Dr. Janet Heinrich, and staff of AAN to help to carry out the purposes, goals and mission of the organization.

INTRODUCTION OF AAN STAFF: Dr. Janet Heinrich, Leslie Zeck, and Tom Barbaro

PRESIDENTS REMARKS: Dr. Pender presented a speech wishing the Academy well in addressing challenges and dilemmas the health care professionals face as well as the Academy's important goals and objectives. She encouraged all Fellows to continue to make a difference.

CERTIFICATES OF SERVICE:

Certificates of Service are being awarded to Academy Fellows who are now completing their terms of office. These awards are in recognition of their contributions to the advancement of new concepts in nursing and health care.

Carole A. Anderson Secretary, Governing Council
1990-1992

Joanne C. McCloskey Member, Governing Council
1989-1992

Grayce M. Sills Member, Governing Council
1989-1992

Patricia A. Moccia Chair, Public Relations Committee
1989-1992
Member, Nominating Committee
1991-1992

Carole A. Lindeman Member, Nominating Committee
1991-1992

Jan R. Atwood Member, Membership Committee
1990-1992

O. Marie Henry Member, Membership Committee
1990-1992

Lorraine O. Walker Member, Membership Committee
1990-1992

Beverly Benfer Member, Finance Committee
1990-1992

Clifford H. Jordon Member, Finance Committee
1990-1992

TELLER'S REPORT:

Dr. Rosemary McCarthy, teller for the 1992 elections reported that the total number of ballots returned was 472 of those 463 were considered valid. 9 were invalid either because of incomplete information, failure to sign, or destruction in the mail. Valid results:

Secretary:	Beverly Malone
Governing Council:	Mi Ja Kim & Grayce Sills
Nominating Committee:	Patti L. Harkin
Membership Committee:	Barbara Carper & Christine Tanner

INTRODUCTION OF THE GOVERNING COUNCIL

At this time, I am pleased to introduce you to the 1992-1993 officers and members of the Governing Council. As I read your name, please join me on the podium.

President	Nola Pender
President-Elect	Angela McBride
Secretary	Beverly Malone
Treasurer	Patricia Forni

Members of the Governing Council

JoAnn Glittenberg

Beverly Hall

Shakè Ketefian

Mi Ja Kim

Grayce Sills

Ann Whall

ANNOUNCEMENTS

Immediately following this meeting, the Commission on Health Care Policy will be presenting their paper entitled, "Health Care Access: Problems and Policy Recommendations". This presentation will be held in the Grand D room just around the corner. Please plan to stay for this presentation.

Plans are underway for the 1993 AAN Annual Meeting and Conference. The conference will be held in Washington, DC, November 15 and 16, 1993 in conjunction with the ANA Council of Nurse Researchers Conference. The theme for this meeting is **Nursing Confronts the NRA: Health Policy Formation, Ramifications and Implications** with the focus on the issue of gun control and implications for violence in our communities. Please mark your calendars now and plan to attend this meeting. In your meeting materials you will find a brief announcement about the meeting.

The 1993 AAN Directory inserts and section tabs will be available by December 1. The Academy staff will advise you by mail as to how to order the updated version.

ADJOURNMENT

This concludes the 1992 Business Meeting of the American Academy of Nursing.

AMERICAN ACADEMY OF NURSING

ANNUAL REPORTS

November 1993
Washington, DC



REPORT OF THE NOMINATING COMMITTEE

Joyce Fitzpatrick, PhD,MBA,RN,FAAN, Chairperson
November 1993

The 1993 Nominating Committee is composed of three elected members of the Academy. The members are:

Joyce Fitzpatrick, PhD,MBA,RN,FAAN (1991-1993)
Patty L. Hawken, PhD,RN,FAAN (1992-1993)
Judith Ryan, PhD,RN,FAAN (1992-1993)

The Nominating Committee met in Washington, DC on May 5, and selected candidates for President-Elect, Treasurer, two Governing Council positions, three Membership Committee positions and three Nominating Committee positions.

During the selection process, the Nominating Committee reviewed materials that included:

1. *"Guidelines for the Work of the Nominating Committee"* that include a balance among candidates' schools, states, ethnicity, sex and geographic locations; minimal replication of Fellows from the same employing institutions and/or states; and to provide opportunities for individuals to serve the Academy who have not had such opportunities before;
2. Actions of the Governing Council related to the selection of candidates;
3. An alphabetical list, by state of Academy Fellows;
4. A list of Fellows who had previously served as officers/committee members; and
5. Nominations received from Academy Fellows for officer and committee positions.

In reviewing the materials submitted for nominations, the Nominating Committee discussed the need for further information on candidates. The following recommendations were proposed:

- a. Future nominations for committee and officer positions must be accompanied by a curriculum vitae for consideration by the Nominating Committee.
- b. A biosketch of each candidate for officer and committee positions will accompany the ballot for review by Fellows.

The mail ballot and related materials were prepared and mailed to all Fellows in good standing for voting. An electronically scannable ballot was used for the election process. The 599 valid ballots were counted on August 16, 1993 at ANA Headquarters, Washington, DC. Patricia Moritz, PhD,RN,FAAN, served as teller to verify the voting

results. Candidates were notified by mail of the outcome of the election. Public announcement of the election results will be made during the 1993 AAN Business Meeting on November 16, 1993 in Washington, DC.

RESULTS OF THE 1993 ELECTION OF OFFICERS AND COMMITTEES

PRESIDENT-ELECT

Barbara Donaho

TREASURER

Robert Piemonte

GOVERNING COUNCIL

Margaret McClure

Patricia Moccia

NOMINATING COMMITTEE (1-YEAR TERM)

Leah Curtin

Judith A. Ryan

Sally Sample

MEMBERSHIP COMMITTEE

Clara Adams Ender

Vivien DeBack

Duane Walker

REPORT OF THE MEMBERSHIP COMMITTEE

Peggy L. Chinn, PhD,RN,FAAN, Chairperson
November 1993

The 1993 Membership Committee consists of six elected members of the Academy. The Committee is composed of the following members:

Peggy L. Chinn, PhD,RN,FAAN, Chairperson (1991-1993)
Barbara E. Bishop, MN,RN,FAAN (1991-1993)
Barbara A. Carper, PhD,RN,FAAN (1993-1995)
Connie R. Curran, PhD,RN,FAAN (1993-1995)
Margaret A. Newman, PhD,RN,FAAN (1991-1993)
Christine A. Tanner, PhD,RN,FAAN (1993-1995)

Responsibilities of the Membership Committee include: (1) soliciting candidates for fellowship in the Academy; (2) disseminating information to potential candidates and sponsors regarding procedures and qualifications; (3) reviewing applications for election of new Fellows, and preparing the ballot for the election of new Fellows; (4) reviewing application forms and selection procedures, and recommending changes to the Governing Council; and (5) monitoring the election of new Fellows.

The Membership Committee met April 30-May 1, 1993 at ANA Headquarters in Washington, DC to review completed applications for fellowship in the Academy, prepare the 1993 ballot and to discuss membership issues.

One hundred fifty (150) applications for membership in the Academy were received at headquarters. The committee reviewed and rated these applications according to procedures established by the Academy. Seventy six (76) applicants were determined to meet the criteria for membership, and the names of these individuals were placed on the 1993 ballot. All applicants and sponsors were notified accordingly.

The mail ballot and related materials were prepared and mailed to all Fellows in good standing for voting. An electronically scannable ballot was used for the election process. The 606 valid ballots cast were counted on August 16, 1993 at ANA Headquarters. Patricia Moritz, PhD,RN,FAAN, served as the teller to monitor the tabulation process. Of the 76 individuals whose names were placed on the ballot, 73 were elected to Fellowship in the Academy, including three honorary fellows. Candidates and sponsors were notified by letter of the outcome of the election.

Currently, there are 910 Fellows in the Academy. This number includes 770 active Fellows, 110 Emeriti Fellows, 19 Honorary Fellows and 11 inactive Fellows. Following this year's induction ceremony on November 16, 1993 (including those who were elected last year and were unable to attend the induction ceremony), there will be a total of 984 Fellows in the Academy.

NEW FELLOWS - ELECTED 1993

Lauren S. Aaronson, PhD, RN
Fairway, KS

BG Nancy R. Adams, RN, MSN
Falls Church, VA

Rhonda Anderson, RN, MPA, CNA
East Hartford, CT

Cheryl Tatano Beck, DNSc, CNM
Portsmouth, RI

Cornelia K. Beck, PhD, RN
Little Rock, AK

Verdelle B. Bellamy, MSN, CNA, RN
Atlanta, GA

Gerald Bennett, PhD, RN
Martinez, GA

Bobbie Berkowitz, PhD, RN, CNA
Olympia, WA

Donna L. Bertram, RN, BSN, MBA
Monument, CO

Janet Hardy Boettcher, RN, C, PhD
Radford, VA

Christine S. Breu, RN, MN, CNA
Louisville, KY

Virginia Carrieri-Kohlman, DNSc, RN
San Anselmo, CA

Marianne Chulay, RN, DNSc
Washington, DC

Rose E. Constantino, PhD, JD, RN
Pittsburgh, PA

Marcia L. Dale, EdD, RN
Cheyenne, WY

Mary J. Denyes, PhD, RN
Ann Arbor, MI

Jacqueline Dienemann, PhD, RN
Rockville, MD

Mary E. Evans, RN, PhD
Slingerlands, NY

James A. Fain, PhD, RN
Warwick, RI

Marsha D. M. Fowler, PhD, MDiv, MS, RN
Pasadena, CA

Catherine H. Garner, RNC, MSN, MPA
Lenexa, KS

Ellen J. Gaucher, RN, MSPH, MS
Whitmore Lake, MI

Kathleen L. Grady, PhD, RN
Arlington Heights, IL

Judith Haber, PhD, RN, CS
Stamford, CT

Catherine E. Hanley, RN, BSN, MPH, FACHE
Tuba City, AZ

Kaye Ann Herth, PhD, RN
Elgin, IL

Carolyn C. Hoch, PhD, RN
Pittsburgh, PA

Bonnie Holaday, DNS, RN
Nashville, TN

Barbara Holder, PhD
Chevy Chase, MD

Carole I. Hudgings, PhD, RN
Gaithersburg, MD

Sharol F. Jacobson, RN, PhD
Edmond, OK

Ruth W. Johnson, EdD, RN
Mt. Vernon, NY

Linda Corson Jones, PhD, RN
Harahan, LA

Maureen R. Keefe, RN, PhD
Englewood, CO

Mary S. Knapp, MSN, CRNP, NHA
Jamison, PA

Gerri S. Lamb, PhD, RN
Tucson, AZ

Patricia J. Larson, RN, DNSc
San Francisco, CA

Carol J. Loveland-Cherry, PhD, RN
Ann Arbor, MI

Carolyn H. Lund, RN, MS
San Francisco, CA

Brenda L. Lyon, DNS, RN
Indianapolis, IN

Joan Kathleen Magilvy, PhD, RN
Littleton, CO

Jean Marshall, MSN, RN
Toms River, NJ

Joanne Martin, DrPH, MS, RN
Indianapolis, IN

Deborah K. Mayer, MSN, OCN
Toronto, Ontario CANADA

Susan C. McMillan, PhD, RN
Temple Terrace, FL

Shirley W. Menard, PhD, RN, CPNP
Schertz, TX

Lillian H. Mood, RN, MPH
Chapin, SC

Pearl Moore, RN, MN
Pittsburgh, PA

Janice M. Morse, RN, PhD
Boalsburg, PA

Joyce P. Murray, EdD
Dunwoody, GA

Kathleen M. Nokes, PhD, RN,C
Stone Ridge, NY

Laurel Northouse, PhD, RN
Ann Arbor, MI

Julia R. Plotnick, MPH, RN
Silver Springs, MD

Cornelia P. Porter, BSN, MNEd, PhD, RN
Ann Arbor, MI

Hilda Richards, EdD, MPA, MEd
Gary, IN

Barbara Riegel, DNSc, RN, CS
San Diego, CA

Beverly Claire Robinson, PhD, RN,C
San Antonio, TX

Judith R. Ronald, EdD, RN
Cheektowaga, NY

Nancy Santilli, RN, PNP, MSN
Charlottesville, VA

Winifred Schmeling, RN, PhD
Tallahassee, FL

Laurie N. Sherwen, PhD, RN
Haddon Heights, NJ

Jean Sorrells-Jones, PhD, RN
Charlottesville, VA

Elizabeth Sorrentino, PhD, ARNP
Miami Beach, FL

Susan M. Sparks, RN, PhD
Bethesda, MD

Carol D. Spengler, PhD, RN
Ann Arbor, MI

Bess Stewart, PhD
San Antonio, TX

Sara Torres, PhD, ARNP
Temple Terrace, FL

Ana Maria Valadez, EdD, RNCNA
Houston, TX

Diana J. Weaver, DNS, RN
Madison, CT

Terri Weaver, PhD, RN, CS
Bryn Mawr, PA

Anna Frances Z. Wenger, PhD, RN
Stone Mountain, GA

1993 Honorary Fellows

Brigadier General Lillian Dunlap
San Antonio, TX

Betty Neuman, PhD, RN
Beverly, OH

Doris E. Roberts, PhD, RN
Chevy Chase, MD

REPORT OF THE GOVERNING COUNCIL

Beverly Malone, PhD, RN, FAAN, Secretary
November 1993

The Governing Council of the American Academy of Nursing met via teleconference December 15, 1992; February 24-26, 1993 in Washington, DC; and July 22-23, 1993 in Annapolis, MD.

One of the top priorities for the Governing Council was the oversight of the implementation of the Memorandum of Understanding (MOU) between the Academy and ANA. Guidelines for the implementation of the MOU were developed to facilitate the working relationship between ANA and AAN. The guidelines will be reviewed on a biennial basis to clarify operational issues and concerns as well as to identify potential organizational system barriers in accomplishing the stated goals of both organizations. A joint meeting of the Executive Committee of AAN and ANA was held March 31, 1993. There was a general evaluation of the working relationship between the two organizations, discussion of potential joint projects, and new approaches to keeping members informed of activities, such as electronic mail.

An example of a joint initiative and quick response to a policy concern was the Managed Care, Managed Competition Workshop hosted by AAN. Policy issues related to managed care and Nursing's Agenda for Health Care Reform were identified and discussed by nurse leaders involved in managed care or implementation of other health care reforms in key states such as California, Minnesota, and Washington. Attendees found the workshop informative and timely. Several persons in attendance also worked with the Clinton health care reform task force. The AAN has published one monograph as a result of the workshop, and a policy paper published by ANA will be forthcoming. New models for quick response to policy needs will be tested in the future.

The AAN has been asked to participate in several national policy forums during the year. Examples have included the National Commission on Children, the Bureau of Health Professions 25th Anniversary Conference, Research on Primary Care Conference, and two forums on women's health. The Academy has also provided written comments on policy issues related to access and strengthening public health under health care reform proposed by the administration. The Committee on National Needs for Biomedical and Behavioral Research Personnel heard recommendations developed by the Academy in collaboration with ANA on the future needs for doctorally prepared nurses. The Academy is beginning to receive requests for experts to serve on national advisory committees and policy work groups on many different topics, such as drug abuse and HIV, hospital staffing and safety, community nursing centers, and primary health care.

The Academy staff has worked with ANA Information Systems to develop a computerized data base that can be updated easily and used to support recommendations of Fellows for national committees, task forces, etc. We are ready to implement E-Mail for use by the Governing Council and Expert Panel Chairpersons and plan to make this available to all fellows with computers as soon as possible.

The first Distinguished Scholar in Residence, a program developed with the Institute of Medicine (IOM) and the American Nurses Foundation, was chosen through a peer review process jointly established by the collaborating organizations. Connie Curran, EdD, RN, FAAN, the first scholar is working with the IOM staff on the topic of the future viability of academic health centers in a climate of health care reform. Future funding for the Distinguished Scholars program is being sought.

Other policy fellows programs are in the process of negotiation with federal agencies and with private foundations. The Governing Council is especially interested in establishing a state policy oriented fellows program.

The agreement with Mosby-Yearbook, Inc. for Nursing Outlook to be the official journal of the Academy has been satisfactory and a three year agreement has been negotiated. Each journal will contain a message from the president, Academy news and updates, as well as advertisements for conferences and publications. The editor is selected by the Governing Council in collaboration with Mosby-Yearbook, Inc. We are committed to making this a premier journal for nursing leaders with Dr. Carole Anderson as the editor.

The Governing Council conducted an evaluation of the Expert Panels and Commission in an effort to develop an infrastructure that will facilitate the work of fellows. Information on the evaluation is provided for you under a separate heading. The Governing Council has also begun to refine the strategic planning process for the AAN and will continue to work on establishing clear priorities during meetings in November, 1993. The strategic planning process involves identifying critical success factors for the Academy, determining the strategies for achieving those factors, and identifying outcome measures of success.

The Membership Committee and the Governing Council continue to discuss the process for fellow selection. There will be a Membership Forum for further discussion of issues related to fellow selection. The Governing Council discussed electronic voting and found that option not to be feasible at this time. Expansion of membership to international fellows and colleagues who are not nurses was discussed and tabled for further study. Included in this mailing is a report on two options for your consideration at the annual meeting: the current membership processes with cost analysis and the enlarged fellow selection committee with cost analysis.

The Governing Council is pleased to honor the Charter Fellows of the Academy at the Twentieth Anniversary Celebration, Monday, November 15, 1993, 6-7:30 pm. This special fund raising reception will feature entertainment by the musical political satire troupe, The Capitol Steps. They are preparing a program that will take a humorous look at many of the serious issues we face in health care reform.

The next annual meeting date for the Academy is set for October 20-23, 1994 in Phoenix, AZ. The theme of the meeting will be the "*Transformation of the Nursing Workforce*". The program planning committee will be appointed at the November, 1993 Governing Council meeting. The 1995 annual meeting will again be held in Washington, DC at the Hyatt Regency on Capitol Hill. The topic recommended by the Governing Council is "*Global Health Issues*".

REPORT OF THE TREASURER

Patricia R. Forni, PhD,RN,FAAN
November, 1993

The Treasurer serves as the Chairperson of the Finance Committee, which prepares the biennial budget, monitors revenues and expenses and recommends financial policies and procedures to the Governing Council. Members of the Finance Committee are Patricia Moritz, PhD,RN,FAAN, and Robert Piemonte, EdD,RN,FAAN.

Several recommendations were made by the Finance Committee and approved by the Governing Council in the past year. These are listed below:

1. A written policy on the reserve funds held by the Academy should be developed wherein a goal of 50% of the operating budget is to be held in reserves with a minimum of 25% to be held in reserves at all times.
2. Program activities should be developed and implemented to assure the financial independence of the Academy with regard to direct costs by a certain date, assuming that ANA will continue to support indirect costs.
3. All educational activities are to be revenue-generating.
4. The Academy should recommend investment guidelines on monies held by the ANF.
5. Academy publications are to be marketed externally to specialty nursing organizations, through press releases, in Nursing Outlook, and to other professional health and consumer organizations.
6. A fund raising reception is recommended to commemorate the 20th anniversary of the Academy, to honor Charter Fellows of the Academy and to increase the funds held in the ANF account.
7. The formula for calculating the amount of the new initiatives fund in the budget should be eliminated with a flat rate being used based on projected activities.
8. Fellows dues will be monitored and delinquent payments followed up with late dues notices and the privileges of fellowship revoked after a third letter is sent that explains procedures for reinstatement, including a \$100 reinstatement fee.
9. A 10% discount on all new AAN publications will be offered to Fellows, and a discount of 20% on older publications.

The 1994 Budget

The Governing Council approved the 1994 AAN budget at its July, 1993 meeting. The total operating revenue for 1994 is \$571,164. This is equal to expected operating expenses.

The 1993 Budget

The total operating revenue budget for 1993 is \$525,756. Total operating expenses are projected at \$570,838, \$45,082 above revenue. A procedure to reduce the cost of mailings was adopted as a result of ongoing concerns of the finance Committee regarding the cost of membership election mailings. As of August, 1993, there was a total of \$79,470 revenue over expenses and an expectation that with ongoing efforts to streamline operations, there will be a positive bottom line at the end of the year.

As of August 31, 1993, the restricted fund held by ANF for AAN totaled \$217,786. This is up from \$206,964 in June 1992. In 1993, Fellows contributed a total of \$2,375 to the ANF held account (donations beyond dues). The only solicitation to Fellows for the restricted fund at this time come with the AAN dues notice in the late fall. Funds have been moved from a money market account to a diversified asset portfolio and US Treasury notes.

Funds held for AAN by ANA total \$378,447 as of August, 1993. The figure for 1992 was \$276,919. Total assets for AAN as of the August 1993 financial statement total \$641,630.

REPORT OF THE PUBLIC RELATIONS COMMITTEE

Patricia A. Moccia, PhD, RN, FAAN, Chairperson
November 1993

The 1993 Public Relations Committee is composed of the following:

Patricia A. Moccia, PhD, RN, FAAN, Chairperson (1989-1993)
Dorothy J. Fishman, EdD, RN, FAAN (1991-1993)
Patricia Sloan, EdD, RN, FAAN (1991-1993)

Grayce M. Sills, PhD, RN, FAAN, serves as the Governing Council's liaison to the committee.

The Public Relations Committee met September 8, 1993 at ANA Headquarters, Washington, DC to review the 1993 Media Award applications.

By consensus, the committee selected the following for the 1993 Media Award:

"Buddy Check-12", a public service project for self-breast examination. The community-wide effort included a video series, instruction cards and reminder stickers for the calendar. The program, submitted by Baptist Medical Center in Jacksonville, Florida, was developed and produced in cooperation with News Channel 12 in Jacksonville.

"Buddy Check 12" presented reports of specific actions taken by women to enhance their health and motivated others to select a partner for monthly reminders to check their breasts. The program has impacted grandchildren, children and women of all ages with broad community involvement of voluntary agencies, corporations and health care provider and is notable for its effective interaction with other local and national efforts to support early detection of breast cancer.

In addition, the Academy awarded five *Certificates of Merit* to the following for motivating actions on the parts of individuals, communities or organizations directed toward enhancing the health and well-being of the American people:

Babysitting Basics - A How-To Workbook for Beginning Babysitters

Submitted by authors Linda P. Christensen and Jackie A. Smith, PhD, the workbook uses 150 illustrations and is written at the fifth grade level for young people, ages 9-11 to teach safety, child-tending skills and first aid. The booklet has gained wide acceptance in classes taught by the American Red Cross, Girl Scouts, 4-H Clubs, YWCA's, YMCA's and hospitals. Over 24,000 copies are in circulation throughout the USA and military bases in Germany and Korea. In New York, Babysitting Basics was used to teach mother/child skills to refugee mothers.

Child Magazine, New York, New York

A series of five articles submitted by Yanick Rice Lamb, Senior Editor, was selected for its potential for motivating health actions of parents with children under age 12. The articles addressed immunization, pain evaluation, vision problems, and childbirth rights. Child Magazine has a circulation of 600,000 nationwide. The Academy recognizes the magazine's ongoing efforts to provide useful health information directly to parents.

Good Morning America - Nursing Feature, May 6, 1992

This video presentation was selected for its focus on the heart, the variety and the autonomy of nurses and nursing. In its unrehearsed reality it affirms the roles and contributions of nurses within a variety of health care situations, including a nurse midwife, and a man who chose nursing as a second career at the Children's Hospital of Buffalo, New York. The program reflected primary care nursing and the partnerships developed by nurses with families and other professional health care providers.

Mental Illness Part 1: The Nurse In Jeopardy**Mental Illness Part 2: The Nurse in Recovery**

This is one of the first videos to directly address the reality of mental illness in nursing was selected. An example of the Texas Peer Assistance Program for Nurses shows depression, chemical abuse, anxiety and bipolar disorders and discusses the need for assisting the mentally ill nurse. The program is targeted to nurses, health care administrators, mental health treatment providers and counselors. The AAN Public Relations Committee recognized its potential as a model for use by State Nursing Associations and others interested in assisting impaired professionals.

Newsweek Magazine

In a series of articles throughout the year, Newsweek Medical Editor Geoffrey Cowley placed AIDS at the forefront of public consciousness. Four stories, "Is a New AIDS Virus Emerging?", "The Mystery Deepens", AIDS or Chronic Fatigue" and "Taming the AIDS Virus" were recognized by the Committee for informing the public and spurring the medical community to action. The content was enhanced by vivid photography which commanded the attention of the reader.

The awards will be presented at the American Academy of Nursing annual banquet on Tuesday, November 16 at 7:00 p.m. in Washington, DC. Representatives of the above-mentioned organizations have been invited to participate in the award presentation.

REPORT OF THE 1993 CONFERENCE PLANNING COMMITTEE

JoAnn E. Glittenberg, PhD,RN,FAAN, Chairperson
November 1993

The Planning Committee for the 1993 Conference, ***"Violence: Nursing Debates the Issues"*** is composed of JoAnn E. Glittenberg, PhD,RN,FAAN, Chairperson; Karen Babich, PhD,RN,FAAN; Jacquelyn C. Campbell, PhD,RN,FAAN, and Ann Whall, PhD,RN,FAAN. Co-Sponsoring organizations and their representatives include: Karen Scipio-Skinner, MS,RN, and Mary Jones Bryant, RN, District of Columbia Nurses Association; and Sadako S. Holmes, MPH, RN, National Black Nurses Association. Other co-sponsoring organizations are: American Association of Critical-Care Nurses; Emergency Nurses Association; and National Association of Hispanic Nurses.

"Violence: Nursing Debates the Issues" will be held November 14-16, 1993 at the Washington Hilton and Towers Hotel in Downtown Washington, DC. The program will immediately follow the American Nurses Association Council of Nurse Researchers 1993 Research Conference at the same site.

The Planning Committee has worked diligently over the past year to develop the unique format for this meeting with invited speakers and workshops. The purpose of the conference is to explore the leadership role of nurses in designing effective anti-violence strategies.

Upon completion of the conference, participants will be able to:

- Evaluate the types and causes of violence and known treatment approaches
- Identify research priorities
- Interact with violence experts and researchers
- Articulate the issues related to gun control
- Draft health and public policy recommendations on the local, state and national levels for the prevention of injuries and deaths from violence for specific populations

*Paid conference participants will be provided with a copy of the conference papers to be published by the American Academy of Nursing.

The conference will include a keynote address by Mark Rosenberg, MD, MPP Acting Associate Director for Public Health Practice, National Center for Injury Prevention and Control, Centers for Disease Control **and Prevention**, will deliver the keynote address at the Academy's 1993 conference. The CDC has made the prevention of violence one of its highest priorities and currently has a variety of projects under way that pertain to reducing the health consequences of violence. The National Plan for Injury Control includes recommendations for the prevention of firearm injuries and guidelines for those who want to develop programs to prevent youth violence in their own communities. The prevention of violence against women is also a very high priority for the CDC.

Conference participants may earn 10.8 contact hours for attending.

REPORT OF THE PUBLICATION ADVISORY COMMITTEE

Shaké Ketefian, PhD,RN,FAAN, Chairperson
November 1993

The Governing Council (GC) appointed a Publication Advisory Committee (PAC) to advise it regarding a publication program for the AAN. The committee has three main goals; these are: (1) To recommend mechanisms to enable the AAN to promulgate and disseminate the products of its intellectual endeavors to the wider community; (2) communicate more regularly with the fellows; (3) serve as a means for generating revenue for the AAN.

Specifically, the charge of the committee is to:

1. Develop a publication program, or plan, for the AAN, including consideration of a range of publications;
2. Develop policies regarding publications;
3. Recommend targeted areas for development (this may in turn suggest areas in which new expert panels or commissions may be appointed);
4. Recommend ways in which the ongoing work of the AAN can be made ready for publications;
5. Plan marketing strategies; utilize available mechanisms, explore new avenues, establish collaborative links, if indicated, with other groups;
6. Develop publication guidelines, including for peer review, editing, preparation of manuscripts for publication, and the like;
7. Develop policies on royalties;
8. Appoint an editor, if indicated, for a given work, review/screen materials, if indicated;
9. Recommend the most efficient mode for publication, e.g. desk-top publishing vs. commercial publishers;
10. Determine if material once published requires updates, warrants a second printing, and the like.

Composition. The committee will be comprised of 3-4 AAN members, with one member being a Governing Council member for close articulation. Once a publication program is initiated and placed on a sound footing, it can be expanded to include members of other disciplines.

Appointment and Reporting. The GC appoints the PAC. The PAC reports to the GC.

EVALUATION OF AAN EXPERT PANELS AND COMMISSIONS

Angela B. McBride, PhD,RN,FAAN, President-Elect
November 1993

The current system of expert panels and commissions organized within AAN has been in existence a relatively short period of time. The revised mission statement and organizational structure were recommended in 1990. Initial implementation occurred in 1991, with many remaining questions about how the expert panels and commissions would be fully operationalized. The primary purpose of the structure was to bring the expertise of Academy Fellows to bear in addressing current and future social and health policy issues.

The original Expert Panels appointed include the following: Infants/Children; Adolescents/Young Adults; Older Adults; Culturally-Sensitive Health Care; Ethics; The Spectrum of HIV Infection; and Violence. Women's Health and International Nursing were added in 1992. Several new topics have been suggested for additional Expert Panels, such as rural health and primary health care. The Governing Council asked that an evaluation of the existing panels and commission be completed before new panels are established.

The Commission on Health Policy was formed as part of the initial implementation of the revised structure. The Commission as originally envisioned, was to provide a forum for the development and implementation of recommended health policies, develop goals for an action plan with input from the expert panels, develop an action plan that includes the review of working documents from expert panels, and develop an evaluation plan.

The evaluation of expert panels/commission(s) that follows is based on written responses from chairpersons/panel members, unsolicited comments from Fellows, and solicited opinion.

It is truly amazing to see the accomplishments of each panel thus far, with modest funding from AAN (\$300) for communications within the panels and broad guidelines to "initiate exploration of the emerging trends and issues in a targeted area". Expert panels were encouraged to develop a working paper addressing problems and potential solutions. Policy issues and recommendations were to be reviewed by the commission and passed on to the Governing Council for approval. Thus far there have been several working papers published in **NURSING OUTLOOK**, draft proposals for demonstration grants to private funding organizations, and a major working paper on Health Care Access prepared by the Commission, circulated to the membership for discussion and comment, and published with broad distribution to federal elected and appointed officials and state nurses associations.

ACCOMPLISHMENTS

PANEL

OUTCOME

Infants/Children

Grant Proposal: Improving the Health of School Aged Children (not funded)

Adolescents

Report: Teenage Pregnancy in the US (draft)

Older Adults	AAN Working Paper: Wellness and Health Promotion of the Elderly (NURSING OUTLOOK 1992)
Culturally/Sensitive Health Care	AAN Working Paper: Culturally Competent Health Care (NURSING OUTLOOK 1992)
Ethics	Working paper (draft)
HIV Infection	AAN resolution and testimony, HIV-infected health care workers, CDC, 1991
Violence	AAN Working Paper: Violence as a Nursing Priority (NURSING OUTLOOK, 1993)

GOALS AND PRIORITIES FOR 1993

PANELS	PLANNED ACTIVITIES
Infants/Children	None at this time
Adolescents	Several members plan to publish papers
Older Adults	Plan "think tank" on HP & Older Adults Develop implementation plan from paper Develop LTC working paper
Culturally-Sensitive HC	Develop implementation plan from paper
Ethics	Compile a current list of individuals interested in ethics Collaborate with other panels Revise working paper on policy & ethics
HIV Infection	Plan "State of the Science" Conference Develop recommendations for AAN meeting 1994
Violence	Plan AAN meeting 1993, "Violence: Nursing Debates the Issues"
Women's Health	First meeting
International Nursing	First meeting; review white paper
Rural Health	First meeting; develop goals
Commission on Health Care Policy	

The Commission on Health Care Policy was appointed in the spring, 1991. Members of the Commission have reviewed draft papers from the expert panels, made recommendations to the panel chairs, and distributed Guidelines for Health Policy Papers. The Commission also developed a monograph entitled *"Access to Health Care: Problems and Policy Recommendations"*.

General Evaluative Comments

Several panel chairs and members offered comments on how the structure is currently working. These comments are listed below:

Strengths

1. The expert panels have focused on timely and important subjects, e.g. AIDS, violence, women's health.
2. Some expert panels have written papers that have been accepted for publication in **NURSING OUTLOOK**, thus setting the stage for the Academy's redesigned journal to have a greater policy oriented stance.
3. The work of the expert panels and the one established commission has shaped program planning at the annual meeting, e.g., the session in 1992 on access and the theme of violence for the 1993 meeting.
4. Fellows with common interests are networking nationally, and find their interactions with colleagues stimulating.
5. Plans are being formulated for new endeavors, e.g. a possible Wingspread Conference, implementation plans for recommendations made in working papers.
6. The ANA has begun to make use of papers generated by expert panels, e.g., the papers on international health and violence.

Limitations

1. The expert panels have been generated by the interests of Fellows, and sometimes that interest is not sustaining.
2. There is no guarantee that the products generated will be used to affect policy, because there is no external demand for the outcomes, e.g., they are not being commissioned as part of a national effort in which nursing is being asked to participate.
3. Some Fellows who join expert panels are not experts in the subject matter, but are using the expert panels as interest groups for learning.
Membership on panels is not consistent from one meeting to the next.
4. No mechanism is in place to evaluate products in order to assess whether they are of the quality to be represented as an Academy paper or statement.
5. The expert panels are described to new Fellows as a means for becoming involved in the Academy, but some expert panels are not at a stage where they welcome new members. Some people perceive the process to be exclusionary.
6. While some principles have been used for creating new expert panels, there is no underlying taxonomy being used to structure the topical divisions so as to represent phenomena of concern to nursing in a comprehensive way.
7. The one commission that was constituted was unclear about its mission, and seemed to function as another expert panel committed to writing a paper.

The expectation that the work of the expert panels would inform the work of the commission was not realized.

8. There is not enough time allocated during the AAN annual meeting for the panels to discuss issues, work on reports, develop plans, and receive comments from colleagues.
9. There is a problem in obtaining timely feedback from the Commission and from the Governing Council on papers and policy recommendations.
10. The panels and commission are underfunded for the work that is expected from volunteers and the AAN staff is too small to provide staff support on an ongoing basis. Funding of activities is inconsistent across panels and volunteers are unsure of how to access funds that are available.

Environmental Scan

Since the expert panels/commission(s) were first proposed, several significant changes have taken place that may call for rethinking of the structure and role of these mechanisms.

1. There are improved collegial relations with ANA, e.g., ANA is increasingly turning to the AAN for commissioned papers in meeting the nursing agenda.
2. The political climate has changed nationally and there is greater interest in phenomena of concern to nursing.
3. An infrastructure has finally been put into place at the AAN, e.g., the Director is in a position to be able to know what topics federal agencies and private foundations are working on and which ones would value collaborating with the AAN.
4. Collaboration between the AAN and the IOM has increased, and steps are being taken to develop closer working relationships between AAN, IOM, and other health policy organizations.

Recommendations

Options for discussion are presented below that focus on Commissions, Expert Panels, and Ad Hoc Policy Analysis Groups. It is important to remember that the original focus was on the involvement of the membership and that topics and involvement in a panel originated with individual members (bottom up approach). Many of the recommendations presented here are approaches to structure the process and link with others involved in the public policy debate.

General Recommendations

1. Encourage the President/Director to appoint an ad hoc advisory group to provide advice on issues the Academy may wish to consider for future development or for policy forum discussions. The Governing Council will review the progress of the expert panels and will consider establishing new expert panels and disbanding panels when activities are completed.
2. Each member of the Governing Council will be asked to be a liaison person for

specified expert panels and be responsible for timely communication regarding necessary actions in response to expert panels. Strengthen the linkages between expert panels and the Governing Council so that policy recommendations may be developed and acted upon.

3. Designate a part of the Governing Council agenda at the annual meeting for the review of goals and accomplishments for each expert panel.

4. Establish formal linkages with other health policy organizations such as the IOM, OTA, the Brookings Institute, NIH, AHCPR, HRSA, etc.

4. Develop guidelines for expert panel papers for publication either in **NURSING OUTLOOK**, as manuscripts or executive summaries, or as AAN monographs.

5. Organize twice a year telephone conference calls among the members of the Governing Council, AAN officers, and Expert Panel Chairs to establish and coordinate agendas, review progress, and prepare for the annual meetings. Other methods for encouraging synergism among the panels, the membership, and the Governing Council need to be explored.

6. Consider the adoption of internal mechanisms and structures for the review and approval by the Fellows of public policies developed by expert panels and approved by the Governing Council.

7. Undertake a major initiative to educate Fellows in the art and practice of developing and influencing public policies. Special meetings, workshops, policy fellowships, and annual meeting activities should be devoted to this effort.

Expert Panels

1. Require a proposal clearly outlining the work or expected product of each panel. The framework and steps of the action plan outlined by the Commission may be used for this purpose. The proposal will be reviewed by the Governing Council before a decision is made to fund the panel project.

2. Panel membership will be specified by the Chair of the Panel in collaboration with the officers of the Academy and with consultation from the membership. The Chair will be appointed by the President.

3. Open panel meetings, forums will be held at the AAN annual meeting to apprise the fellowship of progress or issues.

4. Expert panel members will be allocated 2 to 3 hours for intense work on their objectives at AAN annual meetings.

5. Each panel will submit a yearly budget to achieve their specific objectives at a time that coincides with the AAN budget development process. Progress reports will be submitted to the Governing Council at the annual meeting.

6. Each panel will be reviewed by the Governing Council every two years to determine if they have accomplished their objectives. Expert panels will be discontinued when they have completed their work.

7. New panels may be proposed by members, or charged by the Governing Council for a specific purpose or focus.

Ad Hoc Policy Analysis Groups

1. Encourage members to participate in policy analysis groups that may meet on an ad hoc basis during AAN annual meetings. Topics of interest will be identified prior to meetings so that background papers and meeting space will be available. Group leaders will be identified based on expertise. Policy analysis groups do not need Governing Council approval nor do they require AAN funds.

2. Policy analysis groups may evolve into expert panels if specific objectives are established. A proposal and budget request could be submitted to the Governing Council.

AMERICAN ACADEMY OF NURSING

FORUM ON MEMBERSHIP

Description, Cost Analysis and Proposal

November 1993



CURRENT MEMBERSHIP PROCESS and COST ANALYSIS

Six-Person Membership Committee and Member Voting)

General Description

The existing membership process allows for a 6-person Membership Committee composed of six duly elected members of the Academy for terms of two years, half of whom are elected each year. Fellows may serve no more than two consecutive terms on the Membership Committee.

The Membership Committee has the responsibility for:

- 1) Soliciting candidates for Fellowship in the Academy
- 2) Disseminating information to potential candidates regarding procedure and qualifications
- 3) Reviewing completed applications and preparing the ballot for election of new Fellows
- 4) Reviewing application forms, selected criteria, and selection procedures and recommending changes to the Governing Council
- 5) Reporting on the selection process to the Academy
- 6) Reviewing and approving requests for inactive status

The Membership Committee meets once a year to review applications and prepare the ballot. The Chairperson of the Membership Committee is appointed by the Governing Council. Membership on the committee precludes sponsoring applicants for membership.

Ballots and copies of all applications and sponsor statements (5 pages each) are sent to the entire Academy membership for voting. The following page contains a summary of voting for the past five years, indicating an average return of ballots of 61%. The chart indicates that an average of 39% of all ballots sent out are disregarded (*or not received*). For 1992 this means that 323 members disregarded the ballots costing \$23.70 per member or \$7,655.00.

Also attached is a cost analysis of the current membership voting process.

SUMMARY OF VOTING 1989-1993

YEAR	NUMBER OF APPLICANTS	NUMBER SELECTED for BALLOT	NUMBER ELECTED	NUMBER OF RETURNS	NUMBER OF MEMBERS	%RETURN
1993	150	76	73	606	910	67%
1992	179	116	109	499	822	61%
1991	157	122	114	417	708	58%
1990	127	107	104	424	616	68%
1989	92	62	60	335	551	60%

(1993 - 6 person-Membership Committee and full member voting)

ITEM	STAFF ACTION	COMMITTEE ACTION	EXPENSE	REVENUE
1. Call for Nominations a. photocopying	Develop/copy applications, cover letters, instructions 2 hours (\$53.06)	Chair approves application and cover letter .5 hour	6 pages x 900 @ \$.05/pg \$270	
b. mailing	stuff envelopes; labels on envelopes 2 hours (\$53.06)	none	\$.52 x 900 \$468	
2. Receipt of applications	preliminary check of criteria (SNA member #); enter names into data base; filing; follow up on complete applications 40 hours (\$1061.12)	none		150 X \$50 = \$7500
3. Receipt confirmation - post card mailing	photocopy and mail card to sponsors and candidates 2 hours (\$53.06)	none	150 candidates; 300 sponsors X \$.19 postage = \$85.50	
4. Rating sheets and preliminary rating to Membership Committee	distribute applications and C.V.s among the Committee; copy rating sheets and instructions 4 hours (\$106.12)	Review applications and C.V.s; rate based on criteria (50 applications x each committee member) 40 hours	\$5.00 x 6 committee = \$30.00	
5. Receipt/Calculation of rating sheets	enter data into Excel to determine mean of scores and distribution of scores 3 hours (\$79.59)			
6. Membership Committee Meeting	preparation of files and meeting materials; develop post-meeting reports 20 hours (\$530.60)	Meet in Washington for 3 days to review each application and select candidates for ballot	6 committee x 2 days x \$1000 = \$6000	
7. Ballot printing	order ballots; submit list of names for ballot to I/S dept.; print ballots 10 hours (\$265.30)		3000 sheets ballot paper \$410.00	
8. Photocopy Applications	photocopy applications and sponsor statements for all candidates to appear on ballot 6 hours (\$159.18)		5 pages x 76 candidates x \$.04/page X 917 = \$14,000	

ITEM	STAFF ACTION	COMMITTEE ACTION	EXPENSE	REVENUE
9. Mail Ballots and Applications	coordinate with mail house on collating and mailing process (mail house will handle task of mailing) 40 hours (\$1061.12)		9 attachments x 900 members = \$5000 Postage x 900 = \$2500	
10. Receipt of ballots	secure Teller; scan ballots; draft report 3 hours (\$79.59)			
11. Notify candidates and sponsors of election results	prepare personalized mailing 5 hours (\$132.65)		75 x 3 x \$.29 = \$65.25	
		TOTAL EXPENSES:	\$28,828.75	
		TOTAL REVENUES:		\$ 7500
	TOTAL STAFF COST: \$ 3,660.98	TOTAL EXPENSES OVER REVENUES	\$21,328.75 = \$23.70 cost per Fellow = \$142.19 per applicant	

PROPOSAL:
15-MEMBER FELLOW SELECTION COMMITTEE AND COST ANALYSIS

General Description

A 15-member Fellow Selection committee is proposed to provide for a high quality of decision-making in a cost-effective manner. The proposed restructuring requires substituting the current voting by all fellows of the Academy on a ballot prepared by the Membership Committee, with a selection process by a Fellow Selection Committee, 10 of whom will be elected by the fellows of the Academy on a rotating schedule (two-year term), and 5 of whom will be appointed by the Governing Council to ensure ethnic, geographic, and professional diversity.

The Fellow Selection Committee will have the responsibility for:

- 1) Soliciting candidates for Fellowship in the Academy
- 2) Disseminating information to potential candidates regarding procedure and qualifications
- 3) Reviewing completed applications and all materials presented in support of a nomination for fellowship, including the nominee's curriculum vitae, the nominee's statement supporting their potential to contribute to the Academy, and statements from two sponsors concerning the significance of the nominee's sustained contributions to nursing and potential to contribute to the Academy.
- 4) Selection Committee will vote on membership in the Academy based on their review of candidates. Selection for fellowship will require a two-thirds majority vote of the Selection Committee.
- 5) Reviewing application forms, selected criteria, and selection procedures and recommend changes to the Governing Council
- 6) Reporting on the selection process to the Academy
- 7) Reviewing and approving requests for inactive status

The Selection Committee will meet once a year at Academy headquarters to conduct the selection process. The Chairperson of the Selection Committee is to be appointed by the Governing Council from among those elected to serve on the Committee. Membership on the committee will preclude sponsoring applicants for membership.

PROPOSED MEMBERSHIP SELECTION COMMITTEE COST ANALYSIS
(15-Member Committee - no voting by members)

ITEM	STAFF ACTION	COMMITTEE ACTION	EXPENSE	REVENUE
1. Call for Nominations a. photocopying	develop/copy applications, cover letters, instructions 2 hours (\$53.06)	Chair approves application and cover letter .5 hour	6 pages x 900 @ \$.05/pg \$270	
b. mailing	stuff envelopes; labels on envelopes 2 hours (\$53.06)	none	\$.52 x 900 \$468	
2. Receipt of applications	preliminary check of criteria (SNA member #); enter names into data base; filing; follow up on complete applications 40 hours (\$1061.12)	none		150 X \$50 = \$7500
3. Receipt confirmation - post card mailing	photocopy and mail card to sponsors and candidates 2 hours (\$53.06)	none	150 candidates x \$.19; 300 sponsors x \$.19 postage = \$114	
4. Rating sheets and preliminary rating to Membership Committee	distribute applications and C.V.s among the 15-members of the Selection Committee; copy rating sheets and instructions 10 hours (\$265.30)	Review applications and C.V.s; rate based on criteria (150 applications x each committee member) 120 hours	\$5.50 postage x 15 committee = \$82.50 5 pgs x 150 applications x 15 copies each @ \$.05 = \$563.50	
5. Receipt/Calculation of rating sheets	enter data into Excel to determine mean of scores and distribution of scores 6 hours (\$159.18)			
6. Membership Committee Meeting	preparation of files and meeting materials; develop post-meeting reports 20 hours (\$530.60)	Meet in Washington for 2 days to review each application and select candidates for ballot	15 committee x 2 days x \$1000 = \$15,000	
7. Notify candidates and sponsors of election results	prepare personalized mailing 5 hours (\$132.65)		75 x 3 x \$.29 = \$65.25	

ITEM	STAFF ACTION	COMMITTEE ACTION	EXPENSE	REVENUE
		TOTAL EXPENSES:	\$16,562.25	
		TOTAL REVENUES:		\$ 7500
	TOTAL STAFF COST: \$2,308.03	TOTAL EXPENSES OVER REVENUES \$9,062.25	TOTAL COST PER FELLOW: \$9.53 TOTAL COST PER APPLICANT: \$60.41	



he Capitol Steps, the only group in America that attempts to be funnier than Congress, is a troupe of current and former Congressional staffers who monitor events and personalities on Capitol Hill, in the Oval Office, and in other centers of power and prestige around the world and then take a humorous look at serious issues while providing a nationwide laugh for millions.

Over the past 11 years the group has recorded 11 albums, including: "76 Bad Loans," "We Arm the World," "Stand By Your Dan," and "Fools on the Hill," also the title of their new book. Their albums have sold about 100,000 copies nationwide, and they perform three hundred shows a year all over the country, covering territory from Traverse City, Michigan to Tallahassee and from Pasadena to Pensacola.



The Steps have been featured on three national specials for public television, "Good Morning, America" "The Late Show," "Entertainment Tonight," "Nightline," "The Today Show," "20/20," "CBS Morning News," "ABC's World News Tonight," "NBC Nightly News," and for several years on National Public Radio's "All Things Considered."

Many celebrities and politicians, some of whom have been targets themselves, have performed with the troupe: Sam Donaldson, Secretary Cheney, Vice President Gore, Pat Robertson, Surgeon General Koop, Fawn Hall, and President Bush, to name a few. In fact, the Steps have performed for Presidents Ford, Reagan, Bush, and Clinton.



All of the members have worked on Capitol Hill, some for Democrats, some for Republicans, and some for politicians who sit firmly on the fence. Thanks to the trials and tribulations, scandals and screwups of our elected officials, there's never a shortage of material.



Capitol Steps

Musical Political Satire

Would You Rather See
Famous Public Figures?

OR... Watch Us Make Fun Of Them?!!

"They're the best.
There's no one like them,
no one in their league."
Larry King, CNN

"Washington's
Favorite Political
Cabaret Troupe"
The Washington Post

"!@#*!@,
you guys are funny!"
Tom Clancy, Author

"The Capitol Steps
make it easier, to
leave public office"
President
George Bush



For Bookings And Information Call (703) 683-8330

1505 KING STREET - ALEXANDRIA, VA 22314

REMINDER ON EXPERT PANELS

The Academy Expert Panels have two designated meeting times this year at the Annual Meeting in Washington, DC. Each Expert Panel will develop a plan with specific goals and budget requests for 1994, to be reviewed by the Governing Council on November 17.

Monday, November 15, 1993

7:30 pm - 9:30 pm (immediately following the 20th Anniversary Reception)

Tuesday, November 16, 1993

1:30 pm - 3:00 pm

If you are a member of an expert panel, please be sure to be in attendance.

OPEN FORUM OF EXPERT PANELS

An open forum for Expert Panels to discuss their work is scheduled for Tuesday, November 16, 1993 from 3:00 pm to 3:30 pm, just prior to the Annual Business Meeting. If you are interested in the work of an Expert Panel, please plan to attend. The following Expert Panels will be meeting:

Infants/Children	Doris England, PhD, RN, FAAN, Chairperson
Adolescents/Young Adults	Chairperson to be appointed
Older Adults	Barbara Given, PhD, RN, FAAN, Chairperson
Spectrum of HIV Infection	William Holzemer, PhD, RN, FAAN, Chairperson
Ethics	Chairperson to be appointed
Culturally Competent Health Care	Afaf Meleis, PhD, RN, FAAN, Chairperson
Violence	Jacqueline Campbell, PhD, RN, FAAN, Chairperson
International Nursing	Mi Ja Kim, PhD, RN, FAAN, Chairperson
Women's Health	Nancy F. Woods, PhD, RN, FAAN, Chairperson

MEETINGS OF AD HOC POLICY ANALYSIS GROUPS

Open, informal discussion meetings will be held on Tuesday, November 16 from 1:30 pm to 3:00 pm to explore the potential formation of two new Expert Panels:

Quality of Clinical Care, Judith A. Ryan, PhD, RN, FAAN, Contact

Workforce Projections, Shirley A. Girouard, PhD, RN, FAAN, Contact

BREAKFAST WITH THE EDITOR

COMPLIMENTS OF MOSBY YEARBOOK

Monday, November 15, 1993
7:30 a.m.

First-come, first-served -- Register in advance to guarantee your seat!

Objectives:

- discuss the new mission statement of *Nursing Outlook*
- describe the priorities of the new editor, Carole A. Anderson
- become familiar with author guidelines and manuscript deadlines

☐ YES. I will attend **BREAKFAST WITH THE EDITOR** ON NOVEMBER 15.

NAME _____

PLACE OF BUSINESS _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____

Please mail or fax with registration form to:

AMERICAN ACADEMY OF NURSING
600 Maryland Ave., S.W. - Suite 100 West
Washington, DC 20024-2571

WHILE YOU ARE IN WASHINGTON ...

The American Academy of Nursing is happy to offer pre-arranged tours of favorite Washington, D.C. destinations on Wednesday, November 17 beginning at 9:30 a.m. A description of each tour follows.

If you wish to participate, please fill out the form below and mail it before the deadline of **November 10, 1993**.

WASHINGTON, DC TOUR RESERVATION FORM

YES! I would like to register for the following tour: (please choose only one)

- ☐ Washington National Cathedral \$22.00 per person
☐ The National Museum of Women in the Arts \$35.00 per person

Last Name _____ First _____ MI _____

Employer _____

Mailing Address _____

City _____ State _____ Zip _____

Phone: Business _____ Home _____ FAX _____

TOTAL AMOUNT DUE: _____ AAN FEDERAL ID # 13189 39-23

Method of Payment: I have enclosed my ☐ Check ☐ Money order (Make check payable to American Academy of Nursing.)

I wish to charge the following credit card: ☐ VISA ☐ MasterCard ☐ American Express

Amount \$ _____ Card # _____

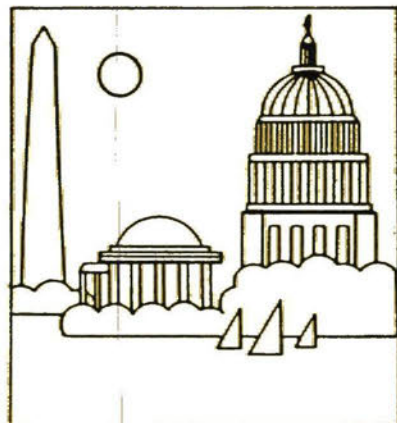
Name on Card _____ Expiration Date _____

Signature _____

Note: If the minimum number of persons required to book the tour is not met, the tour will be cancelled and your money will be refunded to you.

MAIL BY NOVEMBER 10 TO:

American Academy of Nursing
Attn: Leslie Zeck
600 Maryland Avenue, S.W.
Suite 100 West
Washington, DC 20024-2571
202-554-4444, ext. 152
OR SEND BY FAX: 202-554-2262



WASHINGTON NATIONAL CATHEDRAL

"AMEN.....Eight Decades in the Making and Wonderfully Crafted, the Washington National Cathedral is Finally Done"

Three structures dominate the Washington Skyline, the United States Capitol, the Washington Monument, and the Cathedral Church of Saint Peter and Saint Paul, often called the National Cathedral or Washington Cathedral.

The laying of the "awesome" Cathedral's stone foundation was on September 29, 1907. It is the sixth largest cathedral in the world and the second largest in the United States.

The best way to grasp the size and beauty of Washington Cathedral is to circle it on foot with your docent. You will see the pulpit made of stone which came from Canterbury Cathedral in England. It was from the Canterbury Pulpit that Dr. Martin Luther King, Jr., delivered his last sermon before he was killed.

The Gloria in Excelsis Tower is the only one in the world to contain both a 53-bell carillon and a 10-bell ring used in the ancient art of "change" bell ringing.

The above tour is a must for those persons interested in history, art, stained glass and needlework.

En route back to the hotel, we will travel through Embassy Row. Requests for specific embassy viewing are always welcome and will be included with advance notification! We will also pass by the Vice President's residence.

**\$ 22.00 Per Person
(20 Person Minimum)**

Above Includes:

- * Bus Transportation**
- * Professional Guide**
- * Contribution to National Cathedral**
- * All Taxes and Gratuities**

Tour Date:

**Wednesday, November 17
Bus leaves at 9:30 a.m.**

THE NATIONAL MUSEUM OF WOMEN IN THE ARTS
MUSEUM TOUR
TEA AND COOKIES

The National Museum of Women in the Arts, located several blocks from the White House, is the only institution in the world whose primary purpose is to celebrate the achievements of women artists.

Ironically, it is housed in a landmark building that was formerly an all male bastion. Completed in 1911, the building at the intersection of New York Avenue and 13th Street, was designed as a Masonic Temple. The aim of the renaissance revival design was to create a structure of great dignity and simplicity, and entirely in keeping with the classic public buildings for which Washington is well known.

The National Museum of Women in the Arts, recognizing that women are under represented in museum collections, see this museum as a means of the contribution women have made to the history of art.

Our docent will show us the collection which spans from five centuries. There are 500 paintings, prints, drawings, sculptures and pottery, by two hundred and fifty artists, from twenty-five different countries.

After our guided tour, we will visit the museum cafe for tea.

Menu

- * Individual Pots of Assorted Herbal & Flavored Teas
- * Mineral Water with Lemon
- * Assortment of Miniature Pastries
- * Raisin and Plain Scones with Sweet Cream, Butter, Jam and Honey

\$35.00 Per Person
(20 Person Minimum)

What is Included:

- * Bus Transportation
- * Professional Guide
 - * Entrance Fee
 - * Tea and Pastries
- * All Taxes and Gratuities

Tour Date:

Wednesday, November 17
Bus leaves at 9:30 a.m.

The American
Academy
of Nursing in
cooperation with

- ▶ American Nurses
Association
- ▶ Association of
Nurses in AIDS Care
- ▶ Oncology
Nursing Society
- ▶ Division of Nursing,
BHPr, HRSA
- ▶ Division of HIV
Services, BHRD,
HRSA
- ▶ National Institute of
Nursing Research,
NIH
- ▶ AIDS Education and
Training Centers,
HRSA

HIV/AIDS NURSING CARE SUMMIT



January 27-29, 1994
Hyatt Capitol Hill
Washington, DC



Don't miss this unique opportunity to join health care providers, educators, researchers, and consumers in Washington to develop a state-of-the-art plan for the nursing care needs of the second decade of the HIV/AIDS epidemic.

- ▶ Examine the impact of the first decade of the HIV/AIDS epidemic on nursing care for patients and families
- ▶ Anticipate the impact of the second decade of the HIV/AIDS epidemic on patient care and nursing practice
- ▶ Prioritize a research agenda for patient care and nursing practice that is responsive to patient care needs anticipated during the second decade of the HIV/AIDS epidemic;
- ▶ Make recommendations for academic and continuing education activities for nurses caring for HIV/AIDS patients during the second decade
- ▶ Examine the ways in which knowledge and experience gained in responding to the HIV/AIDS epidemic contribute to our larger understanding of society, health, patient care, and nursing practice.

Panels, plenary sessions, workgroups, PHS Regional discussions

Guest Speaker: KRISTINE M. GEBBIE, MN, RN, FAAN,
new AIDS Policy Coordinator at the White House (invited)

CALL FOR POSTERS: Submit for peer review a one page description that reports on innovative research, education or practice projects for possible presentation.

For information call: Leslie Zeck 202/554-4444 ext. 152



American Academy of Nursing

Established 1973 Under the Aegis of the American Nurses' Association

HIV/AIDS NURSING CARE SUMMIT

CALL FOR ABSTRACTS FOR POSTER PRESENTATION

The American Academy of Nursing announces the call for abstracts for posters that report on innovative research, education or practice projects for the upcoming ***HIV/AIDS Nursing Care Summit*** to be held in Washington, DC, January 27-29, 1994. The Summit is being presented in conjunction with: American Nurses Association, Association of Nurses in AIDS Care, Oncology Nursing Society, Division of Nursing, BHP, HRSA, Division of HIV Services, BHRD, HRSA, National Institute of Nursing Research, NIH, and the AIDS Education and Training Center, HRSA.

The abstracts will be reviewed by the AAN Expert Panel on HIV, which is chaired by William Holzemer, PHD, RN, FAAN. Posters will be presented at a Resource Center and Reception entitled: ***Celebrating Nursing*** on Thursday, January 27 from 6:00 pm to 8:00 pm, and will be displayed on Friday, January 28, 1994.

The purpose of the HIV/AIDS Nursing Care Summit is to assess the impact of the first decade of the HIV/AIDS epidemic on health and patient care from the perspectives of health care providers, educators, researchers, and consumers, in order to plan for the client care needs for the second decade of the HIV/AIDS epidemic.

Instructions for abstract submission are attached. For questions or additional information, please contact Leslie Zeck, conference coordinator, at 202-554-4444, ext. 152 or Jan Heinrich, DrPH, RN, FAAN, director, ext. 150.

LZ:hivconfabstract.ltr
9/22/93

CALL FOR POSTERS

HIV/AIDS Nursing Care Summit

January 27-29, 1994

Hyatt Regency Capitol Hill
Washington, DC

Persons wishing to contribute abstracts for posters to be considered for presentation at the American Academy of Nursing HIV/AIDS Nursing Care Summit must submit this form **no later than MONDAY, November 1, 1993** to: AMERICAN ACADEMY OF NURSING, 600 MARYLAND AVENUE, S.W., SUITE 100 WEST, WASHINGTON, DC 20024-2571.

INSTRUCTIONS

1. Type title of project in bold, upper case letters, and center on page above description.
2. Type names of project director/coordinators, institution/organization, city and state, and phone number in bold letters and centered under project title.
3. Type abstract text, flush left, single-spaced, within parameters of box, using standard size type (10 or 11 pt.)
4. Complete both sides of abstract form.
5. Abstract should be of camera ready quality.
6. Send original abstract and nine copies of the abstract, accompanied by a self-addressed stamped envelope for notification of acceptance or rejection.
7. Enclose a stamped, self-addressed POSTCARD if you want notification of receipt of abstract.
8. FAX copies of the abstract will NOT be accepted.
9. If requirements and instructions are not followed, abstract will not be considered for review by the American Academy of Nursing Expert Panel on Violence.
10. Audio/visual presentations will not be accepted.

Deadline for receipt of abstracts is November 1, 1993.
Notification of acceptance will be mailed in December, 1993.

Please include the following:

1. Name of Project/Program
2. Statement of issue
3. Description of nursing interventions/practice
4. Program funding



AMERICAN ACADEMY OF NURSING
HIV/AIDS NURSING CARE SUMMIT
ABSTRACT SUBMISSION FOR POSTER PRESENTATION

PROJECT TITLE: _____

NAME: _____

**ORGANIZATION/
INSTITUTION** _____

TITLE: _____

ADDRESS: _____

CITY: _____ **ST** _____ **ZIP** _____

TELEPHONE: _____

FAX: _____

PLEASE TYPE ABSTRACT ON REVERSE AND SUBMIT NO LATER THAN
NOVEMBER 1, 1993 TO:

Leslie Zeck, Conference Coordinator
American Academy of Nursing
600 Maryland Avenue, S.W.
Suite 100 West
Washington, DC 20024-2571
202-554-4444, ext. 152

DO NOT EXTEND BEYOND PARAMETERS OF BOX

Audio/Visual Presentations Will Not Be Permitted.



