

**FIRST LADY HILLARY RODHAM CLINTON
REMARKS TO THE AMERICAN NURSES ASSOCIATION
SAN ANTONIO, TEXAS
JUNE 11, 1994**

DRAFT

[Acknowledgments: Virginia (Ginna) Trotter Betts]

It's a pleasure to be here with all of you who have devoted so much energy and wisdom to health care reform. I know the President expressed his thanks to you in person last month, not just for your work, but also for the award you established in honor of Virginia Kelley.

Those of us who were fortunate enough to know the President's mother knew how dedicated she was to the nursing profession. Like the nurses of the ANA, she was on the front lines of our health care system every day, often treating people who were very ill. She took that role very seriously. To her, nursing was a calling, one that demanded exceptional dedication and skill.

That's why the ideas and insights of the ANA leadership are so critical to this health care debate. Your members have a unique relationship with patients. Your members have a unique perspective on the way care is delivered. And you have a unique ability to help us achieve reform that is real, and lasting, and substantive.

My husband is fond of joking that I had never set foot in a hospital until my daughter was born. But in the past few years I've had many occasions to visit hospitals -- when my father was sick last year, and also on trips around the country when I was gathering information about reform.

What strikes me over and over is the skill and compassion of those of you in the nursing field. And that has been true since the inception of nursing as an organized profession in the 19th century.

We all know about Florence Nightingale's courageous work in the Crimean War and her system of training nurses. We know about Clara Barton's selfless determination in tending to the wounded as an unpaid nurse during the Civil War (a career, by the way, that she followed only after resigning from her original job as a teacher when a man was promoted over her). And, of course, we know that she later founded the American Red Cross.

These are the mothers of the modern nursing profession, the women whose credo of commitment to helping others continues to

inspire more than 2 million nurses in America today.

Yet that philosophy of care is jeopardized more and more by a health care system that is gravely out of whack.

[anecdotes from your travels]

As leaders of the ANA, you recognize the stakes in this health care debate. You know first-hand, in very human terms, what reform can mean for our health care system.

You know that uncompensated care and cost-shifting have disrupted the system in ways that compromise quality and wreak havoc on the rest of our economy.

About 27 percent of hospitals have begun downsizing their workforces. And, although nurses are one of the most critical links in the delivery of health care to patients, too many nurses are being laid off around the country.

Critics of reform would have you believe nurses are losing their jobs because hospitals are restructuring in anticipation of reform. But that's a pretty simplistic -- and wholly inaccurate -- explanation. Uncompensated care, cost shifting, too much paperwork, and all of the other things that contribute to spiraling health care costs and reductions in hospital staffing existed before reform.

And those problems will only get worse if we don't achieve reform now. For one, we know from study after study that the level of hospital staffing is correlated to patient care. Fewer nurses means lower quality. Fewer nurses means higher mortality rates. Fewer nurses means more medical complications, longer hospital stays, and higher costs.

We can't afford to keep moving in the wrong direction.

But how do we change course?

The cornerstone of reform -- the most important factor in solving the problems I've just outlined -- is to make sure that every American is guaranteed private health insurance.

When Linda Shinn [executive director of the ANA] testified before the Senate Labor and Human Resources Committee last October, she talked about how nurses see people every day who are denied care because they lack adequate insurance.

* Universal coverage is an economic and a moral imperative.

* Health care reform will lead our nation to a philosophy

of primary and preventive care in which nurses will play a crucial role.

* Reform will augment the training and preparation of health care providers, including all kinds of nurses.

* Reform will enable patients to choose their health care providers and to maintain long, trusting relationships with doctors and nurses.

It's fair to say that the ANA's "Agenda for Reform" is mirrored in the President's approach.

Already we have ample evidence that nurses can play a broader role -- as well as help improve quality and reduce overall costs -- while serving patients in a variety of settings.

From Philadelphia, to Tuscon, to the Beethoven Project in Chicago, to Washington state, there are certified nurse specialists treating low birthweight babies in homes, serving as midwives, providing care for older Americans in their homes, working inside corporations to expand preventive services, working out of trailers and churches and recreations centers to bring basic health care to low-income and rural populations, and working in schools to immunize children.

In all of these ways, and in all of these settings, nurses are helping improve our system that we can cut costs, improve quality, and make our communities healthier.

In the coming weeks and months, Congress will act on health care legislation. This is not a time for incrementalism. It is not a time to stumble and bumble and only go half the distance to the finish line.

If we don't guarantee coverage to everyone, employers will continue to drop coverage and millions of families -- most of them hard-working citizens -- will be denied coverage and care. Costs will continued to spiral out of control. Prices will get higher and higher.

As nurses, you know the importance of holistic treatments -- of treating the entire patient, not just one symptom here and one there.

The same holistic approach must prevail with health care reform. Band-aid treatment will not suffice when our whole system needs a transfusion.

A couple of days ago, the President and I returned from a week-long trip to Europe to commemorate D-Day and the beginning of the end of World War II. Every day, at every stop -- in Italy,

in England, and in France -- we were reminded that ordinary men and women sometimes come together to accomplish extraordinary things. Often against extraordinary odds.

I'm reminded of the heroism, the commitment, the courage of those World War II veterans because we are at one of those singular -- if more subtle -- moments in history right now.

This is a rare opportunity. It may be our last opportunity. That's why all of us who care about the health of our families, our friends, our neighbors -- and our nation -- must step up and make our voices heard.

I urge every member of the ANA -- every one of you and all the nurses you represent -- to write your member of Congress. Call your senators. Tell them the American people cannot afford half-baked reform. And tell them that Americans who work hard every day and play by the rules deserve more than half-hearted solutions to our health care crisis.

With your help, we will succeed, and our nation will be healthier and happier because of it.

Thank you very much.

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much longer period of time as a percentage of your income. So even if you're going to take a job that doesn't pay a lot of money, you'll always be able to limit your repayment to a percentage of your income.

So we've lowered the interest rates and made the repayments easier. And that should mean that no one should ever be discouraged from going to college again, even if they have to borrow the money, because they can pay it back in a responsible and bearable fashion.

Ms. Casey. Where do you want to go to school?

Q. URI.

The President. A paid political announcement. [Laughter]

Infrastructure Improvements

[A participant asked what has been done to rebuild America's infrastructure.]

The President. First of all, we have fully funded for 2 years in a row now the ISTEA program, the intermodal transportation program that was adopted several years ago, to make sure we can push the money out more quickly. Secondly, I have now our people studying, with the benefit of folks from all over the country who are experts in transportation investment, what other options we have, short of some big tax increase which I don't think we can enact, to increase the funding flowing to infrastructure investments, and especially to road and bridge improvement.

These things, by the way, create a lot of jobs in the economy, and they're basically good-paying jobs. And they often go to people who otherwise couldn't get them. And they dramatically increase the society's productivity.

Many of the Asian countries that we're competing with that have far higher savings rates are spending massive amounts of money on fast trains, on new airports, on major new transportation systems. So it's a big issue in terms of our long-term economic health. And I believe—keep in mind we're keeping a pretty fast pace here. I had to work on the economy first and then pass the education programs. And now we're working on the health care and the crime bill.

Q. A lot of bumpy roads.

The President. A lot of bumpy roads. But I think we will have an infrastructure built to take some advantage of this, but not until early next year in 1995.

Mr. White. Mr. President, thank you ever so much. Unfortunately, we are just about out of time. We want to thank you very much for coming to visit not only Rhode Island but us here at Channel 10.

The President. Thank you.

Mr. White. Our 10 Town Meeting is coming to a close. And we'd like to invite you, Mr. President, if you'd like, to stay behind and say hello to some of our friends.

The President. Thank you. I have very much enjoyed this. The questions were wonderful, and I thank the folks in Springfield and New Haven, too.

NOTE: The town meeting began at 8 p.m. at the WJAR-TV studio. The President was introduced by moderators Doug White and Ginger Casey. A tape was not available for verification of the content of these remarks.

Remarks to the American Nurses Association Conference

May 10, 1994

Thank you so much. Thank you for your warm welcome. And thank you, Ginna, for that award.

I arrived a few moments ago, and I remember the first time I ever heard your president speak. I knew that she had worked for Vice President Gore, and I thought it was so interesting to hear the head of a national association who was speaking without an accent. [Laughter]

I want to say a special word of appreciation to your first vice president, Ellen Sanders, who's participated in White House and congressional meetings on health reform, and to Diane Weaver, the president of the Association of Nurse Executives, who cosponsored this breakfast.

I am very proud to share the stage today with all the fine nurses in the executive and the legislative branches whom you have honored. And I thank you for doing that. And I thank them for their service. I also want to say a special word of thanks to all of you and to the ANA for the courage and the vi-

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sion you have demonstrated by fighting for health care reform, and the right kind of health care reform, long before it was a hot issue. As you know, the position paper you put out on national health reform probably more closely parallels the recommendations that our administration has made than that of any other professional health care group in the country. And I thank you for that very much.

I want to thank you, too, for recognizing my mother, who worked for 30 years and then some as a nurse and was deeply proud of what she did. I remember when I was little boy watching her get up in the middle of the night always starting work by 7 a.m. or 7:30 a.m. in the morning, always telling me stories that indicated that there was literally nothing in the world more important to her than dealing with a person frightened, in pain, with a caring and effective manner. This award will help to expand the frontiers of nursing in the areas of women's health, something that she would have been very proud to be a part of.

My mother, as all of you now know, completed her memoirs, which became her autobiography shortly before she died. She went over about half of it and was able to do the final editing. And it was my privilege after she passed away to work with the author and just try to make sure all the facts were right. I got very stern instructions from her. She said, "Now if you have to do this do not change one word I said about you"—[laughter]—"especially the part about your manners not always being great." [Laughter] "And make sure you get the facts straight. Otherwise leave it alone."

But I was very pleased with the two book reviews that her book got yesterday. One by the great American author, Joyce Carol Oates in the New York Times, and then another one here in the Washington Post. But it tickled me, the one in the Washington Post said that if you read this book, you would understand why I perplexed people in Washington. I was actually brought up by real people, and occasionally I still acted like one. [Laughter] I didn't know what that—[laughter]—I'm trying to get over it, but it's hard even here.

Anyway, here's something my mother said about her work, which would apply to all of

you and those whom you represent. But it meant a lot to me. It was just her words. "Nurse anesthetist work is all-consuming. You don't do it halfway. You don't daydream. You don't let your emotions wander. You're the person responsible for putting another human being into a state of unconsciousness, somewhere between life and death. For 30 years, from the minute that I would walk into the operating room and start talking to the patient and begin putting him to sleep, until I got him safely back to the recovery room, nothing in the world could have crossed my mind. I don't care what problems were on the outside. I don't care what problems I might have been having at home. I never thought of my life beyond the moment."

I remember when I was also a child, things were somewhat more informal. My mother used to take me to the hospital and let me meet the other nurses and the doctors and watch the emergency room and watch people go into the operating room. It was utterly fascinating. And the work you do has always sort of captured my imagination.

My own wife had never been in a hospital before in her entire life until our daughter was born, never been in a hospital for any kind of sickness. And learned only a few moments before the happy event that she was going to have to have a C-section. And we had gone through Lamaze, and we had done all this stuff, and I was supposed to be in the operating room. And our hospital at that time had never before let a father into the delivery room if it wasn't a natural birth. It was a big deal. So I said, "Look, I've been watching people get cut on and bleed since I was a little boy. I'll do fine." [Laughter] "But she had never been here before, and she may not—you better let me come in." [Laughter] So they did and actually changed the policy so that if fathers had been through the Lamaze course and then the mothers eventually had to have a C-section, they got to go. So I felt—that's my one contribution to medical advances. [Laughter]

But I owe all that to my mother, who was a remarkably determined woman in the face of often excruciating adversity. I think one of the reasons that the Nurses Association has been so forthright about this health care reform issue is that you see it from the grass-

roots up in human terms and you don't get so hung up as some people do on all the political rhetoric and the positioning and the characterizations that have, frankly, put a lot of Members of Congress at a severe disadvantage because they haven't had the chance to spend the time and make the effort to deal with this issue that you have. It is, after all, a mind-bendingly complex problem. It's 14.5 percent of our income, and for people who don't live in it every day, it can be a very difficult thing.

But I just wanted to thank you because I believe that the personal experiences you have shared, so many of you common to the ones that my own mother shared, really animated the Nurses Association to take the position that you have taken.

I want to emphasize today that what I seek, contrary to the attacks, and what you have sought, is not a Government-run health system, it's a private insurance health system that covers everybody, where the health care professionals run it and not the insurance companies. That's what we seek.

We seek private insurance that can never be taken away. It's wrong to treat seriously ill children in an emergency room who could have been treated more easily and more inexpensively if their parents had just had the coverage. With our reforms, every family will have that kind of quality insurance. We ought to reform the insurance system that today often only covers the healthiest people and even then will deny them coverage for anything they've been sick with before.

When you go to a patient's bedside, you ask, "Why does it hurt? Where does it hurt? How can I help?" You don't ask whether this is a preexisting condition you're looking at. [Laughter] It's a very important issue.

If you think about all this preexisting condition business, there are 81 million Americans who live in families where there's been a child with diabetes or a mother that had cancer prematurely or a father that had an early heart attack or some other problem. I see these people everywhere. This is no small number. Now, we get action lickety-split up here all the time when a million people or 2 million people are adversely affected by something if they are well organized. But these 81 million people, they're professionals

and blue-collar workers; they're old folks and young folks; they're all different kinds of people; and they are by definition disorganized. There is no national association of people with preexisting conditions. [Laughter] You think about it; if there were, and 10 million of them showed up here, we'd have health care reform so fast you couldn't blink.

You must be their voice in an organized way. And you can be. So we ought to cover everybody with private insurance, and we ought to have insurance reforms that deal with preexisting conditions and don't discriminate people based on age. This is somewhat controversial. I know that. But I believe if we went back to health insurance the way it originally was when Blue Cross first started writing it, where everybody was put in a large group, risk was broadly spread, and people paid a fee against the day when they would be sick, it would be fairer for all Americans. And our economy would work better, our society would have a stronger sense of community, our families would function better. People would be free of a lot of the anxiety that comes—

Hillary and I have received about a million letters. And whenever I go somewhere now, they arrange for some of the letter writers to come see me. And it's just gripping to see people just over and over and over and stunning to see how they do come from all walks of life and how they have been broken by the things which have happened.

The third thing I think we should do is to preserve the Medicare program. It's interesting, the people who criticize our program say this is Government-run health care which, of course, it isn't. And if you tried to take away Medicare, which is a Government-funded health care, well, they would be up in a tree somewhere screaming about it.

But we don't want to do anything to the Medicare program, except to make it better. I do believe we should add a prescription drug benefit and phase in long-term care that is community-based or home-based for two simple reasons. One is, there are an awful lot of elderly people who aren't poor enough to be on Medicaid but aren't well off, who have significant medical bills. We know the elderly use 4 times the prescription drugs

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Now, most Americans, believe it or not, don't know either one of those things, even though they may be caught up in it, and I think it's very important. Our plan is designed, number one, to increase the choices that consumers have. We're moving to more managed care. There can be a lot of good things in it, but under our plan, every year, every person would have a choice between at least three plans, or among at least three plans but in all probability many more. And number two, under our plan, medical profes-

What's going to happen is we'll continue to see these trends occur unless we find a way to give health care providers reimbursement for all the people for whom they care, at an appropriate level in an appropriate way. More than a decade of research now shows

that more and better trained nurses result in shorter hospital stays, better survival rates, fewer complications, whether you're dealing with low birthweight babies or older people.

You do not have to work for the Congressional Budget Office to understand that healthier patients and shorter stays means lower health care costs. Sometimes I think if you do work for the Congressional Budget Office you will never get that, but—[laughter]—we're working pretty well on the whole. This is a big deal. This choice issue and maintaining an array of qualified people doing the things for which they are best qualified is terribly important.

Finally, let me say—and this, I guess, is, except for this whole issue of whether this is a Government program, which it isn't, is the most controversial part of it—our reform is based on providing guaranteed benefits at work. Now the reason for that is simple, for the people in this country that have health insurance, 9 out of 10 of them have it at work where there is some shared responsibility between the employer and the employee. For the people who don't have insurance, 8 out of 10 of them have someone in their family who is working.

It seems to me that the fairest and simplest, and if you will, the most conservative way to achieve universal coverage, to have health care security for everybody, is to ask employers and employees who aren't doing anything or barely doing anything to do more so that they can fulfill their own responsibilities and then use tax funds to cover the unemployed, uninsured people for whom you could say, "Well, there's a general responsibility just like Medicare and Medicaid" and then organize the market so that smaller businesses and self-employed people, (a) get discounts if they need it and (b) are able to buy good insurance on the same terms that those of us who are insured by Government or larger businesses can.

Now it seems to me that is a fair and simple and obvious way to do this. I think that any other way will sooner or later involve either a radical change, that is, getting rid of the whole health insurance market and substituting taxes for it, or involve people who are already paying too much for their own health care, having to pay something for peo-

ple who won't do anything for themselves because they say they should be exempt.

Now I think that this is a very important issue. You know, again, we lose sight of the fact that most small businesses are making an effort to cover their employees. We have brought hundreds and hundreds of small businesses to Washington to talk to the Congress, but they are not organized. There is no association called: small businesses who cover their employees and are mad their competitors don't and mad they can't get better insurance rates—[laughter]—and wish somebody would help them. So an association that may have a lot of folks in the insurance industry, along with other small businesses, says, "Don't do this; the whole small business economy will break," says this, and there's no association on the other side. You have to be their voice.

Had a car dealer from a town of 7,000 people in Arkansas up staying with me the other night, he and his wife, long-time friends of mine. She's a college teacher. He's a car dealer. He said to me the other night—it was funny—he said, "You know, for 20 years I have been feeling sorry for myself because I've provided a good health plan for my employees, and none of my competitors did." So he said, "I was so happy when you proposed this just because I thought I was going to get even." [Laughter] And then he said, "But you know, then I remembered that in the last 20 years I put three of my competitors out of business. And I'm making more money than I ever have. And the reason is I still got the same folks working for me I had 20 years ago because I gave them health benefits."

And yesterday I went to New York and I visited this Pathmark store. They have 175 stores, 28,000 employees, the 10th biggest supermarket chain in the country. We're all told, "Oh, if you do this, the retailing business will go to pieces." These people have put new stores in inner-city areas that other chains would not touch, fine new stores. They are making money, and they have always provided comprehensive health benefits to their employees. And they are now sacking their groceries in a bag that says they favor health care benefits to all Americans, guaranteed through the workplace.

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I say this to you because, as you know, there are a lot of nurses that don't have any health care coverage and a lot of nurses who are single parents who don't have health care coverage. And this is the other point I want to make that I did to all those young people working in that grocery store yesterday: Everybody now in Washington is for welfare reform, and I guess it means different things to different people. But I have basically a 3-point strategy to achieve what I think would end the welfare system as we know it: One was embodied in last year's economic plan, lower income taxes for working people who are hovering just above the poverty line with children. This year one in six American working families will be eligible for lower income taxes so they can succeed at work and can succeed as parents.

Strategy number two, give people education and training and then give them a certain amount of time to find a job. And if they don't, require them to take it. And if they can't, provide some public subsidy in the private sector or some publicly funded job so that work is preferable to welfare.

Strategy number three has got to be cover the people with health insurance. Consider this: All these people on welfare in this country who are dying to get off—and by the way, that's most of them—who are dying to get off, most of them have limited education. Suppose they go through a little training program and they get a job that pays a modest wage but is still more than the welfare benefits. But they go to work for an employer who does not provide for health care.

Think about this: You are a mother with two children. You give up being on welfare to take a job that pays more than the welfare check, but you lose health care coverage for your kids. What are you going to do if your kid has to go to the dentist? What are you going to do if your child is desperately ill? How are you going to feel every week, every 2 weeks or every month when you get your paycheck and you see what's taken out of it in taxes and you realize those taxes are going to pay for the health care benefits of people who decided to stay on welfare instead of going to work? You don't have to be as bright as a tree full of owls to figure out that this doesn't make a lot of sense. [Laughter]

Now a lot of American nurses are in this situation today, getting up every day, slaving away, trying to take care of people who have children without insurance, caring for people who come into their office who are on public assistance who have children with insurance because of the Medicaid program. It is not fair. It is not right. It is not smart.

And you could say, "Well, all this inability to cover everybody, if this were fueling some enormous American economic expansion, because we were saving so much money on health care, maybe you could deal with that." But the truth is we're spending over 40 percent more of our income on health care than any other country in the world. Oh yes, some of it because we're more violent, and that's something we pay for. Some of it because we have better medical research and technology, and that's worth paying for. But a whole lot of it, as you well know, is because of the way we have financed health care, which has employed hundreds of thousands of people in doctors' offices, in clinics, in hospitals, and in insurance companies to read the fine print on thousands and thousands of policies to see who and what is not covered. And it has rifled inefficiencies through this system that we are all paying for.

We can fix this. We can fix it by having a law which fixes what's wrong, keeps what's right, provides health care security to everybody through a private system, increases the choices consumers have, and increases the decisions that doctors and nurses and other qualified providers make without oversight by others. We can do it.

In order to do it, we have to recognize we have to go through a fog of misinformation, a torrent of labels which aren't right, and recognize, too, that you have to lobby and stand up for, in an organized and very personal way, that great association that doesn't exist, the association of 81 million Americans and families with preexisting conditions, the association of hundreds of thousands of small businesses who are doing the right thing and being punished for it, the association of all the poor women in this country who are out there working their hearts out and their fingers to the bone to do right by their kids without health insurance and paying taxes for people on public assistance

who have it for their children. All of those associations are disorganized.

You have devoted your lives to providing health care to all Americans. You have honored my favorite nurse today. You have given me a chance to hope that my mother and my grandmother are looking down on me thinking I was the first generation in three that didn't produce anybody that was caring for other people in health care. So they think at least I walked off with the award today. [Laughter.] It means more to me than I can say.

But the determination that my mother showed in getting up off the pavement many times in her life is the same sort of determination you have to show for us to get health care reform this year. And remember, most of these Members of Congress want to do the right thing. But they don't know what you know; they haven't spent the time that you've spent; they haven't had the experiences you have had. You have to help them. And the people in their districts that really need their help are not in those great national associations.

You keep them in your mind and keep that example in your mind. Don't let this year go by. We can do this this year with your help and your leadership.

Thank you, and God bless you all.

NOTE: The President spoke at 9:56 a.m. in the Regency A Ballroom at the Hyatt Regency. In his remarks, he referred to Virginia Trotter Betts, president, American Nurses Association. A tape was not available for verification of the content of these remarks.

Remarks to the Advisory Committee on Trade Policy and Negotiations

May 10, 1994

Thank you for being here and thank you for that warm welcome. As all of you know, this is the first meeting of our Advisory Committee on Trade Policy and Negotiations and the Intergovernmental and Policy Advisory Committee.

There are a lot of people in this room with whom I have worked for many years on a wide variety of issues, especially on the economy. I am pleased with where we are going.

You may know the blue chip forecast came out today, saying that there is no sign of inflation in the economy this year and next year and predicting a growth rate in the range of 3.5 percent this year, which means a continued effort to create jobs and move our economy forward. In the last 15 months or so, our economy has produced about 3 million jobs, most of them in the private sector, which is a real departure in terms of the percentage of new jobs in the private sector from the last few years, a million jobs in the first 4 months of this year, over a quarter of a million in April alone.

So, I'm encouraged about the direction in which we are going. The Congress is moving rapidly to adopt the budget that I sent up which, if adopted as it is, will eliminate 100 programs, cut 200 more, still save some new money for education and training, for Head Start, for new technologies, for medical research; but represent the first overall reduction in domestic discretionary spending since 1969. And it will produce the first 3 years of declining deficits since Harry Truman was President if this budget passes.

So I think we are moving in the right direction. But we all know we have to do more to try to spark global economic growth and to spark growth in our country from global economic affairs. Last year we had NAFTA, we had APEC meeting, we had an export policy which involved removing any number of items from export controls which had previously been placed on them during the cold war. And we've continued that work in this year.

But the most important thing we can do this year, plainly, if we want to create hundreds of thousands of high-paying jobs in America, is for Congress to ratify the GATT agreement. The Uruguay round cuts tariffs by over a third on manufactured products. Three-quarters of the world's trade growth over the next decade will come from the developing world, and GATT is expanded to cover things that it formerly has not covered, including intellectual property and services. We have got to adopt the GATT in the Congress this year.

This is about exports and jobs. It's also about our leadership in the world. We broke 7 years of global gridlock last year to get this

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Plenary Address

"Building Blocks of Health Reform: Health Information and Quality Assessment"

A National Conference Co-sponsored By:

American Medical Peer Review Association
Coalition for Consumer Protection and Quality
in Health Care Reform
National Association of Health Data Organizations
National Business Coalition on Health

Washington, D.C. May 12, 1994

Omni Shoreham Hotel

Improving Quality Under Health Care Reform

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Department of Health and Human Services

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INTRODUCTION

Good morning. It's a pleasure to be here. I especially welcome this opportunity to meet you for whom the term "quality" is a defining purpose -- not simply a "buzzword." I am also excited to be here because this meeting symbolizes a "partnership" that I personally am committed to 100% - a "partnership" to improve quality of care.

1994, is almost certain to be our generation's best chance for health care reform. The groundwork for this was laid over the last two years as strong Presidential leadership helped to keep health care reform at the forefront of the public policy debate. The President's commitment to universal coverage coupled with real cost containment strategies has framed the ensuing debate. As you have just heard, the Congress is now moving ahead to fashion a bill that will garner the support needed to result in enactment this year.

The President's proposal to achieve universal coverage while containing costs builds on what works in our system today while eliminating the insurance practices that have contributed to the current crisis. No longer will plans be

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able to compete on the basis of low risk selection and benefit package designs that use confusing fine print to deny necessary services. Under the new system, a level playing field -- where everyone is insured, health plans must accept those who choose to enroll, and consumers, not employers, are the ones making the decisions -- creates a stronger competitive market based on the quality and cost of the service offered. This approach will work only if we commit ourselves to a comprehensive national strategy for quality management that is grounded on accurate, reliable, and science based comparative information. It is this strategy that I wish to speak to you about today. It is also a strategy that enjoys significant support in Congress as you have just heard. Finally, it is a strategy that is incorporated into most of the major proposals before Congress and recognizes a clear federal role in assuring health care quality.

FOCUS ON QUALITY - WHY NOW?

But before describing this component of health reform, it is important to remember the setting within which the national debate is occurring. Health care reform is now taking place -- and will continue to take place -- even without national legislation. Health care reform is already a reality for many States, some of which are well ahead of the Federal government. In fact, nearly every

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State has initiated or enacted measures to improve access to health care and to contain costs.

But even without State-level action, significant changes have occurred and will continue in the way that medical care is delivered in this country. For example, managed care enrollment has grown by an average 13% per year since 1980, and 45 million people were enrolled in HMO's last year. In fact, in 1993, 51% of employees were in some form of managed care, in large part because fewer employees were offered a conventional fee-for-service plan by their employer. The strong incentives in managed care to contain costs which could lead to underutilization of effective services has been a concern of many and has activated consumer groups across the Nation. Their voice is helping to shape the debate today in Congress, pushing for enhance consumer protection provisions and real commitments to quality improvement.

This move toward organized risk-bearing delivery systems, though clearly stemming from the imperative to control costs, has also been coupled with increasing interest on the part of purchasers of health care, generally employers today, in getting value for their health care dollar, or "value purchasing". Managed care organizations and health care providers are coming under growing pressure to prove that they offer high quality, cost-effective care. In

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fact, a recent report by Foster Higgins showed that more than 70% of the plans and providers they surveyed had received requests for outcomes data in the last year and that these requests largely came from employers [92%]. Plans are responding to this new demand of the market and a number of plans are investing significant resources in beginning to document and report their performance through report cards which include information on health outcomes.

This focus on outcomes is also driven by the increasing body of scientific literature showing that variations in care stem largely from differences in physician practice style and are rarely linked to differences in health outcomes. Estimates of the amount of care provided that is unnecessary vary from 10% to 40%. Similarly, variations in outcomes across regions and sites have shown us that where one is cared for and who provides the care can have dramatic impact on outcome, even after adjusting for risk factors. The fact that high rates of unnecessary care are not unique to this country -- they exist in most industrialized countries -- points to the fact that just changing the way care is financed or organized will not eliminate waste or reduce inappropriate care. Understanding what works -- and what does not -- and communicating this effectively to providers AND patients to inform clinical decisionmaking is what is essential to improving the quality of care.

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**THE HEALTH SECURITY ACT: A COMPREHENSIVE NATIONAL STRATEGY TO
IMPROVE QUALITY**

The ultimate goal of national health reform is to improve the health status of Americans by improving the quality of health services and enabling consumer to become partners in their health care. To achieve this, the Health Security Act creates a national framework where a market with a level playing field is maintained and the information that is made available to consumers to activate the market is unbiased, valid and reliable. It also recognizes that certain standards must be incorporated to assure that consumers are protected. Finally, the Act adopts an approach where plans, providers, and consumers each share a responsibility for improved quality.

The Federal government supports this new market through education and research, thus providing the scientific underpinning of performance monitoring and quality improvement. Plans, providers, and regional quality foundations implement quality improvement strategies, while the market rewards efficient quality performance through consumer choice and market share.

The Administration's approach to quality management rests on three interrelated strategies. First, it provides information for consumer choice through

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performance measurement. Second, it expands the tools and information available for quality improvement, including:

- the establishment of dynamic, community based, organizations focused on quality;
- expansions in outcomes and quality research and technology assessment;
- a new and comprehensive strategy for maximizing the effectiveness of clinical practice guidelines; and
- expansions in research on the prevention of diseases and disorders.

Third, it includes several provisions for consumer protection designed to assure that consumers know what they are getting, have opportunities to question practices, and plans are held accountable for their practices. Each of these three approaches has at its core a commitment to producing and providing information, moving us beyond the "black box" of medical care and health care systems, to a system that is explicit and accountable.

This information will come from many sources. The Health Security Act includes important provisions for the creation of a new framework for health data and information systems. These systems would provide the information needed to support the administration and operations of the health care system,

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advance public health objectives and programs, and monitor the implementation of health reform and assess its impact.

The basic features of this new system include a universal health security card, uniform health data sets for enrollment and encounter information, electronic data transmission and a data network that includes regional data centers. All of these features are currently being discussed as they understandably raise many issues such as the role of the regional data organizations, questions as to data ownership, the actual nature of a public / private partnership approach to implementation of this system, and the determinants of access to and uses of the information.

But the information needs of a dynamic quality management system go well beyond the data system being proposed. Administrative data sets will be only one source of information on quality. Others will include medical records and surveys of both consumers and plans.

Administrative data sets which include encounter and enrollment information will provide many of the items necessary for performance monitoring, by furnishing values for both denominator and numerators in rate determinations. However these data sets will also serve a second, important

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function by providing the sampling frames for the conduct of both consumer surveys and targeted medical record reviews.

Populations likely to be underserved or to have poor experiences with the health care system could be identified and selectively surveyed. Individuals with complex conditions could be selected and their medical records reviewed to identify processes of care likely to benefit from quality improvement strategies. The examples of such types of applications are many.

Now I would like to discuss in more detail the 3 components of the quality improvement strategy.

I. INFORMATION FOR CONSUMER CHOICE

Consumers make choices at three stages in their health care and each of these decision points will require different types of information. First, individuals select a health plan to provide coverage for themselves and their family. Next, they choose a health care provider from whom they will receive the majority of their care. Often, these first two decisions are intertwined, as many will choose their health plan based on their ability to establish or maintain a relationship with a particular physician or group of providers. The third time

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that consumers make important decisions about their health care is when they are confronted with having to select a course of treatment for a health problem that has been identified. Plan selection, provider selection, and choice of care management - all of these decision points are opportunities for rewarding quality, effectiveness, and efficiency.

Standardized report cards will provide the vehicle for informing plan choice decisions by including indicators of plan performance on a number of dimensions. In contrast, provider choice decisions will initially continue to be based on simple information about the types, locations, and qualifications of providers available rather than on indicators of their relative performance. As the science of quality measurement improves and large statistically sound data bases are developed, performance measures of individual providers will evolve. Plans, PRO's, and quality improvement foundations are actively developing these now to help internal quality improvement. Consumers will ultimately want access to this information as well. Finally, participation of patients in the decisions of care management must be enhanced by the availability of educational materials translating outcomes research, effectiveness trials, and practice guidelines for the consumer, enabling them to discuss their treatment options with their provider. This newly evolving field of "shared decisionmaking" often supported by technology such as interactive video discs,

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will strengthen the hand of consumers in improving quality.

I would like to comment here that as part of the health reform and quality debate, there is not much talk about costs or the "R" word. Well how do you discuss the interface between quality and costs without the "R" word? In fact, it is very easy. Reducing rates of unnecessary surgery by 50% through utilization review, pre-admission certification, or some other bureaucratic process is viewed as the R word - rationing - by the consumer. However, achieving the same reduction in unnecessary surgery through "shared decision-making" with consumers is considered "GOOD CHOICE". Now which sounds better: Good choice or Rationing?

For consumers to make all of these decisions, they will need standardized information that is not only valid and scientifically based but UNDERSTANDABLE to them so that it actually enables them to make choices that result in improved quality. This need for accurate, timely, and scientifically based information that is uniform across plans and practice settings provides the rationale for a STRONG FEDERAL RESPONSIBILITY in assuring the empirical base for performance measurement and quality improvement.

This federal responsibility is exercised in partnership with the National

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Quality Management Council, an advisory body of private citizens with representation from plans, providers, and the purchasers of care. The Health Security Act charges the Council with developing a set of national measures of quality performance indicators to encompass the following dimensions:

- access to health care by consumers;
- appropriateness of care;
- outcomes of care;
- health promotion and disease prevention; and
- consumer satisfaction with care.

These indicators will be chosen to reflect the full range of services provided by plans under the comprehensive benefit package and therefore will include physical and mental health services, substance abuse services, dental and vision care. Reliability, validity, and links to health outcomes are other criteria that will guide selection of the set of measures.

It is clear that some of these criteria for indicator selection will be more easily met than others. In certain areas, significant investments in research and development must be made. It is for this reason that the Agency for Health Care Policy and Research is already moving ahead on a number of initiatives to support the implementation of performance monitoring and quality improvement.

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The Agency provides the government locus for proactive investments in the science of quality measurement and will support an expanded research and demonstration program in quality improvement. The Administration's bill calls for an increase in health services research of \$500 million in 1996 of which a large part will go to outcomes research, technology assessment, effectiveness trials, quality measurement, and quality improvement. We hope to begin much of this work in FY 1995 and will do this in partnership with our sister agency HCFA and with organizations like yours.

The data required for the production of valid and comparable report cards will come from a number of sources. As most of the performance indicators will focus on plan performance, enrollment and encounter data sets will be the source of both denominator data for service utilization rates as well as performance in certain areas, such as immunization rates or the utilization of preventive health services, or survival rates for surgeries. As I mentioned earlier, encounter and enrollment data sets will also serve as sampling frames for the identification of records to be the source of more detailed clinical information on certain conditions. It is for these reasons that a symbiotic relationship between Health Data Organizations and Regional Quality Foundations must be developed.

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However, to truly reflect quality performance and aid consumer choice, report cards must also include information on patient access to and satisfaction with care. To be valid and uniform across plans, this information must come from standardized consumer surveys that address not only satisfaction, access, and health status and perceived health outcomes from specific care encounters.

Here again, the imperative for unbiased information calls for clear federal leadership in the development and implementation of these surveys, which are specified in the Act to be plan by plan, state by state and include a focus on vulnerable populations. The AHCPR is committed to this fundamental aspect of accountability and consumer empowerment and is now moving ahead with efforts to both better understand what it is that consumers want to know and to identify areas where more research is needed.

We have already convened representatives of consumer groups and consumer researchers. We are holding a series of focus groups, and this summer a national poll will be conducted to identify what consumers want to know about quality. Finally, we are planning a national conference in September to bring together consumer groups and scientists working in consumer survey research to define the scope and content of a model national consumer survey. We realize that this is an area where the industry itself is currently very active

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and it is my hope that we can work together as this will only improve the final product - a standardized, state of the art, national strategy on consumer surveys.

II. TOOLS AND INFORMATION FOR QUALITY IMPROVEMENT

The second foundation of the President's strategy for health care quality is the establishment of an infrastructure for quality improvement that is enriched by ongoing investments in the essential tools of quality improvement. As this audience well knows, quality improvement in health care is a dynamic, iterative process which must be continually updated by the latest advancements in science as well as detailed information on organizational and clinical best practices. It therefore requires an approach that establishes and nurtures partnerships between researchers, providers, and consumers, and emphasizes the quick diffusion of new information into clinical practice.

This partnership is embodied in the health reform debate by the Regional Professional Foundations or the Quality Improvement Foundations - a term developed in part by AMPRA. The functions and governance of the Regional Quality Foundations is being currently debated in Congress. However, whatever their final form, to be successful they must:

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- 1) forge real trust between professionals and consumers;
- 2) be seen as resources by plans and providers;
- 3) be capable of using the latest tools for quality improvement; and
- 4) be partners with researchers in developing new tools.

In a new system based on quality and accountability, the AHCPR is responsible for the development of the essential information tools for quality improvement. The Regional Quality Foundations provide the laboratory for the testing and refining these new tools as well as assuring their timely diffusion into health plans. Finally, health plans are responsible for incorporating these advances into the real world of health care practice. But this is not a one way flow of information. Innovations in quality improvement strategies at the plan and Foundation level must also inform and guide further investments in research and development by AHCPR. Just as in a Venn diagram, each player has both unique as well as shared responsibilities. The essential feature of this relationship is the constant flow of information and the commitment to science and innovation as the driving forces in quality management.

The tools for quality improvement to be developed by the AHCPR include:

- information from outcomes and effectiveness research - including effectiveness trials;

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- **technology assessments and clinical practice guidelines;and finally**
- **research on methodological issues related to quality.**

Significant expansions in our outcomes research portfolio will provide the science base for the development of new guidelines, while moving AHCPR into effectiveness trials will assure that gaps in knowledge identified by outcomes research are addressed. Other areas which must also receive significant attention are cost effectiveness research methods, systems research, and risk adjustment and severity measures.

In the areas of technology assessment and clinical practice guidelines AHCPR will adopt a fundamentally different strategy that I am very excited about. In a restructured market driven by efficiency, quality, and the provision of a standard benefit package, technology assessment takes on an even more crucial role in assuring that coverage decisions are based on science and that these decisions result in cost-effective allocation of resources. AHCPR was given in 1993 a broader responsibility to set priorities for, coordinate, and conduct technology assessments in a timely manner. Beginning this fall, AHCPR will significantly expand its activities in this area to meet that challenge.

The role of the agency in clinical practice guidelines must be re-thought.

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It is clear from the current debate and the direction of the market today that guidelines will play an increasing role in assuring the provision of appropriate, effective, and COST-effective care. The demand for science based and timely information will only increase. To respond to this demand, AHCPR will not only speed up the development of guidelines, but re-focus its activities toward a strategy that maximizes federal and private sector investments in guideline development. This new strategy is detailed in the Health Security Act and includes the establishment of standards for guideline development and charging AHCPR with the evaluation, certification, and dissemination of guidelines, including those produced by other groups. This approach will significantly expand the efficiency and timeliness of the process, and allow AHCPR guideline development activities to focus only on those conditions or populations not likely to be otherwise addressed.

Publishing a guideline is only the beginning and alone will not result in the behavioral change that we are seeking from both providers and patients. We must promote the integration of guidelines into practice, evaluate their impact, and learn from each one how best to present information to both providers and patients. The Regional Quality Foundations of the future provide an ideal laboratory for much of this process.

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Finally, AHCPR must advance the science of quality improvement strategies themselves - what methods are successful, which lead to quantifiable change, which organizational and financing structures are most suited to which types of management approaches, the questions are many.

III. CONSUMER PROTECTION

The third and final strategy for quality management in the President's approach is consumer protection. While we firmly believe that a commitment to a pro-active quality improvement philosophy will assure quality, we recognize that it must be coupled with real and uniform safeguards for patients. The Health Security Act lays out a number of provisions to achieve this. In the new system, health plans are held accountable at each step of their interactions with the patients they serve. First, States will certify plans for doing business in that State based on a number of criteria, including the quality of the plan, the plan's financial stability, and finally, the plan's ability to deliver the comprehensive benefit package to the service area.

Disclosure requirements will assure that plans adhere to truth in marketing standards, inform consumers of their rights and responsibilities, and publish their utilization management procedures. In addition, plans must

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establish explicit grievance procedures with clear timelines for resolution, a second, de novo review, and expedited review in urgent cases as well as disclosure of reasons for denial of a claim. In addition, an ombudsman at the alliance level, complaint review offices at the State level, and finally additional legal remedies are provided for instances when a grievance procedure fails to resolve a patient complaint.

However, consumer protection in the Health Security Act go beyond this and establishes a national framework for privacy protection for individually identifiable health information. This framework provides much greater protection than now exists. Individuals would be guaranteed certain rights concerning the use of information contained about them in the system and their unique identification number could not be used to link health information in the system with other sources of data about the individual.

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IN CONCLUDING -- let me just emphasize what a tremendous opportunity we have before us to achieve major reforms and improvements in this Nation's health care system. As part of this reform, I hope that I have made it as clear to you as it is to me how important valid, reliable, and science based information will be to the new system. Whether it is used to inform consumer choice or clinical decisionmaking, or to drive quality improvement strategies, or finally to assure safeguards in the system for consumers, information is the key to creating and maintaining the market environment this country needs to contain costs and improve quality.

THANK YOU

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LENGTH: 604 words

HEADLINE: Ariz. Hospital operating first nursing HMO

BYLINE: Linda Perry

BODY:

A hospital in Arizona is operating what is believed to be the first nursing health maintenance organization.

The nursing division of St. Mary's Hospital and Health Center in Tucson formed an HMO to deliver nursing services to senior citizens enrolled in Medicare's risk-contract program. Some 15,000 senior citizens are enrolled in the program. The nursing HMO has provided services to 700 enrollees since June 1, 1990, when the program began.

St. Mary's declined to identify the Medicare risk contractor.

The hospital, which also provides inpatient and outpatient medical services to Medicare recipients enrolled in the HMO program, believes integration of medical and nursing services will lead to a decrease in the average length of stay.

The nursing HMO is based on the concept of case management. Twenty-two nursing case managers oversee patient care, ensuring that each patient's ailments are cared for in the most economical setting.

The managers arrange for inpatient and outpatient stays. They also help patients locate other community services, such as subsidized transportation for the elderly.

"A lot of elderly people operate under a knowledge deficit," said Carol Falk, who manages the nursing HMO. St. Mary's case managers have found that most of their clients don't know about the myriad public and not-for-profit services available for the elderly, she said.

After a hospital stay, elderly patients, particularly those who live alone, often require home nursing care or at least some help cooking and cleaning. If those services are provided, patients often can leave the hospital earlier than they'd be able to otherwise, reducing the length of stay and the cost of care.

Another important determinant of length of stay is "where in the episode of care hospitalization takes place," said John Halfen, chief financial officer of the hospital group that includes St. Mary's; St. Joseph's Hospital and Health Center, Tucson; and Holy Cross Hospital and Health Center, Nogales, Ariz.

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FOCUS

St. Louis-based Health Care Corp. of the Sisters of St. Joseph of Carondelet owns the facilities.

Because case managers are in touch with patients on a regular basis, they know when a patient's chronic illness becomes acute, requiring hospitalization.

Without constant monitoring, patients often don't receive care until they're so sick that an abnormally long hospital stay is required.

Since the program's inception, the average length of stay for enrollees has been cut in half, but hospital executives declined to reveal that number.

The nursing HMO also emphasizes education and prevention.

"We want to move beyond acute illness. We want to look at healthcare from the state of health rather than only focusing on the state of disease," Ms. Falk said.

For example, nurses taught one diabetic patient how to give herself insulin injections at home. Before the patient was enrolled in the program, she traveled to the hospital every day for her injection.

The nursing division spends about \$ 5 per enrollee and is reimbursed for about 50% of that amount, but the hospital is renegotiating the contract, Mr. Halfen said.

Under the ideal contract, the hospital would receive a set amount of money per enrollee for all medical and nursing services. Under the current contract, the hospital is paid on a per diem basis for inpatient services and a discounted charge basis for outpatient services, he said.

Ultimately, St. Mary's wants to structure every HMO contract so the hospital is at risk financially, using the case-management system to efficiently manage the costs of providing care.

LANGUAGE: ENGLISH

Who Would Incremental Reform Really Hurt? Middle Class Families

Some propose an incremental approach to health reforms aimed not at guaranteed coverage for everyone, but at trying to increase the number of people with some insurance reforms and subsidies for the poor. Employers could continue to drop coverage, and millions of families would continue to go without insurance.

It's hard-working Americans -- the middle class -- who would be hurt by such an approach. It's middle class families who will continue to lose their coverage when they change a job; to take out a second mortgage to pay the bills from a child's illness, to forego career advancement for fear of losing the coverage they have with their current job.

Besides, all the evidence suggests an incremental approach won't work; in fact, health reform that falls short of universal coverage could actually make things worse. Millions would remain uncovered, including some previously insured through their company. Costs would not be controlled, leading to higher prices for working families and a ballooning federal deficit.

Millions of families remain at risk

- Incremental reform bills will not cover everyone -- not even close. An estimated 24 - 40 million people would remain uninsured without universal coverage.
- One in six Americans will still lose their health insurance at some point during the year.

Middle class will take the hardest hit

- Since the poor and non-working would get free coverage, and since wealthy Americans could afford coverage on their own even if costs continue to rise, those hardest hit by incremental reform would be middle-class working families.
- Under a non-universal, managed competition-style reform plan, an estimated 24-40 million people, more than two thirds of them in middle-class, working families, would remain uninsured. The main reason these families wouldn't be covered is the cost of insurance.
- What's worse, many people who now have insurance protection today would find themselves without coverage under an incremental reform plan. An estimated one in ten workers with employer-sponsored insurance would be dropped by their employer.

The cost shift will continue

- Under the Band-Aid approach, those who take responsibility for insurance coverage will continue to pay for those who do not. Senator Chafee, a Republican from Rhode Island, puts it this way: "If there's no mandate that people have to belong, then young healthy males who don't ride motorcycles aren't going to join and so the costs are going to be carried by those who are sick." Alain Enthoven, the so-called "father" of managed competition, adds that "such a system would be destroyed by free-riders".

The deficit will increase

- Without any change to the existing system, two-thirds of the growth in federal spending between 1993 and 1996 will be accounted for by health care spending.
- Incremental reform plans aim to extend coverage to low-income families and the unemployed by providing government subsidies to those Americans. Under a plan with subsidies for the poor but no universal coverage, CBO says there would be over \$300 billion added to the deficit in financing the subsidies for low income Americans. By contrast, the President's plan is expected to curb expenditures by \$30 billion by the year 2000, and by \$150 billion by 2004.

Universal coverage is the only way to guarantee controllable costs, and fair, equitable financing of health care.

Imagine a diner where everyone in a community goes for lunch. Most people have lunch, pay, and leave, but every eighth person who walks into the diner sits down, orders (usually the most expensive thing off the menu because they're famished), and gets up and walks out without paying. The cost of that patron is spread over the other seven who did pay. It only makes sense that when that eighth person pays for their lunch like everybody else, and orders like everybody else, the cost to the other seven paying diners will go down.

We don't think the solution is to charge working families through the nose for lunch, and let the poor eat for free by taxing everyone who orders a steak. We think the free lunch should end.

All Americans deserve the security of high quality health care coverage they can't lose, even if they move or take a better job. The American health care system will be stronger, better, and less costly if Congress finishes the job they've started and guarantees private health insurance to all Americans this year.

To: Claire Wofford - with speech writing office
From: Joan Meehan - 202-270-2937
2 pages

NATIONAL PERSPECTIVE ON ADVANCED PRACTICE NURSES

1. Virginia Trotter Betts, American Nurses Association President - as part of Nursing's Agenda for Health Care Reform recommends removing anticompetitive barriers to APNs practice, increased access to primary care in schools, workplaces, community settings.

CONTACT: ANA Communications Office - 202/554-4444, ext. 244, 242, 240.

2. Barbara Safriet, Associate Dean, Yale Law School - has written about the regulatory barriers that prevent advanced practice nurses from working to their full potential.

CONTACT: 203/432-1685

EXAMPLES OF ADVANCED PRACTICE NURSES PROVIDING PRIMARY CARE:

1. In Tucson, Arizona, nurse practitioners run 17 community health clinics located in such places as trailer parks and apartment buildings. The nurses provide health screenings and maintenance to the area's large senior citizen populations. Studies show that this level of on-going care keeps seniors in their homes, reducing and delaying the need for hospitalization and therefore, keeping costs down. For 15,000 Medicare enrollees, inpatient days have been reduced by one-third/1,000 enrollees; saving \$300,000/1,000 enrollees. This site, Carondelet-St. Mary's, is one of four community nursing organizations participating in a Health Care Financing Administration demonstration project.

CONTACT: Gerri Lamb, 602/622-5833, Ext. 1474

2. In Ocala, Florida, two hospitals have opened a joint venture clinic providing primary care to the area's indigent. NPs provide the care and the hospitals have seen a significant reduction of costs.

CONTACT: Paye Gaston, nurse executive, Marion Community Hospital, 914/368-1105

3. In Cambridge, Massachusetts, five nurse practitioners provide women's health care services to about 3,000 clients. Nurse Practitioner Associates was started in 1984 by Mimi Secor.

CONTACT: Mimi Secor, 617/354-6028

4. In Philadelphia, five nurse practitioners operate Golden Horizons. They specialize in the evaluation and treatment of urinary incontinence, a primary factor in placing someone in a nursing home. The practice is under contract with the County of Philadelphia to provide services to the elderly.

CONTACT: Diane Newman, 215/296-4855

5. In Washington, DC, two nurse practitioners and one physician share a family practice that serves the Shaw Community. Opened in 1978, the Georgetown Midwifery program also practices out of the clinic.

CONTACT: Veneta Masson, 202/408-9835

6. The Frontier Nursing Service, Hyden, Kentucky, employs NPs to deliver primary care to the underserved in Appalachia.

CONTACT: Barbara Gibson, 606/672-2317 or 2318, 2312

Growth in numbers of Advanced Practice Nurses

nurse practitioners:

1977 - 9,634*

1980 - 16,758*

1984 - 18,642*

1988 - 25,000

1992 - 49,500

Almost 100% increase between 1988 and 1992

*** reported nurse practitioners/nurse mid-wives together**

clinical nurse specialists

1988 - 40,000

1992 - 58,000

45% increase

certified nurse midwives

1988 - 5,000

1992 - 6,000

20% increase

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Division of Nursing.

The Health Security Act

NURSES AND OTHER HEALTH CARE PROFESSIONALS

The Health Security Act will increase the role of nurses, nurse midwives, and other health care professionals in primary and preventive care. It will reduce professional barriers for these health care providers and cut the paperwork that forces them to spend more time at desks than at bedsides. The Act will allow nurses, physician assistants, and other health care professionals to work to their full potentials.

Expands Nurses' Roles

- 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.

Removes Inappropriate Barriers to Practice

- Efforts to reduce state barriers to practice will allow nurses and allied health professionals to contribute on the basis of their skills and work to the full scope of their training.
- Advanced practice nurses will play a crucial role in ensuring that every American receives high quality health care. They will work in partnership with physicians and other health providers to ensure high-quality care.

Increases Training Funds

- Funding for training of nurse practitioners and physicians assistants will be increased to expand existing programs and the number of graduates annually.
- The Act will help increase racial and ethnic diversity among nurses so that patients can be served by providers sensitive to cultural differences.

Reduces Paperwork

- Use of standard claim forms and expanded electronic billing will reduce paperwork so that nurses can concentrate on providing care to patients -- not filling out forms.
- Introduction of comprehensive benefits will save nurses hours and hours of frustration now spent in determining if patients are covered for certain procedures.

Provides New Practice Opportunities

- The new home and community-based long-term care program for older Americans, persons with disabilities, the chronically ill, and other vulnerable populations such as the mentally ill and children with special needs, will expand professional opportunities for nurses.
- The Act provides incentives for nurses and other health care providers to work in underserved rural and urban areas.

April 1, 1994

**The Health Security Act and Nurses:
Enhancing Nursing Services as a Key Strategy for
Reforming the Health Care System**

Our approach recognizes the crucial role that nurses now play in health care and their importance to a truly reformed health care system. It specifically targets improvements for both the education and the practice of nurses - all toward the end of assuring that these key providers will be able to work to their full potential.

Expansion of Nurses' Roles:

- Health care reform will rely on nurses playing greater roles in a variety of settings, including primary care, public health, mental health, school health, the National Health Service Corps and long term care. Advanced practice nurses and those practicing in community health settings have been identified as key opponents of guaranteeing that all Americans receive high-quality care.
- Our approach will provide many opportunities for nurses to be involved in the management, quality assurance and overall direction of the new system.
- This approach provides new practice opportunities for nurses. For example:

The new home and community-based long term care program for older Americans, persons with disabilities, the chronically ill, and other vulnerable populations such as the mentally ill and children with special needs, will expand professional opportunities for nurses.

The plan provides incentives for nurses and other health care providers to work in underserved rural and urban areas.

Reduction of Inappropriate Barriers to Practice:

- The President's approach seeks to assure that state practice acts are not unnecessarily restrictive, so that nurses can contribute to the fullest extent possible, based on knowledge and skill.
- Model practice acts will be developed to assist states in their efforts to improve unnecessarily restrictive practice acts.
- Incentives and reimbursements for advanced practice nurses will be improved to assure their full participation in providing needed services.

Tax relief and incentives will attract more nurses and other providers to work in underserved areas.

- Our approach will assure that qualified providers, such as nurses, will be able to fully participate - without discrimination - in the new system.
- It will dramatically reduce the amount of paperwork now required of nurses in all settings, in order to assure that they can give their full attention to providing needed services.

Increasing Support for Education:

- The President's approach creates an ongoing source of funding to support the expansion of the advanced practice nursing workforce.

Significant increases in existing support for education of nurses are proposed, particularly for those seeking to serve in community-based settings.
- The National Institute of Healthcare Workforce, a joint venture between the Department of Labor and the Department of Health and Human Services, will be created to address needs for continuing training and retraining of nurses and others to assure their optimal participation in the new system.
- There will be increased support for education that will result in an increase in racial and ethnic diversity among nurses, thus enabling patients to be served by nurses who have roots in those communities.

NURSES AND HEALTH CARE: The Current System

NURSES ARE THE BACKBONE OF THE HEALTH CARE SYSTEM

- Our nation's 1.8 million working nurses form the backbone of our health care system, the largest group of health care providers in America.
- Nurses work on the front lines of medicine. They are the professionals that people turn to first when they walk into the hospital or clinic.

NURSES PROVIDE PREVENTIVE AND PRIMARY CARE

- Nurses make an important contribution to preventive and primary care - getting people the care they need before they become seriously ill.
- Nurse practitioners, nurse midwives and certified registered nurse anesthetists have a record of delivering high-quality, cost-effective care, particularly in rural and urban areas.

UNNECESSARY BARRIERS PREVENT NURSES FROM GIVING CARE

- Unnecessary barriers prevent nurses from giving all the care they are trained to provide. In today's system, nurses are often not allowed to work to the full scope of their practice and prevented from receiving direct payment for their services. Those restrictions make it difficult to practice in underserved areas.

PAPERWORK TAKES UP TOO MUCH OF NURSES' TIME

- The burden of paperwork forces nurses to turn their attention away from patients.

NURSES NEEDED IN UNDERSERVED AREAS

- More nurses are needed in rural and urban areas where people often have trouble obtaining the care they need. Many of these nurses can work in primary care and community-based settings, such as public health, schools and home health.
- Although the ranks of nurses traditionally have included more members

of ethnic and racial minorities than other health professionals. the number of nurses from minority groups still must be increased to more closely reflect the populations they serve.

**NURSES AND HEALTH CARE:
Questions and Answers**

Q: Will the Clinton plan make me see a nurse when I want to see a doctor?

A: No, but under reform, nurses will play a much greater role in giving primary and preventive care -- a role in which they have proven effective. Health plans will ensure that patients have a choice of whom to see for care.

Q: Will nurses be thrown out of work under the Clinton plan?

A: No. Reform will help nurses return to doing what they were trained to do -- caring for people in need. The Clinton plan will increase the number of nurses practicing in community settings.

Q: How will the Clinton plan make sure that nurses are located in areas where they are needed?

A: The Clinton plan will make funding available for training programs that target current and projected needs for care in underserved areas and increasing the number of nurses who come from those communities.

Q: Won't the Clinton plan pit nurses against physicians as it moves to make nurses more independent?

A: No. The Clinton plan will enable nurses to perform to the full scope of their skills and training in partnership with other health providers. Nurses will not assume the role of the physician. Reform will set the stage for improved relations within teams of providers. It will eliminate the difficult and costly process of states making case-by-case changes in practice guidelines for advanced practice nurses. It will mean higher-quality, affordable care for more Americans.

THE WHITE HOUSE

WASHINGTON

May 9, 1994

REMARKS TO AMERICAN NURSES ASSOCIATION: ANA HONORS VIRGINIA KELLEY

DATE: Tuesday, May 10, 1994
LOCATION: Hyatt Regency, Washington, D.C.
TIME: 10:00 AM
From: Mike Lux
Debbie Fine
through Alexis Herman

I. PURPOSE

From the message perspective, this is another opportunity to emphasize guaranteed health benefits at work, which is part of the administration's continuing two week focus. It is also a chance to underscore the importance of quality care for patients. Politically, your remarks provide a chance to: (1) thank the American Nurses Association (ANA) and the nursing community at large for their support; (2) reassure them that they are important to you and to this debate; (3) energize them for their Congressional visits while they are in Washington; and (4) mobilize them when they return to their communities. This event will demonstrate your connection to and appreciation for nurses in a more personal way than usual.

II. BACKGROUND

The ANA is the largest nursing association, representing 200,000 nurses, and has been a strong supporter since early on in the campaign primarily because of the administration's efforts with health care reform. As you know, providers have been identified as one of the key swing constituencies in this debate, making the support of the nursing community particularly important.

"A Salute to Nurses In Congress and the Executive Branch"

In honor of National Nurses Week this week, the ANA will be giving you an award in memory of Virginia Kelley. As you probably know, the nursing community looks to Virginia Kelley as a role model and an inspiration -- a nurse anesthetist who built her career when opportunities for women and nurses were rare. The research grant is a tribute to her achievements, and will be awarded to a nurse scholar who has not yet been identified, and will be named at a future date. The ANA will also be honoring fifteen nurses working in Congress and the Administration at this breakfast. They are:

Brigadier General Nancy Adams, FAAN; Chief of U.S. Army Nurse Corps
Sheila Burke, MPA, RN, FAAN; Chief of Staff to Senator Bob Dole
Shirley Chater, PhD, RN, FAAN; Commissioner of Social Security Administration
Pat Ford-Roegner, MSW, RN; Administrator of Region IV, HHS
Kristine Gebbie, MN, RN, FAAN; National AIDS Policy Coordinator
Kathleen Hastings, JD, MPH, RN, FAAN; Chief Nurse Office at the Agency
 for Health Policy and Research,
 HHS
Ada Sue Hinshaw, PhD, RN, FAAN; Director of the National Institute of Nursing
 Research
Mary Lou Keener, JD, RN; General Counsel, Department of Veterans Affairs
Rear Admiral Julia Plotnick, FAAN; Chief Officer, U.S. Public Health Service
Marla Salmon, ScD, RN, FAAN; Director of the Division of Nursing at the Bureau
 of Health Professions, HHS
Rear Admiral Mariann Stratton; Director of U.S. Navy Nurse Corps
Brigadier General Sue Turner; Director of Nursing Services, U.S. Air Force
Nancy Valentine, PhD, Rn, FAAN; Assistant Chief Medical Director of
 Nursing Programs, Department of Veterans
 Affairs
Cynthia Vlasich; Chief Nurse Executive at the American Red Cross
Mary Wakefield, PhD, RN, FSSN; Chief of Staff to Senator Kent Conrad

The Award

In honor of your mother, the ANA has created a \$40,000 endowed research fund within the American Nurses Foundation. Each year, a beginning nurse researcher will be selected as the Virginia Kelley Scholar and receive a research grant in the area of women's health. You will be notified of the name of the scholar and the specific research topic annually. As stated above, the recipient for this year has not yet been chosen.

The American Nurses Foundation (ANF) Presidential Research Award has funded careers of nurse researchers for approximately forty years. They have chosen to fund nursing research because they identify it as the only real measure of effectiveness and outcome of what nurses do, further providing the means to expand methods of treatment for patients. Recipients of the research award have tended to rise to respected positions in the nursing community -- becoming deans of nursing schools, directors of health centers, etc.

Association of Nurse Executives (AONE)

Although they are not sponsoring or participating in the award, AONE is co-sponsoring this breakfast with the ANA. AONE is an organizational unit within the American Hospital Association (AHA), representing 6,000 nurse managers and nurse executives. We have not worked extensively with them.

Health Care Activities

The ANA is active on both a grassroots and a national level. Through the Health Care Reform Project, they participate in grassroots activities in targeted districts around the country, leafletting, crowd-building at town hall meetings and other public forums, and perhaps most importantly, participating in provider press conferences in support of the Health Security Act (HSA). They have also developed an independent grassroots lobbying network, called Nurses Strategic Action Team or N-STAT, to promote health care reform at the federal level. N-STAT coordinates the lobbying activities of nurses around the country and works to generate free-media in support of the administration's approach.

The First Lady has met with them multiple times, as have other White House officials. Although they have participated in meetings and events with other groups at the White House, including a Rose Garden ceremony with you in honor of National Nurses Week last May, this is your first event with them alone on health care. They are thrilled that you are coming to the breakfast and personally accepting the Virginia Kelley Research Award.

Key Issues

The nursing community has been very supportive of the HSA and of the administration's approach to health care reform overall. As front line providers who see many of the weaknesses in the health care system, they have been striving to achieve health care reform for years. The issues that are most important to them are:

- universal coverage;
- choice of plan and provider;
- built-in incentives for expansion of the roles of allied professionals or non-physician providers;
- quality of care.

The biggest issue of concern in the nursing community at this point is the effect of hospital restructuring on staff nurses. Although the HSA supports the career development of registered nurses by providing incentives to expand nurses' roles, there is a growing fear in the nursing community that hospital efforts to contain costs are and will continue to result in job loss for registered nurses. As hospitals search for ways to cut costs in the short term, they are often decreasing use of registered nurses and increasing use of lower-paid assistive personnel. In addition to the obvious concern about job loss, the nursing community perceives this as endangering quality and safety of patient care in the long-term.

Some hospital administrators are blaming the administration's health care reform initiative as the reason for the down-sizing. In reality, hospitals have been restructuring for several reasons, including:

- too many hospital beds per capita;
- loss of managed care contracts by acute care hospitals;

- shift of services from inpatient to outpatient, partially due to insurance practices;
- mergers, acquisitions and closures of hospitals;
- employer concerns over financial impact of potential health care reform;
- general economic trends.

In response to this concern it is important to note that restructuring in the health care industry was well underway before your election. The restructuring poses uncertainties as well as opportunities for the professional role and employment security of hospital nurses. In attempt to deal with this, the HSA increases support for education of nurses. This includes establishment of the National Institute of Healthcare Workforce, a joint venture between the Departments of Labor and Health and Human Services, to address needs for continuing training and retraining of nurses and others to assure their optimal participation in the new system.

On the Politics

Although the nursing community continues to be one of our most loyal supporters, you should be aware of some tension in the nursing community because of:

- the 'choice of doctor' message we have decided to underscore in the five-point message. They feel that we should include the word provider; however the message team felt strongly based on polling that it was important to stay with doctor.
- the fear of nurse cutbacks due to hospital restructuring, as described above.

III. PARTICIPANTS

Virginia Trotter Betts (Ginna), JD, MSN, RN: President of the ANA. She is a strong, long-time supporter. She participated in a meeting with the leadership of allied groups in March; she introduced you at a Rose Garden ceremony last year announcing National Nurses week; she also introduced the First Lady at a DNC teleconference recently. She was on the Vice President's staff when he was on the Senate.

Ellen Sanders, MS, RN: She is First Vice President of ANA and a founding partner of Innovative Health Care Services, a health care consulting firm in Boca Raton, Florida. She has participated in White House and Congressional meetings on health care reform policy development. She is a Congressional and Legislative District Coordinator for Florida Nurses Association.

Diane Weaver: President of the Association of Nurse Executives.

On the Dais

Top Tier (from stage left):

Mary Wakefield, PhD, RN, FAAN
Cynthia Vlasich, BSN, RN
Nancy Valentine, PhD, RN, FAAN
Brigadier General Sue Turner
Rear Admiral Mariann Stratton
Marla Salmon, ScD, RN, FAAN
Rear Admiral Julia Plotnick
Mary Lou Keener, JD, RN
Ada Sue Hinshaw, PhD, RN, FAAN
Kathleen Hastings, JD, MPH, RN, FAAN

Bottom Tier (from stage left):

Kristine Gebbie, MN, RN, FAAN
Pat Ford-Roegner, MSW, RN
Father Donald Joyce: He is doing the invocation.
Diane Weaver
Virginia Trotter Betts, JD, MSN, RN
Georg Strait: ABC News Correspondent who is speaking on, "How the News Media
 Has Shaped Health Care Reform."
Shirley Chater, PhD, RN, FAAN
Sheila Burke, MPA, RN, FAAN
Brigadier General Nancy Adams

The Audience

The audience will be comprised of approximately 420 nurses, members of Congress and other guests of the ANA.

Congressional Members planning to attend the breakfast are:

Neil Abercrombie (D-HI)
Maria Cantwell (D-WA)
Howard Coble (R-NC)
John Dingell (D-MI)
Anna Eshoo (D-CA)
Sam Farr (D-CA)
Herb Klein (D-NJ)
Larry LaRocco (D-ID)
Nita Lowey (D-NY)
Marjorie Margolies Mezvinsky (D-PA)
Patsy Mink (D-HI)
Jim Moran (D-VA)
Marge Roukema (R-NJ)
Cliff Stearns (R-FL)
Charles Taylor (R-NC)

Jim Walsh (R -NY)
Lynn Woolsey (D-CA)

Senator Kent Conrad (D-ND)
Senator Charles Grassley (R-IA)
Representative Carlos Romero-Barcelo (PR)

Other Notables in Audience:

Surgeon General Joycelyn Elders
Dick Davidson, President of the American Hospital Association

In the Meet and Greet Following Remarks

The following nurses will be coming to the White House following the breakfast to do regional satellite feeds and radio and print interviews in their hometowns in support of health care reform as part of the Office of Public Liaison Constituency Day program:

Patricia Bell, RN, MS:	Instructor, Bachelors Program for Nurses, East Central University, Oklahoma
Frances Edwards, MSN, RN:	Assistant in Surgery, Section of Surgical Sciences, Vanderbilt University School of Medicine, Tennessee
Lorraine Freitas, PhD, RN:	Associate Director, School of Nursing, San Diego State University, California
Louise Hart, RN, DNS:	President, Indiana State Nurses Association
Carol Oeljen, BSN:	Community Educator, Visiting Nurses Association, Washington State
Susan Pascoe, MSN, RN:	Regional Consultant, Home Health Services, Daughters of Charity National Health System, TX
Patricia Ryan-Dudek, RN, MS:	Nurse Clinician, Neurology Department, Children's Hospital of Buffalo, New York
Patricia Underwood, PhD, RN:	Coordinator, Grand Valley State University Graduate Nursing Program, Michigan
Margaret Wheatley, MSN, RN:	President, Ohio Nurses Association

IV. PRESS PLAN

Expanded pool coverage and specialty press. The Health and Sciences Television Network, which is Dallas based, will carry your remarks live via satellite to 2000 locations (1200 hospitals and 800 long term care facilities) with an audience of physicians, hospital administrators, nurses and other leadership of the facilities.

V. SEQUENCE OF EVENTS

- You will be greeted at arrival by Ellen Sanders, Executive Vice President of the ANA.
- She will accompany you to the breakfast, entering the room stage left.
- Following an off stage announcement, Sanders will accompany you to the dais, and return to her seat in the audience.
- Ginna Betts will introduce you and present you with a plaque representing the Virginia Kelley Research Award.
- You will accept the plaque and deliver remarks.
- You will work the dais, and exit stage right.
- You will work the ropeline, and exit the room where you entered stage left.
- You will proceed to the Holding Room accompanied by Diana Weaver, AONE President, and Ginna Betts where you will meet and greet ANA Constituency Day participants.

VI. REMARKS

To be provided by speechwriters.

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HomeCall

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Successful candidates must have at least 3 years of experience, a MSN, and certification as an Adult, Geriatric or Family Nurse Practitioner.

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We require at least 3 years of professional experience and a MSN; a MSN is preferred. Previous management experience is required; ambulatory nursing experience preferred.

Picture yourself in a vital role and help us keep our promise to those who served. For immediate consideration, call Ann T. Melvin, RN, Nurse Recruiter, at (410) 605-7043. The Baltimore VA Medical Center, 10 N. Greene Street, Baltimore, MD 21201. An equal opportunity employer.

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Registry Nurses

You can choose from a range of areas, including Critical Care, Oncology, Orthopedic, Med/Surg (evenings of 4 or 8-hour shifts), Nursery, Post-partum or High-Risk OB/GYN. All shifts are available and GBMC's in-house Registry offers free parking, on-site day care and the following hourly rates (each requires at least 24 hours of work per month): Registry A-\$22 days, \$24 evenings, \$26 nights; Registry B-\$18 days, \$20 evenings, \$22 nights. For immediate consideration, please contact Pat Ryan, Nurse Recruiter, 6701 N. Charles Street, Baltimore, MD 21204, (410) 828-2206. EOE.

GBMC
Greater Baltimore Medical Center

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Alexandria Hospital, a full service 350-bed facility, is positioning itself to meet the demands of healthcare in the 90's. Now's the time to join us in one of the following leadership roles.

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Our family birthing center boasts almost 3,500 births per year. To enhance our continued success, we have an excellent opportunity for a dynamic and innovative Director. Strong leadership skills are essential to assume 24-hour responsibility for our Family Birthing Center, High Risk Center and Women's Specialty Unit. A BSN is required with a Master's degree preferred. A minimum of three years L&D experience is also required with prior management experience.

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We seek a dynamic and energetic Coordinator for our Emergency Department that treats 52,000 patients annually. Our busy department encompasses a Level II Trauma Center, Chest Pain Clinic and Express Care Center. You will assume 24-hour responsibility for the clinical and management functions of the department. The successful candidate will possess a BSN and 3 years of recent Emergency Department experience as well as previous supervisory experience. CEN and ACLS highly desirable. Excellent communication skills are essential.

Alexandria offers competitive salaries and excellent benefits. For consideration FAX your resume to Tara McPartland, Nurse Recruitment at (703) 504-7833 or forward to: Nurse Recruitment, Alexandria Hospital, 4320 Seminary Road, Alexandria, VA 22304. For more information, call (703) 504-3145. EOE.

**ALEXANDRIA
HOSPITAL**

Spectrum

RN White House Intern

Caroline Sniffen, RN, BSN

Growing up near the nation's capital, I was surrounded by politics and legislative activities. Throughout my undergraduate nursing studies at Georgetown University School of Nursing, I became even more aware of government and public policy issues. My current roles as perioperative nurse, research nurse, and as a master's degree student have provided opportunities for me to become more actively involved in healthcare issues. I wanted to make a contribution to improve healthcare; so, after looking into a few possibilities, I accepted an internship with The White House Health Care Reform Information Center. The Center opened two months ago to personally respond to the information needs of the American people. I'm one of 20 interns who earn graduate credits (mine are toward an MSN)—24 hours of active participation each week for an entire semester. As interns and volunteers, we are continuously briefed on changes, and we are trained in under-

standing the new legislation. This helps us to meet the immediate informational needs.

My day-to-day role at the Information Center is to respond in a timely manner to every letter I read and to answer all questions about the Clinton Administration's Health Security Act. People frequently ask, "How will the reform measures affect me?" When questions and comments flood in from all areas of the country, my first responsibility is to triage and then to respond. A major part of my day is spent reading and categorizing letters that are addressed to the First Lady—some relate to healthcare reform issues; others are heartfelt, personal stories that relate to healthcare. After the letters are sorted, I enter requests and viewpoints into a database from which reports are created and sent to the President, to White House staff, and to Congress.



Caroline Sniffen, RN, BSN.

Our rich past lends promise to a brilliant future!

For 127 years, Sinai Hospital of Baltimore has provided patients with superior and progressive health care by constantly challenging our professionals to seek new and better answers. As we head toward the next century, we continue to pioneer new techniques and innovations at every turn.

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You will be responsible for instructional activities including orientation training and continuing education of professional and ancillary staff. Masters degree in Nursing or Education and recent med/surg clinical experience required. Previous teaching experience is mandatory. Past experience in Psych a plus.

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Currently, a challenging opportunity both clinically and administratively in a primary care clinic associated with an Outpatient Methadone Program is available.

We offer a competitive salary and an excellent benefits package including on-site child day-care. Please send or fax resume to: Joan Quisgard, Manager - Recruitment, Sinai Hospital of Baltimore, 2401 W. Belvedere Ave., Baltimore, MD 21215. PH#: (410) 578-5669. FAX#: (410) 578-9055. TTY#: (410) 578-9199. EOE M/F/D/V.

**SINAI
HOSPITAL OF
BALTIMORE**

There are many RNs and nursing students who are currently involved as interns and as volunteers in this office. RNs here have earned a reputation for knowing the issues, seeing the needs, and rolling up their sleeves. As nurses, we become resources who are equipped to interpret medical terminology and diagnoses. This knowledge helps us to better brief policymakers. It's interesting to note that more than 100 letters come in each day—many from nurses.

I love what I do. Every time I walk into the Center's communications office, I feel a surge of excitement. I feel like I'm part of history in the making. At the Center, there is no formal staff, so interns and volunteers really play a vital part. As an insider, I can view the political process through hands-on participation and camaraderie. I feel like I'm helping to change the landscape of healthcare in the United States.

Besides being regarded as an insider, I am expanding my education through the office's weekly seminars and monthly guest speakers composed of major administrative department heads. If you are an RN who is interested and enthusiastic about healthcare issues and want to volunteer your time, call Judy Craig at 202/435-6060.

Caroline Sniffen, RN, BSN, works as a perioperative nurse and as a research nurse at Georgetown University Medical Center. She is an intern with The White House Health Care Reform Information Center.

NOTE TO: BUDDY MENN
ROGER GOLDBLATT

FROM: JUDY CRAIG
WH HCRIC
VOLUNTEER/INTERN COORDINATOR

DATE: MAY 23, 1994

RE: FIRST LADY'S SPEECH
AMERICAN NURSES ASSOCIATION CONVENTION
SAN ANTONIO, TX - JUNE 11, 1994

*Log -
Briefing book
material?
Buddy*

The First Lady is scheduled to address the American Nurses Association Convention in San Antonio, Texas during the afternoon of June 11, 1994. I would like to request that the First Lady mention the nurses and interns' efforts toward health care reform.

Rationale and possible speaking points:

1. 90% of the White House Health Care Reform Information Center's volunteers/interns are health care professionals.
2. Nurse volunteers have become resources who are equipped to interpret medical terminology and diagnosis information from the letters the center receives. This knowledge helps brief policymakers.
3. Nurses are wonderful volunteers because they have earned the reputation from knowing the health care issues, seeing the needs, and rolling up their sleeves for work.
4. More than 100 letters which come in daily are written by nurses.
5. Nurses are continuously briefed on health care reform changes and are trained in understanding the new legislation. This helps the nurses meet the immediate informational needs and helps educate the public upon request.
6. Nurses and other health care professionals help in the three main functions of the center which are: operation of a phone bank, researching "personal stories", and preparing and responding to health care correspondence.

The NURSING spectrum®

D.C./Baltimore Metro Edition ■ The Ultimate Career Guide ■ For RNs, By RNs

May 16, 1994

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VOLUME 4, NO. 10

Global Nursing





AMERICAN NURSES ASSOCIATION
 Maryland Avenue, SW, Suite 100 West
 Washington, DC 20024-2571
 Voice: (202) 554-4444
 Fax: (202) 554-0185 (202) 554-2262

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Hopper, First Lady's Office, White House

Fax: _____

a M. Wyatt

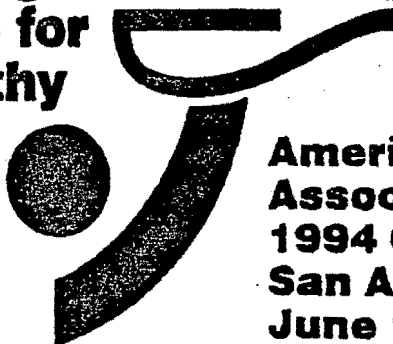
Phone: 202-554-4444 X240

12-94

Total Pages with Cover: 3

Julie - Attached is letter of invitation
 Dated December 13, 1993.

**Nurses:
 Charting the
 Course for
 a Healthy
 Nation**



**American Nurses
 Association
 1994 Convention
 San Antonio, Texas
 June 10-15, 1994**



American Nurses Association

600 Maryland Avenue SW, Suite 100 West, Washington, DC 20024-2571
202-554-4444 • Fax: 202-554-2262

Virginia Trotter Betts, JD, MSN, RN
President

Shirley A. Girouard, PhD, MSN, RN, FAAN
Executive Director

December 13, 1993

VIA HAND DELIVERY

Hillary Rodham Clinton
Chairperson
President's National Health Reform Task Force
The White House
Washington, D.C. 20500

Dear Mrs. Clinton:

This is the third follow up on our invitation to you to be our Keynote Speaker at The American Nurses Association 1994 Biennial Convention to be held June 10-15, 1994 in San Antonio Texas. The keynote address is scheduled on Saturday, June 11, 1994 from 2:15 p.m. - 2:45 p.m. in the Arena of the San Antonio Convention Center.

210-399-8500

As the Chairperson of the White House Task force on National Health Care Reform, we believe you are the most qualified person to address the vision and direction of the new national policy for health care reform in the United States. We are well aware of your positive impact at the American Medical Association and the American Hospital Association Conventions and want our ANA delegates to have the same significant opportunity to hear directly from you.

As I mentioned in my prior letters (July 19, 1993 and September 1, 1993), your participation at our convention will inspire the 6000 or more nurse leaders, who will be coming from all 53 states and territories, to continue to chart their own professional course as innovators and implementers of reformed health delivery. We also hope to confer on your husband the title of " Honorary Nurse " pursuant to a unanimous resolution of our House of Delegates in June, 1993.

In speaking with Bart Handford in your scheduling office, it is our understanding the invitations which you receive are not examined until 6 weeks in advance of the conference. At that time, tentative plans are made which are not confirmed until 45 days in advance. This is problematic in planning for a national meeting of this scope. Therefore, JoyceLyn Elders M.D., U.S. Surgeon General has been identified as our quality speaker back-up. Could you therefore use your influence and help us to be able to get some type of commitment now.

The US Member of the International Council of Nurses
ANA - An Equal Opportunity Employer

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Will June 11
Patti Melanne
Strongly rec. we
do something with
them!

Hillary Rodham Clinton

13, 1993

We sincerely hope you will be able to join us in San Antonio next June to deliver the Keynote address to our members. As soon as possible please respond to Dr. RoAnne Dahlen-Hartfield at (202)-554-4444 (ext. 324) if you or the Dr. Elders can be with us at our convention. Our very best wishes for peace and joy this holiday season and a new year of health, happiness and prosperity.

Sincerely,

Virginia Trotter Betts, JD, MSN, RN
President

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2012-1004-5

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INITIALS: MO DATE: 10-19-12

~~CONFIDENTIAL~~

TO: Patty Solies, White House Scheduling
Debbie Fine, Health Care

FROM: Cheryl A. Peterson, MSN, RN
Assistant Director
Governmental Affairs

DATE: June 3, 1994

Total # of Pages with Cover: 07

FYI - Attached are some additional talking points and the theme or focus of the convention for use in crafting Mrs. Clinton's remarks.

Secondly, I leave today for the weekend and convention. I will be staying at the Hyatt Regency, 210-222-1234, starting on Tuesday, June 7. The fax number at the hotel is 210-227-4925. As always, I will continue to check my voice mail at work frequently.

Thanks. Cheryl

AMERICAN NURSES ASSOCIATION

TO: White House Staff of Hillary Rodham Clinton

FROM: American Nurses Association

DATE: June 2, 1994

RE: Suggested themes for Mrs. Clinton's remarks at the
American Nurses Association Convention, June 11, 1994
San Antonio, TX

The recurring theme at the ANA convention will be on the quality of patient care and the essential role that nurses play in delivering that care. We are focusing on this message because of the high number of registered nurses who are being laid off during the past year in light of hospital restructuring in anticipation of health care reform.

ANA's staff nurse members, 65% of our total membership, are most concerned about this issue and nursing layoffs.

If Mrs. Clinton could mention that these layoffs are distressing and harmful to the quality of patient care it would be extremely well received by our membership and would go far toward continuing nursing's support of the President's health care reform plan.

Attached are ANA's four major messages for health care reform and "talking points" on the quality of patient care. I have marked the best talking points that would have the most impact. President Clinton used these same talking points during his speech at the May 10 "Salute to Nurses" event and the crowd was enormously responsive!

If you have any questions, please call our Director of Communications, Lisa Wyatt at (202) 651-7019 or the Assistant Director of Communications, Joan Meehan, at (202) 651-7020.

Thank you very much.

American Nurses Association

Health Care Reform Messages for Congress -- Spring/Summer 1994

May 4, 1994



Quality Equals RNs

The quality of care Americans receive in hospitals and other settings is directly related to the services provided by registered nurses. Inappropriate substitution for registered nurses in direct patient care compromises safety and quality. Health care reform must guarantee quality nursing care to all consumers.

Access Equals Coverage Plus Services

Every American must have access to and coverage for high quality preventive, primary, acute and community care services. Registered nurses make access to health care affordable, available, acceptable, and accountable.

Delivery of Care

In a reformed health care delivery system, nurses must play meaningful leadership roles in the development of new models of care and in their implementation to ensure quality health and illness services. Appropriate numbers of registered nurses are essential to maintaining the safety and quality of patient care. Programs must be established to support all nurses in assuming their essential and varied roles in the new health care system.

Cost

Cost containment is essential in health care reform. However, short-term cost containment efforts, without consideration for quality and safety, are a poor investment for the nation. Quality, cost-effective care in a reformed health care system equals the right provider in the right setting at the right time.

Quality of Patient Care in Hospitals Talking Points

April 1994

Major Talking Points

- * o Nurses are key to maintaining health care quality
- * o Every patient deserves a nurse.
- o A registered nurse at the bedside is your best safety net.

Nursing Services Improve Quality Care in Hospitals

* Let the research speak for itself. In more than a dozen studies, hospitals that have a higher percentage of nurses per patient have lower mortality rates. Hospitals with a higher ratio of nurses to patients have six fewer deaths per 1,000 patients than hospitals with fewer RNs on staff. (Hartz et al, 1989).

A study of patients in 17 hospitals found the higher the qualifications of the nursing staff, the better the quality of care. (Scott, Forrest, and Brown, 1976)

More than a decade of research on a large number of hospitals has found that the higher the level of nurse staffing, the lower the mortality rates and a lower length of stay in the hospital. (Nursing: An Important Component of Hospital Survival Under a Reformed Health Care System, Nursing Economics, 1993)

The main reason people are in the hospital is to receive nursing care. In other words, hospital patients are too ill or their treatment is so complex that they shouldn't be at home. It doesn't make good sense to give hospital patients less access to a registered nurse.

* All the evidence shows that nurse staffing levels and skill mix make a difference in the outcomes of hospitalized patients. Research shows that when you have more nurses you'll have lower mortality rates, shorter length of stay, lower costs, and fewer complications. (Nursing: An Important Component of Hospital Survival Under a Reformed Health Care System).

In addition to nursing's affect on lower mortality rates in hospitals, nurses also affect other important measures such as the length of stay and the costs of care. Low birth weight babies that were cared for by a nurse specialist were discharged on average 11 days earlier than control babies at a savings of approximately \$18,560. (Brooten and colleagues, 1986).

Nursing's Impact on Hospital Costs

Nursing comprises, on average, only 23 percent of a hospital's labor costs (AHA, 1991-1992). There are other factors that are driving the growth in hospital costs, such as the intensity of medical services and wasteful hospital practices. When you're giving MRIs for a twisted knee, you're driving up costs. The main factor driving hospital costs is new technology (Newhouse 1993).

The cost of nursing care is only 20 percent or less of hospital charges (Stafan, Gillies & Blordi, 1992). Yet, a survey of 663 hospital CEOs ranked nursing care as the most important contributor to hospital quality. (Hospitals, 1989).

*

An industry study of 281 hospitals nationwide that was reported in Modern Healthcare found that hospitals that reduced their staffing by 8 percent or more were 400 times more likely to see an increase in patient illness or mortality rates. (Modern Healthcare, November 1993)

The California Nurses Association conducted a survey of hundreds of RNs in 19 Bay Area hospitals. Eighty (80) percent of the respondents said that staffing has worsened and 86 percent said current staffing does not allow time for unexpected events in the hospital. (CNA)

In a study of 10,000 nurses conducted by the Service Employees International Union, nearly 70 percent of the respondents said current staffing levels in hospitals are inadequate. Hospital nurses reported that patient loads were 50% higher than they should be. (SEIU Survey, Jan 1993)

We're not talking about saving money on the production line or building a better car, we're talking about people's health. When people's lives are at stake, bottom line thinking without assessing how it will affect the quality of patient care can have dire consequences.

New Models of Care

New models of patient care delivery are being introduced by hospitals and other health care providers on an almost basis. In most cases, these new programs are experimental and untested. They are embraced and adopted without data on the outcomes of implementation. Unfortunately, the product is not cars or computer chips, but people (CNA).

The most commonly used phrase for hospital restructuring is "patient focused care." A 1993 industry survey cited by Hospitals magazine (Feb 1993) found 311 hospital CEOs planning to or already implementing patient focused care. More than half cited lower costs as a primary goal. (CNA)

Typically, "patient focused care" involves cross training of hospital employees so that direct care nursing now done by RNs can be shifted to lower paid employees. The result is a sharp reduction in the ratio of RNs to patients, accompanied by a cut in total employee positions.

For patients, the consequences can be alarming. Such fundamental patient care functions as giving medication, inserting catheters, changing dressing and charting are already ending up in the hands of employees who may have had only a few weeks of training as compared to the two to four years of intensive nursing education of a registered nurse. (CNA)

* Hospitals today have fewer patients because of the trend towards rapid discharge and outpatient surgeries. Subsequently, the patients who remain in hospital beds tend to be older, and more ill. They are in need of greater patient care, not less, which is what they are often receiving in understaffed facilities. (CNA)

Government Standards

The Health Care Financing Administration (HCFA) should develop its own standards for evaluating hospitals and other health care facilities.

Currently, hospitals are regulated by the Joint Commission on the Accreditation of Health Organizations. However, that governing body is still dominated by hospital administrators. Outpatient and home care settings are often unregulated. (CNA)

Safe Staffing Standards

Much of the current crisis stems from widespread restructuring in the health care industry, which is leading to downsizing, deskilling, short staffing, and shifting acute care services from hospitals to unregulated outpatient or home care settings.

* The by-product of some of the hospital restructuring can be a growing danger to patient safety, fragmented nursing care, and serious understaffing and overwork of RNs and other care givers.

* Not long ago, it was common for RNs to comprise 90 percent of the work force involved in direct patient care. Today that skill mix is often down to 65 - 75%. (CNA)

* Short staffing in hospitals places a heavy burden on nurses because they have more patients to care for, the patients being treated in hospitals tend to be sicker and older, and the nurses have less time to spend with each patient. ~~Short staffing can lead to medication errors, lapses in infection control, and more patients falling, according to a survey of 10,000 nurses conducted last year.~~ (SEIU survey, Jan 1993)

Rebuttal Points to Counter Any Questions that Nurses May Be Doing to UAPs What Doctors Did To Nurses

When we talk about nurses substituting for physicians we're talking about delivering primary health care to mostly healthy people. In this case, we're talking about low skilled workers providing direct patient care to sick patients in hospitals - people who may die from their illnesses. I know that if my mother is in the hospital for open heart surgery, I want a nurse taking care of her not an unlicensed aide who's there to save money for the hospital.

No, we are not talking about providing an immunization or treating a cold, which are examples of primary care that nurses deliver as well as doctors. We're talking about using unlicensed aides to deliver direct patient care to people that are so ill that they are in the hospital. This is happening so that hospitals can save money, not because it is better for patients.

The issue is one of unlicensed vs. licensed workers. All RNs and MDs are licensed, so there is an automatic mechanism for public accountability, discipline, and consumer recourse. The unlicensed aide in the hospital is not held to the same standard. In fact, nurses fear the potential liability from unlicensed aides' mistakes.

There is a great need for primary care and a shortage of primary care providers. There is however, no overall shortage of RNs at this time that would justify the indiscriminate use of unlicensed workers to replace them. The only need that many hospitals have in restructuring is a need to save money.

We're talking about consumer choice. Organized Nursing has lobbied to give patients the choice whether to see an advanced practice nurse or a physician. We have never asked to close out patients' options for an MD. The consumer in the hospital doesn't currently have this choice, nor do they even know much about the person taking care of them. Most people probably assume a nurse is at the bedside, which may not be the case.