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Nursing Facts

FROM THE AMERICAN NURSES ASSOCIATION

Primary Health Care: The Nurse Solution

Although the United States will spend more than $900 billion in 1993 for health care, many Americans lack access to basic primary health care or the means to pay for it. A lack of solid primary health care takes its toll in many ways—overburdened emergency rooms, premature death from preventable or manageable diseases, high infant mortality rates, and public disgruntlement with the high cost of health care—all of which has fueled much of the current health care crisis.

America's 2.2 million registered nurses see improvements in primary health care delivery as the heart of health care reform. America's nurses are calling for:

- ▲ A basic core of essential services to be available to everyone.
- ▲ Reducing the high costs associated with physician-centered care by greater utilization of non-physician health care providers.
- ▲ Changing the current focus in health care from an emphasis on cure and technology to an emphasis on health care and prevention.
- ▲ Delivering primary and preventive health care in schools, workplaces, and other convenient community locations.

Clearly, the more effective utilization of registered nurses to provide primary health care services is part of the solution to the cost and accessibility problems in health care today. Studies have shown that 60 to 80 percent of primary and preventive care, traditionally done by doctors, can be done by a nurse for less money. Currently, there is a pool of approximately 400,000 registered nurses, including about 100,000 in advanced practice who already provide primary care services, and some 300,000 others in a variety of community and ambulatory settings who deliver many aspects of primary care, and who, with additional education, could be prepared as primary care providers to supplement the shortage of primary care physicians in this country.

What is primary health care?

Broadly defined, it means basic, initial health care for general complaints, frequently given in an ambulatory setting such as an office or clinic, and usually representing a person's first contact with the health care system. Primary health care is continuous, comprehensive, family-centered care that focuses on managing current health care needs, preventing future problems, and referring to specialists when appropriate. Primary care providers are the *gatekeepers* to the health care system.

Essential primary health care services include. . .

- ▲ Performing physical exams and taking health histories
- ▲ Assessing and evaluating common symptoms of acute illnesses like colds, infections, and asthma
- ▲ Prescribing and managing medication regimens for common or acute conditions
- ▲ Managing chronic health problems like diabetes, high blood pressure, and depression
- ▲ Screening and preventive services—blood pressure screening, nutrition counseling, immunization, smoking cessation
- ▲ Prenatal care, family planning, and delivery of normal pregnancies
- ▲ Identifying health needs that require referral for more specialized care.

Nursing Facts

FROM THE AMERICAN NURSES ASSOCIATION

Registered Nurses: A Distinctive Health Care Profession

In 1992 alone, about 90,000 persons were licensed as registered nurses, joining 2.2 million other RNs in the nation's largest health care profession.

Each followed a distinct path of education to become a registered nurse, and after obtaining the RN license, increased his or her expertise as a direct health care provider in work settings ranging from acute care hospitals to home and community centers to corporate work sites.

From the basic education required of an RN to the advanced educational and clinical paths taken by more experienced nurses, the depth and breadth of the nursing profession is meeting different health care needs of the population.

What is nursing?

Florence Nightingale, in her *Notes on Nursing: What It Is and What It Is Not,* defined nursing as having "charge of the personal health of somebody...and what nursing has to do...is to put the patient in the best condition for nature to act upon him." The philosophy has been restated and refined since 1859, but the essence is the same. In the words of nursing theorist Virginia Henderson, nurses help people, sick or well, to do those things needed for health or a peaceful death that people would do on their own if they had the strength, will, or knowledge.

The human response...

What defines nursing and sets it apart from other health care professions, particularly medicine with which it has long been considered part and parcel? It is nurses' focus—in theory and practice—on the *response* of the individual and the family to actual or potential health problems. Nurses are educated to be attuned to the whole person, not just the unique presenting health problem. While a medical diagnosis of an illness may be fairly circumscribed, the human response to a health problem may be much more fluid and variable, and may have a great effect on the individual's ability to overcome the initial medical problem. It's often said that physicians *cure*, and nurses *care*. In what some describe as a blend of biology and psychology, nurses build on their understanding of the disease and illness process to promote the restoration and maintenance of health in their clients.

Nurses: Charting the course for a healthy nation.

Nurses' broad-based education and holistic focus positions them as the logical network of providers on which to build a true ***health care*** system for the future. With a growing realization that individuals have considerable responsibility for their personal health may come a recognition that there is a professional group whose focus in education and practice is to enable individuals to reach their fullest health potential—registered nurses.

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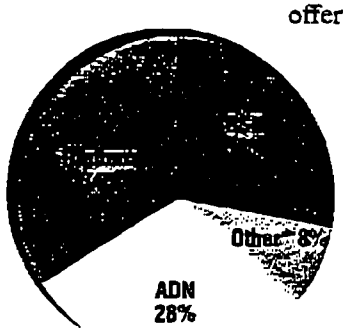
Nursing education

To gain the RN title, an individual must graduate from a state-approved school of nursing—either a four-year university program, a two-year associate degree program, or a three-year diploma program—and pass a state RN licensing exam.

BSN

The four-year university-based **Bachelor of Science in Nursing** (BSN) degree provides the nursing theory, science, humanities, and behavioral science preparation necessary for the full scope of professional nursing responsibilities, and provides the knowledge base necessary for advanced education in specialized clinical practice, research, or primary health care. About 636 U.S. colleges and universities offer the BSN or advanced nursing degree.

Education of RN workforce, March 1992
*Master's or Doctorate



First two years: General preparation including psychology, human growth and development, biology, microbiology, organic chemistry, nutrition, and anatomy and physiology.

Final two years: Nursing curriculum such as adult acute and chronic disease; maternal/child health; pediatrics; psychiatric/mental health nursing; and community health nursing. Also, nursing theory, bioethics, management, research and statistics, health assessment, pharmacology, pathophysiology, and electives in complex nursing processes.

Supervised **clinical practice** is obtained during the last two years in hospitals, nursing homes, and community settings.

ADN

A two-year program granting an **Associate Degree in Nursing** (ADN) prepares individuals for a defined technical scope of practice. Set in the framework of general education, clinical and classroom preparation prepares ADN nurses for a wide range of nursing roles that require nursing theory and technical proficiency. Many RNs whose first degree is an ADN return to school during their working life to earn a bachelor's degree or higher.

Diploma

Usually associated with a hospital, the **Diploma in Nursing** program combines classroom and clinical instruction, usually over three years. Although once a common educational route for RNs, diploma programs have diminished steadily—to 10 percent of all basic RN education programs in 1990—as nursing education has shifted from hospitals to academic institutions.

Licensing

Upon graduation, an individual must pass the National Council Licensure Examination for Registered Nurses (NCLEX–RN) to obtain a license to practice registered nursing and use the RN title. State boards of nursing govern licensing requirements, set continuing education or competency requirements, and handle disciplinary actions against RNs.

So what is a licensed practical nurse?

A licensed practical nurse is not a registered nurse. Also called a licensed vocational nurse (LVN) in some states, an LPN has taken a 12–14 month post-high school educational course that focuses on basic nursing care. LPNs also must pass a licensing exam (the NCLEX–PN). In 1992, there were about 962,000 LPNs in the United States. About 655,000 were working at an average salary of $22,714. The membership of the American Nurses Association consists only of registered nurses (RNs).

(3)

Where do RNs work?

As members of the nation's largest health care profession, registered nurses practice wherever people need nursing care, including such common sites as hospitals, homes, schools, workplaces, and community centers, and uncommon areas such as children's camps, homeless shelters, and tourist sites. Nearly 1.9 million of the nation's 2.2 million RNs were employed in 1992, about one-third of them on a part-time basis.

About 66 percent of nurses currently work in hospitals, including:

General units	149,000	Emergency room	76,000
Intensive care units	203,000	Labor and delivery	63,000
Operating/recovery room	128,000	Outpatient units	62,000
Stepdown unit	70,000		

The median salary of a staff nurse working full-time in hospitals in 1992 was $33,278. Head nurses earned a median of $47,335.

Other settings where registered nurses work include:

Community/public health	180,000	Nursing education	36,500
Ambulatory care	144,000	Insurance companies	20,000
Nursing homes	129,000	Occupational health	19,000
School health	51,000		

Advanced practice nurses

The **advanced practice nurse** (APN) is an umbrella term given to a registered nurse who has met advanced educational and clinical practice requirements, usually at the Master's level, beyond the basic nursing education and licensing required of all RNs. Under this umbrella fall four principal types of APNs:

Leading the way...

Nurse practitioner (NP)—Working in clinics, nursing homes, hospitals, or private offices, more than 49,000 nurse practitioners are qualified to provide a wide range of primary and preventive health care services, prescribe medication, and diagnose and treat common minor illnesses and injuries.

Certified nurse-midwife (CNM)—About 6,000 CNMs provide well-woman gynecological and low-risk obstetrical care. In 1990, CNMs delivered more than 148,000 babies, or about 3.6 percent of all U.S. births that year, in hospitals, birth centers, and homes.

Clinical nurse specialist (CNS)—Working in hospitals, clinics, nursing homes, private offices, and community-based settings, some 58,000 CNSs handle a wide range of physical and mental health problems, and also work in consultation, research, education, and administration.

Certified registered nurse anesthetists (CRNA)—The oldest of the advanced nursing specialties, CRNAs administer more than 65 percent of anesthetics given to patients each year, and are the sole providers of anesthetics in 85 percent of rural hospitals. There were about 25,000 CRNAs in practice in 1992.

To a healthier future...

There are more than 100,000 advanced practice nurses in the United States today, helping to bring needed primary health care services to the population and paving the way for increased use of such nurses in the future. Average salary of a nurse practitioner or nurse-midwife in 1992 was $43,500; a nurse anesthetist earned an average $77,500.

Baccalaureate and advanced education prepares nurses for the independent clinical judgment necessary in a more complex environment. While in 1977, only 18 percent of RNs had a bachelor's degree, by 1992, 30 percent of nurses had at least a BSN and nearly 40 percent of all new nursing students were enrolled in four-year programs. More than 117,000 students—11 percent of them men—enrolled in BSN programs in the 1992–1993 academic year.

(4)

The nursing process A common thread...

The common thread uniting different types of nurses who work in varied areas is the **nursing process—the essential core of how a registered nurse** delivers holistic, patient-focused care.

Assessment

An RN uses a systematic, dynamic way to collect and analyze data about a client, the first step in delivering nursing care. **Assessment** includes not only physical data, but psychological, sociocultural, spiritual, economic, or life-style factors as well. For example, a nurse's assessment of a hospitalized patient in pain includes not only the physical causes and manifestations of pain, but the patient's *response*—inability to get out of bed, refusal to eat, withdrawal from family members, anger directed at hospital staff, fear, or request for more pain medication.

Diagnosis

The nursing **diagnosis** is the nurse's clinical judgment about the client's *response* to actual or potential health conditions or needs. The diagnosis reflects not only that the patient is in pain, but that the pain *has caused* other problems such as anxiety, poor nutrition, and conflict within the family, or *has the potential* to cause complications—for example, respiratory infection is a potential hazard to an immobilized patient. The diagnosis is the basis for the nurse's care plan.

Outcomes/Planning

Based on the assessment and diagnosis, the nurse sets measurable and achievable short- and long-range **goals** for this patient that might include moving from bed to chair at least three times per day; maintaining adequate nutrition by eating smaller, more frequent meals; resolving conflict through counseling, or managing pain through adequate medication. Assessment data, diagnosis, and goals are written in the patient's **care plan** so that nurses as well as other health professionals caring for the patient have access to it.

Implementation

Nursing care is **implemented** according to the care plan, so there is a continuity of care for the patient during hospitalization and in preparation for discharge. Care is documented in the patient's record.

Evaluation

Both the patient's status and the effectiveness of the nursing care must be continuously **evaluated,** and the care plan modified as needed.

References

American Nurses Association. (1980). *Nursing, A Social Policy Statement.* Kansas City, MO: Author.

American Nurses Association. (1991). *Standards of Clinical Nursing Practice.* Washington, DC: Author.

Henderson, V. (1961). *Basic Principles of Nursing Care.* London: International Council of Nurses.

Nightingale, F. (1859). *Notes on Nursing: What It Is and What It Is Not.* London: Harrison and Sons. (Facsimile edition, J.B. Lippincott Company, 1946.)

University of Texas Medical Branch at Galveston. (1992, October). *National Survey of Hospital and Medical School Salaries, 1992.* Galveston, TX: Author.

U.S. Department of Health and Human Services, Bureau of Health Professions, Division of Nursing. (April, October 1992). *The Registered Nurse Population. Findings from the National Sample Survey of Registered Nurses, 1992.* Rockville, MD: Author.

To purchase multiple copies of Registered Nurses: A Distinctive Health Care Profession *(in packages of 50), call 800-637-0323.*

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

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or better than care provided by physicians." Nurse midwives manage normal pregnancy as well or better than physicians, and their patients were found to have shorter inpatient stays in hospitals and fewer premature deliveries than similar patients of physicians.

Registered nurses in staff positions

Additionally, some 300,000 nurses form an important pool of personnel that with an additional 12-18 months of education, could increase the nation's supply of primary health care providers for far less money than increasing the supply of primary care physicians. These include:

- ▲ 125,000 in physician offices, freestanding clinics, ambulatory surgical centers and health maintenance organizations (HMOs)
- ▲ 111,000 in community/public health settings
- ▲ 48,000 in school health
- ▲ 22,000 in occupational health

Where do nurses give primary health care?

In the community: The Corporate School of Chicago is a network of 70 agencies with a school nurse "hub coordinator" serving as the community's health professional.

A nursing HMO at Carondelet St. Mary's Hospital and Health Center in Tucson, AZ, has 15,000 enrollees in 15 community health centers and has cut by 1/3 the number of inpatient days experienced per 1,000 enrollees, for a $300,000 savings.

Health education, resource, and referral services provided by the Northwest Aging Association's Parish Nurse Project in Spencer, Iowa, allowed 118 elderly persons to remain in their homes for needed care, avoiding long-term institutional care.

In the workplace: The SAS Institute, a North Carolina software company, realized a $791,000 savings in 1987 through its self-funded insurance fund and an on-site, nurse-managed primary care center that emphasizes early intervention and comprehensive care.

Tennessee-based Northern Telecom's on-site primary care by nurse practitioners and nurse clinicians has netted the company an estimated annual benefit of more than $2.4 million, when contrasted with comparable costs for care.

In the hospital: Hospital nurses, who comprise 65 percent of all registered nurses, today perform health assessment and treatment procedures previously performed only by physicians. For example, emergency room patients are triaged and treated based on nurses' assessment of their need for care. Research shows that nurses can substitute for physicians in many areas, freeing physicians for more complex patient care.

Transitional home follow-up care: Costly hospital stays can be shortened by substituting a portion of hospital care with a comprehensive home follow-up by nurse specialists. Clinical nurse specialists prepare patients for early discharge, conduct home visits, and are available by phone with consultation from physicians. Research shows that patients had better outcomes and greater satisfaction and hospital costs were lower.

This type of care was initially used with very low birthweight babies, where it reduced hospital charges by 27 percent and physician charges by 22 percent.

Similarly, specialized neonatal care of eight infants whose mothers received no prenatal care cost the state of South Dakota more than half a million dollars, twice the cost of providing prenatal care to all women in that state who did not receive it.

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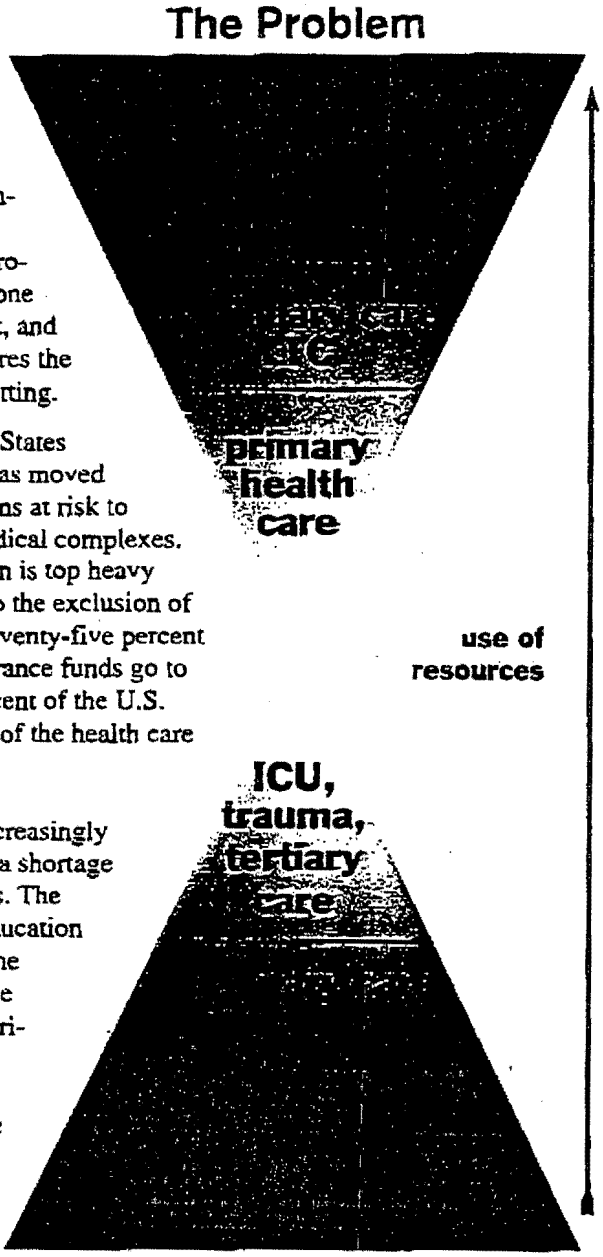
Building on a strong foundation. . .

Primary health care can be seen as the broad base of a pyramid on which is built **secondary care**—more sophisticated evaluation and continuous treatment and support such as that given in hospitals or long-term care (LTC) settings—and **tertiary care**—highly specialized health care for complex health problems such as that given in intensive care, coronary care, or trauma units.

Ideally, health care resources should be targeted at providing basic, primary health care services to all segments of the U.S. population, most of whom are generally healthy and could maintain their health with adequate primary health care. A smaller proportion of the population at any one time is hospitalized for treatment, and an even smaller proportion requires the specialized care of the tertiary setting.



The reverse is true in the United States today. Health services delivery has moved from communities and populations at risk to centralized, high-technology medical complexes. Most experts agree that the nation is top heavy with sophisticated tertiary care to the exclusion of needed primary care services. Seventy-five percent of public and private health insurance funds go to pay for hospitalization. Five percent of the U.S. population consumes 58 percent of the health care dollars.

Who provides primary health care?

As organized medicine grows increasingly specialized, there has developed a shortage of primary health care physicians. The Council on Graduate Medical Education (COGME) predicts that even if the trend toward specialization can be reversed, sufficient numbers of primary care physicians may not be available until the year 2040—**creating a need that nurses, the largest single group of health care providers in the nation, are meeting now and could meet in a larger way under a reformed health care system.**

Advanced practice nurses

There are approximately 100,000 advanced practice nurses—including nurse practitioners, certified nurse-midwives, and clinical nurse specialists—who have education and clinical experience beyond the 2–4 years of registered nurse education. Advanced practice nurses deliver a variety of services in diverse settings; some are primary care providers, while others deliver a mix of primary and specialty care.

Nurse practitioners are qualified to handle a wide range of basic health problems: the NP usually focuses on a population such as adults, women, the elderly, children, newborns, or family. A widely cited government report found NP care to be "as good

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Advanced practice nurses... a primary part of U.S. health care

The U.S. health care system is largely based on a "medical model" of care that relies on physicians to be the "gatekeepers" to services. As medical specialization has grown, there has been a parallel growth in sophisticated medical technology and treatment to the exclusion of needed basic primary health care services.

Advanced practice nurses are capable of providing much of that needed basic care. Most preventive and primary health care does not require the expensive specialization that characterizes physician education today. America's nurses believe that:

- the health care system must be restructured to focus on prevention and primary care rather than high-tech treatment and cure of disease.
- regulatory and legislative barriers to increased use of nurses as health care providers must be removed.
- basic health care services must be available to all citizens in convenient community locations.

References

"Executive Summary: A Meta-Analysis of Process of Care, Clinical Outcomes, and Cost Effectiveness of Nurses in Primary Care Roles: Nurse Practitioners and Nurse-Midwives," American Nurses Association, January 1993.

"Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing," *Yale Journal on Regulation*. 9 (2). B. Safriet, Summer, 1992.

Monthly Vital Statistics Report. 41 (9) (s), National Center for Health Statistics. February 25, 1993. DHHS Pub. No. (PHS) 93–1120.

"Nurse Anesthesia and the American Association of Nurse Anesthetists." American Association of Nurse Anesthetists, July 1992.

"Nursing's Agenda for Health Care Reform," American Nurses Publishing, February 1992.

"Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis." HCS 37. Congress of the United States Office of Technology Assessment, December 1986.

"The Registered Nurse Population. Findings from the National Sample Survey of Registered Nurses. March 1992 (preliminary)," U.S. Department of Health and Human Services. Bureau of Health Professions, Division of Nursing, April 1993.

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NEWS RELEASE

FOR IMMEDIATE RELEASE:
February 16, 1994

CONTACT: Erin Eckles, ext. 248

ANA TELLS HOUSE COMMITTEE THAT HEALTH CARE REFORM MUST INCLUDE RETRAINING AND REDEPLOYMENT OF WORKFORCE

If consumers are to fully benefit from a reformed health care system, such reform efforts must be accompanied by adequate retraining and redeployment of the professional health care workforce, said the American Nurses Association (ANA) in testimony before the House Education and Labor Subcommittee on Labor-Management Relations, February 10, 1994.

The ANA supports the Clinton Health Security Act, which is currently the only health care reform proposal before Congress that addresses the education and retraining needs of nurses and other health professionals. These provisions are critical since reform is expected to result in a shift to a community-based system of care and a partial redeployment of the current nursing workforce.

"To move ahead with health care reform without addressing the impact it will have on the current industry workforce would be like writing only the first act of a two-act play. We can't afford to wait until a new health care structure is set up to find out whether we have the qualified persons to deliver promised services," said Gwendylon E. Johnson, MA, RN, C, member of the Board of Directors for American Nurses Association.

During her testimony, Johnson urged Congress to enact interim quality protectors to safeguard patients as a means of ensuring that hospital efforts to restructure and contain costs are handled responsibly. The ANA is concerned that the quality of care may be adversely

MORE...

affected by hospital cost savings strategies. While this may be a necessary part of the transition to a new health care system, ANA warned about the potential for deterioration in the quality of care.

The ANA urged the Committee to consider the implications of the following workplace issues:

1. Changes in demand for health care under the Health Security Act will require an adequate supply of appropriately educated health care providers. Health care reform efforts must be accompanied by adequate retraining and redeployment of the professional health care workforce. This will include training and dislocated worker services as well as a dedicated funding stream for graduate nursing students to prepare for the increased need for advanced practice nurses.

2. Hospital efforts to restructure and contain costs must be handled responsibly. Proactive downsizing with increased reliance on unlicensed aides, without a full assessment of the impact on patient care, may seriously jeopardize patient safety and access to quality care. Congress should enact interim quality protectors to safeguard patient care during this period of transition.

The ANA supports the provisions in the Health Security Act designed to address these workforce issues, and it supports the development of the National Institute for Health Care Workforce Development. The National Institute would analyze the workforce needs and be made up of representatives from health care institutions, labor unions, educators, and consumers - all of whom have a stake in creating a health care system that works.

Johnson said retraining the nursing workforce will require transferring hospital skills to other settings. Funding must be made available to support the education and retraining of nurses who are forced to leave the acute care workforce for jobs in community, primary and preventive care practice.

Currently there is one nurse practitioner available for every seven open positions, and it is anticipated

TESTIMONY/3...

that under a reformed health care delivery system this demand will increase. Preliminary data from a study being conducted at the University of Wisconsin under a Robert Wood Johnson Grant show that when nurse practitioners are used by HMOs the need for MDs decrease by 30-50 percent. The data also show that the inclusion of an NP on the patient care team doubled the team's efficiency.

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distribution: entire

To: Lissa
From: Claire
Re: Requested Material
Date: June 7, 1993

Nursing

I. History

The practice of nursing, or caring for the sick and disabled and promoting good health practices, probably began as early as man himself. It has evolved through the centuries from a practice based largely in mysticism and magic to one grounded in the rules of science and nature. Historically, as nursing is based upon notions of compassion and assistance, religious organizations have been primary in the development of the profession. From the Knights Hospitalers of St. John (now the Knights of Mala) to untrained lay volunteers such as Walt Whitman and Dorthea Dix, such caretaking has always maintained a foundation of caring and good will.

Nursing as an instituted profession truly began in the 19th century. With the transition from home health care to institutions for such care, both the opportunity and the demand for nurses grew tremendously. As institutionalized care primarily occurred in prisons or mental health facilities, and individualized care in the home, the blending of this segmentation provided a unique opportunity for the development of nursing skills, treatments, and patient care.

Yet, it is Florence Nightingale who stands as the primary catalyst for this transition. Although expected to follow the "proper lifestyle" for a woman of her day, she began her nursing career in a nursing home in England. After deciding that lack of training was the primary weakness of caregiving, she began negotiations with a local college for the necessary courses. With the outbreak of the Crimean War, however, she once again turned her focus upon the tragedy of cholera, war, inadequate supplies and unsanitary conditions. Later, she reformed all midwifery services and established the British health visitor service. Still known as an "Angel of Mercy", her system of training is still utilized throughout the world.

Clara Barton also stands as a leading figure in the nursing profession. Although originally employed as a teacher (she resigned when a male was given a superior position), she became an unpaid nurse during the Civil War. Subsequently, in her position as superintendent of the Department of Nurses of the Army of the James, she urged women's organizations to donate food and bandages to the soldiers; she herself delivered the items to the front. After traveling extensively in Europe, she organized the American Red Cross in 1877 and served as its first President until 1904 (Encyclopedia Britannica, 1993; The Book of Women's Firsts, 1992).

II. Statistics

1. In 1992, 90,000 persons were licensed as registered nurses, bringing the total number of nurses to almost 2.3 million.

2. Place of Employment

   a. Hospitals - 1,051,000
      1. general units - 449, 000
      2. intensive care - 203,000
      3. operating/recovery room - 128,000
      4. stepdown unit - 70,000
      5. emergency room - 76.000
      6. labor/delivery - 63,000
      7. outpatient units - 62,000
   b. Community/Public Health - 180,000
   c. Ambulatory Care - 144,000
   d. Nursing Homes - 129,000
   e. School Health - 51,000
   f. Nursing Education - 36,500
   g. Insurance Companies - 20,000
   h. Occupational Health - 19,000

3. Salary (available for hospital nurses only)

   a. Staff nurse - $33,278
   b. Head nurse - $47,335

4. Employment
   a. 27% of hospitals have begun downsizing their workforce (1993).
   b. In the last 18 months, Georgetown University Hospital and Children's Hospital, and Fairfax County's INOVA reduced their RN staff.
   c. Hospitals which reduce staffing by 7.75% or more were 400 times more likely to see an increase in patient illness and mortality rates (1993, conducted by E.C. Murphy Ltd.)

III. Role in Primary Health Care

1. Perform physical exams.
2. Take health histories.
3. Assess and evaluate common symptoms of acute illnesses like asthma, infections, and colds.
4. Prescribe and manage medication regimens for common or acute conditions.
5. Manage chronic health problems like diabetes, high blood pressure, and depression.
6. Screenings and preventative services - blood pressure, immunization, smoking cessation.

7. Prenatal care.
8. Family planning.
9. Delivery of normal pregnancies.
10. Referrals for specialized care.

(Source-"Nursing Facts" from the American Nurses Association).

IV. Trends for the Future

The nursing profession is currently experiencing the development of several new trends. Generally, as with the entire medical profession, the trend is towards increased specialization. Having historically performed such functions as dental assistants, pediatric nursing, psychiatric nursing, and even operating-room nurses, they may today enter into fields of cardiac care, neurological nursing, kidney-dialysis nursing, intensive care nursing, geriatric nursing, rehabilitation, and the care of terminally ill patients (Encyclopedia Britannica, 1993).

V. Personal Stories

1. Helen Briggs Ramsey was a member of the Red Cross assisting wounded soldiers during World War II (see enclosed story).

2. Helen Fitzgerald was a nurse during the Normandy invasion. She served with the Army Nurse Corps with the Fifth Harvard Medical Unit. She was an operating room nurse-anaesthetist in England and France and took part in the Normandy invasion (Boston Globe, February 5, 1992).

3. May Alm was a nurse during World War II (see enclosed story-quotes may be helpful).

See page 9

October 5, 1993, Tuesday

SECTION: CAPITOL HILL HEARING TESTIMONY

LENGTH: 12023 words

HEADLINE: TESTIMONY OCTOBER 5, 1993 LINDA SHINN EXEC. DIREC. AMER. NURSES ASSOC. SENATE LABOR VIEWS OF HEALTHCARE PROVIDERS

BODY:

TESTIMONY OF THE AMERICAN NURSES ASSOCIATION

BEFORE THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE

ON HEALTH CARE REFORM

OCTOBER 5,1993

Mr. Chairman and members of the Committee. I am Linda Shinn, MBA, RN, CAE, Executive Director (Interim) of the American Nurses Association (ANA). Thank you for inviting us to testify today on President Clinton's health care reform proposal.

The American Nurses Association is the only full-service professional organization representing the nation's two million registered nurses including staff nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by working closely with the U.S. Congress and regulatory agencies on health care issues affecting nurses and the public.

Access to high quality, affordable health care is of concern to millions of Americans -not only to the over @ seven million who are uninsured, but to the growing number of currently insured who fear that changing or losing their jobs will result in loss of coverage or that skyrocketing costs will make their dependent's coverage or their own out-of-pocket health care costs unaffordable.

We are also testifying on behalf of the:

American Association of Critical Care Nurses (AACN), the largest specialty nursing association in the United States with over 73,000 members who are dedicated to the welfare of people experiencing critical illness or injury. AACN has pledged its strong support of the Clinton Administration's health care plan;

American Association of Nurse Anesthetists (AANA), the professional society that represents over 24,000 certified registered nurse anesthetists (CRNAs), which is 96 percent of all nurse anesthetists who practice across the United States. AANA's Board has voted to support the Clinton Plan; American Association of Colleges of Nursing, with over 432 members offering baccalaureate, master's, and doctoral nursing education; The Association of

Operating Room Nurses, Inc., the professional organization of perioperative nurses dedicated to enhancing the professionalism of perioperative nurses, promoting standards of perioperative nursing practice to better serve the needs of society and providing a forum for interaction and exchange of ideas related to perioperative health care; Emergency Nurses Association, the voluntary membership association of over 21,000 professional nurses committed to the advancement of emergency nursing practice; and National Nurse Practitioner Coalition, a group of nurse practitioners who advocate for universal access to basic health care and the removal of barriers to consumer access to nurse practitioner care. Mr. Chairman, we commend you on your leadership on health care reform and we were proud to support S. 1227 in the 102nd Congress as one of the first steps in this process. We you for your attention to nursings' issues throughout your leadership with this Committee.

America's two million registered nurses deliver many essential health care services in the United States today in a variety of settings -- hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice and in managed care settings. Nurses know firsthand of the inequities and problems with our nation's health care system. Because we are there -- twenty-four hours a day, seven days a week -- we know all too well how the system succeeds so masterfully for some, yet continues to fail shamefully for all too many others.

Nurses see people on a daily basis who are denied or delayed in obtaining appropriate care because they lack adequate health insurance or are unable to pay for care. These people often postpone seeking help until they appear in a hospital emergency department in an advanced stage of illness or with problems that could have been treated earlier in less costly settings or, more appropriately, prevented altogether with earlier treatment or prevention services. Delayed access to needed care is associated with problems of increased morbidity and mortality as well as countless hours of lost productivity in the workplace. Infants and children, pregnant women, the frail elderly, people with persistent health problems, rural and inner city residents and minorities are disproportionately represented among these most vulnerable uninsured groups. Their complex and diverse needs are not met by the existing system.

Nursing is concerned by the failures in our current health care system. More than 37 million people have no health insurance and millions more are critically underinsured. Our health care systems are oriented toward expensive interventions to treat illness, rather than essential health services designed to promote and maintain health. As a nation, we have failed to develop appropriate ways to allocate available health care resources and services. Unfortunately, the burden of the reality of the failures of our health care system are disproportionately felt by vulnerable segments of our nation's population. This includes the very young, the very old, the poor, the illiterate and those who live in rural and frontier communities and low-income urban communities.

Like President and Mrs. Clinton and so many Members of Congress, America's nurses believe that it is time to frame a bold new vision for reform - one that keeps what works best in our current system, but casts aside institutions and policies that fail to meet present and future needs -- a plan that addresses the triad of problems that exist in the current system: inequitable and limited access, soaring costs and inconsistencies in quality and appropriateness of

care delivered.

NURSINGS AGENDA FOR HEALTH CARE REFORM

For the last three years, nursing has worked to develop a plan which encompasses the profession's best vision of a health care system for the future. To ensure that all areas of specialty practice (i.e., critical care, operating room, emergency nurse, nurse practitioner and other advanced practice nurses, etc.) and unique geographic differences were sufficiently represented in the development of this plan, ANA convened a special task force of nursing experts. They evaluated the current health care system in the United States, as well as those of other nations, and subsequently developed a plan for reform that is uniquely American.

To date, in addition to ANA's state and territorial associations, more than 80 national nursing and health-related organizations have endorsed this proposal for health care reform, entitled "Nursing's Agenda for Health Care Reform".'

Nursing defines the health care crisis in terms of the need to restructure, reorient and decentralize the health care system in order to guarantee access to services, contain costs and ensure quality. Fundamental restructuring must occur because patchwork approaches have failed. Health care reform must be comprehensive and not limited to addressing only one or two components of the problem. Nursing's proposal does not define the problem only in terms of the uninsured or underinsured; rather, it addresses the health care needs of the entire nation. "Nursing's Agenda for Health Care Reform" calls for building a new foundation for health care in America while preserving the best elements of the existing system. Influencing the direction of health care reform is a complex, demanding task. Nurses know, however, that in order to preserve the health and well-being of our country and its people we must make important, fundamental changes in how, where and to whom health care is delivered.

Today, America's two million registered nurses are united in urging that the nation's health care system be cured ... and cured now. We must reshape and redirect the system away from inappropriate use of the expensive, technology-driven, hospital-based models we currently have. A balance must be struck between high-tech treatment and prevention. It is nursing's belief that the system must emphasize and support health promotion and disease prevention and show compassion for those who need acute and long-term care.

Among the basic components of "Nursing's Agenda for Health Care Reform" are the following:

* universal access for all citizens and residents provided through a restructured health care system;

* a federally-defined standard package of health care services including preventive, prenatal, well-child, mental health, acute and short duration long-term care services;

* guarantees that coverage is provided for the poor with a plan administered by the states in order to anticipate the health care needs and changing demographics of the population. Elimination and restrictions on co-payments and deductibles for those near or under the poverty level;

* an employer mandate to ensure that all employed persons have access to health insurance with a standard benefits package;

* a shift in focus to provide a better balance among treatment of disease, health promotion and illness prevention such as coverage for immunizations, prenatal care, and health screening which has proven effective in preventing costly and devastating disease (e.g., colorectal and testicular exams, pap smears and mammograms);

* enhanced consumer access to services by delivering primary health care in community based settings. The new system would facilitate utilization of the most cost-effective providers and therapeutic options in the most appropriate settings;

* Steps to reduce health care costs, such as:

-ensuring consumer access to a full range of qualified health care providers;

-providing early treatment and prevention services at convenient sites, such as schools, the workplace, and other familiar community settings;

-reducing defensive medicine and unnecessary practices;

-controlled growth of the health care system through planning and prudent resource allocation; and

-elimination of unnecessary bureaucracy and decreased administrative requirements through the use of uniform claim forms and electronic billing;

* utilization of case management for people with continuing health care problems to promote active participation in their care and reduce fragmentation of the health care system;

* provision of long-term care services of short duration and in addition to a program of extended care in order to prevent personal impoverishment. This proposal win require more shared community responsibility for care. It will prevent impoverishment due to extended long-term care needs;

* insurance reforms are required to ensure improved access to coverage, including community ratings, affordable premiums, reinsurance pools for catastrophic coverage and other proposals to assist the small group market;

* access to services are ensured by no payment at the point of service and elimination of balance billing in all health plans.

There are several key features of "Nursing's Agenda for Health Care Reform" that are very similar to provisions contained in President Clinton's "American Health Security Act".

Universal Access Like the Clinton Administration, nursing believes that universal access to health care services is a principle that can not be compromised. The Clinton Administration proposal would ensure that health care would be available to everyone -- including those who are now uninsured, underinsured and those who are potentially uninsured. For any health care

reform plan to be successful, it is critical that it address not only access to health insurance, but also access to health care services. Under the Clinton Administration's proposal, the health care setting could be restructured and reoriented so that services would be available in schools, workplaces and community settings as well as in hospitals and providers' offices. Consumer access to health care services must be maximized. Consumer education must be prioritized to foster increased awareness and responsibility for personal health and self care and to provide a greater capacity for informed decision making in selective health care services. In addition, criteria for outcomes of care should reflect the joint perspective of both the health care consumer and the health care provider. The plan's emphasis on preventive and primary care services is also crucial, because it means that consumers will have a relationship with a primary care provider including nurses, nurse practitioners, certified nurse midwives, etc., that begins when they are still well -- so that disease can be prevented whenever possible and so that the provider will be able to intervene earlier, to minimize the severity of illness.

We commend the Administration's plan for recognizing that there will be a greatly increased need for primary care providers in order to ensure access to care and for addressing this need in a comprehensive manner. The plan calls for increased funding for primary care providers -- including advanced practice nurses such as nurse practitioners, clinical nurse specialists and certified nurse midwives. It also calls for removing barriers to the practice of these advanced practice nurses so that consumers' access to these much-needed services is not restricted.

We applaud these moves because they will greatly assist in achieving the goal of universal access to care. The role of nurse providers is very important to the issues of access to high quality health care. The health care system will need a substantial increase in hours of care of these providers.

We are also extremely pleased to see that the Administration plan has addressed the need for increased access to services in rural areas by creating incentives, including financial incentives for health care providers to serve in those areas. Again, nurse providers can play a key role in treating the newly insured populations under health reform. One of the mechanisms that the Administration is proposing to increase access to health care in rural areas is the expansion of the National Health Service Corps. Nursing applauds the Administration for proposing a 20 percent set aside within this program for providers other an physicians.

As the members of this Committee know, there is a growing trend in this country toward part-time and intermittent employment. Unfortunately, such employment status has often meant foregoing benefits, including health insurance benefits. Women comprise the majority of these part-time employees. Nurses have not been immune to this trend, and nursing associations are very concerned about it. Increasingly, nurses in both full-time and part-time employment are losing their employment benefits including health insurance. We know of registered nurses employed full-time at $10.00 per hour and with no health care benefits. Their salary does not permit purchase of individual insurance. Guaranteeing health insurance to all employees is something that is of great importance to nurses both as health professionals and as employees.

Standards Benefits Package

A cornerstone of "Nursing's Agenda for Health Care Reform" has been the guarantee of a standard health benefits package. We are gratified that the Administration's proposal provides a guaranteed package of benefits, emphasizing a broad scope of quality health services, not just treatment of disease. It supports school-based clinics, enhanced services for underserved populations and health education. It includes such critical elements as home-based care and public health initiatives and also takes an important step toward addressing the growing need for better and more accessible long-term care services. In addition, the Administration's package includes such important preventive services as immunizations, screening and prenatal care. It places new emphasis on primary care and preventive services delivered not only by physicians, but also by nurses and other qualified health care providers in convenient, accessible settings.

By including services that are geared toward preventing and minimizing disease, the Administration's plan can save the health care system immense amounts of money and ensure a healthier population. One of the clearest examples of preventive care saving long term costs in the health care system is the provision of pre-natal care. Numerous studies have shown that receipt of adequate pre-natal care is associated with the improvements in pregnancy outcome, particularly a reduction in the risk of low birth weight infants. Health care costs for newborns is significantly lower for babies with mothers who have had adequate pre-natal care. In one study in Missouri, adequate pre-natal care during pregnancies resulted in a savings of $1.49 for each extra $1 spend on pre-natal care.

We urge the Committee to act to ensure that full and complete reproductive health services are available to women and that preventive screening services, such as mammograms and Pap smears, be available in intervals that are sufficient to detect disease in a timely fashion. Prevention screening for breast and cervical cancer literally saves thousands of lives. The incidence of breast cancer in the United States approximates 150,000 women per year and about 44,000 of those women will die of the disease. Early detection of breast cancer is important because survival is directly related to tumor size and lymph node status. Small, non-palpable cancers found by screening mammography have a 10-year survival rate of 95 percent. When nodes are involved, the survival rate drops to 53 percent or less. Currently, the majority of breast cancers are detected at this latter stage.

THE ROLE OF THE NURSE PROVIDER

The expanded role of nurses in a reformed health care delivery system, including advanced practice nurses such as nurse practitioners, is apparent throughout President Clinton's proposal. It is an important element of the plan's emphasis on preventive health services--services which have been at the center of nursing practice since the inception of the nursing profession. Nurses are key providers in acute care, school and community health clinics, in home care, hospice care and ambulatory care, all of which are part of the package of benefits to be available under the President's plan.

Nurses, including advanced practice nurses, are well-positioned to fill many of the current gaps in accessibility and availability of primary and preventive health care services. There are over I 00,000 advanced practice nurses with advanced education and training in providing primary care services. As many as 300,000 additional nurses could be prepared to provide such services with

additional training.

Virtually every study of patient care provided by providers other than physicians has concluded that these providers can deliver services of the same quality as physicians at lower costs. To meet the estimated additional 64 million nonemergency ambulatory care visits under a universal access health care system, 9,000 additional general and family practice physicians would be required at an office expense of $2.1 million. Alternatively, less than 17,000 nurse practitioners could provide the same level of services at a similar level of quality for about $1.5 million, a savings of 25 percent.

For example, in Philadelphia, a new model for home care of very low birth-weight infants is run by a group of certified nurse specialists. This project yields the same health outcomes as those generated by physicians, but at an average savings of over $18,000 per infant. A family nurse practitioner in Washington, Kansas directs a clinic serving the critically underserved, as defined by the Kansas Department of Health and Environment. The physician director of this clinic left in 1986, and the clinic subsequently lost its Federal funding. At this time, the clinic is being leased by a country hospital from a non-profit corporation and has contracted with the advanced practice nurse to run the clinic which includes eight exam rooms and is fully equipped. Since a physician is not on the premises, the advanced practice nurse needs to be eligible for direct reimbursement of her services. As she serves in a rural area, she became eligible for reimbursement under Medicare in 1991. She also works through the Kansas Blue Cross and Blue Shield office, the state Medicaid Bureau, and other private insurers to obtain reimbursement under each of their systems. Currently, in the town of Washington, Kansas, there is only one family physician and only three physicians in the entire county. The nurse run clinic is essential to providing the citizens of Washington, Kansas with health care services.

The Marriott Corporation has a nurse-managed program that administers a multifaceted approach to work site health care including primary, secondary and tertiary care. Marriott estimates that with the services of each nurse, the company saves $250,000 per year in health care costs and lost productivity. Occupational health nurses work as employee advocates handling worker's injuries and collaborating with physicians to make sure injured workers receive appropriate care as well as providing primary and preventive care to ensure workplace safety. The Department of Labor is currently using registered nurses as case managers for workers compensation cases. The use of registered nurses has enabled the participating states to reduce case backlog and has facilitated earlier rehabilitation and return to work of the injured employees.

In Spencer, Iowa, a program entitled "The Northwest Aging Association's Parish Nurse Project" provides health education, resources and referral to elderly persons and facilitates implementation of volunteers and support groups. These interventions have provided assistance which has allowed II 8 of the elderly in Spencer to remain in their homes -- a cost savings to both the families and the health care system.

In Chicago, there is a program called the Beethoven Project. This program occupies 10 renovated apartments in a Chicago public housing project which has a high level of poverty and crime. Comprehensive services, such as primary health care, Head Start and a full-time child care center in addition to drop-in counseling, psychological consultation and care management are provided by the

nurse directors.

Nursing centers with nurse practitioners in 17 nursing centers in southern Arizona provide health care to about 6,500 patients each year, including many traditionally underserved and at risk populations (e.g., especially senior citizens, Hispanics, and Native Americans). For a half day each week, the Community Nursing Network sets up health centers in churches, recreation centers, physicians' offices, and retirement communities. Registered nurses manage 25,000 visits each year, performing physicals, treating minor illnesses, and monitoring chronically-ill patients. These programs provide free care for those with no insurance coverage. However, the ability of nurses to provide health care services has been continually hampered by a number of artificial barriers that serve to cut the consumer off from access to services provided by these competent and qualified health providers. These barriers include restrictive reimbursement policies by Federal and state programs and private insurers. They include irrational restrictions on nursing practice such as physician supervision requirements by laws and regulations at the state level. We have a Medicare program that denies payment for needed health care services by nurse practitioners or clinical nurse specialists in non-rural areas, including underserved urban areas. The laws regarding reimbursement for advanced practice nurses are complicated and convoluted as to which categories of advanced practice nurses may be reimbursed, in what geographic areas, who may be paid and whether or not collaboration with other health providers is required. They are confusing and complex enough, to carrier, provider and consumer alike, as to provide a barrier to access to these services in and of themselves. In addition, there are state Medicaid programs that deny reimbursement to certified registered nurse anesthetists and many categories of nurse practitioners and clinical nurse specialists, even when they are the only providers willing to furnish services to underserved Medicaid recipients. Laws and regulations in many states put unneeded restrictions on the practice of nurses, including advanced practice nurses, to provide services to patients, to provide routine care and medications, to bill insurance companies, operate a private practice, obtain clinical privileges or admit patients to a hospital.

For example, in Vancouver, Washington, one nurse practitioner provides health screening, immunizations and other services to over 2,000 poor children in five inner-city schools which she visits weekly in her mobile van. In other state such as Illinois, this nurse practitioner could not perform these services, as state law would prohibit her from being directly reimbursed by Medicaid.

Inconsistent state restrictions on prescriptive authority for advanced practice nurses is another barrier to health care and promotes the costly use of an additional provider.

In addition to the general examples of barriers to practice just noted, there are three specific Medicare reimbursement barriers to practice that exist for certified registered nurse anesthetists (CRNAs). First, the current Medicare conditions of payment for anesthesiology services that anesthesiologists must meet in order to be paid for Medicare for medically directing a CRNA, restrict CRNAs from performing all the components of an anesthesia service that they are legally authorized to perform. For example, some anesthesiologists insist on performing the anesthesia induction on all patients themselves, then leaving the CRNA to finish the case. Second, the current Medicare hospital condition of participation for anesthesia services

and the Medicare ambulatory surgical center condition of participation for coverage for surgical services restrict CRNA practice by requiring physician supervision of CRNAS. Third, the current Medicare regulation on payment for the services of CRNAs states that if a CRNA and anesthesiologist work together on one case, the anesthesiologist may bill the case as if he/she personally performed it and receive I 00 percent of the Medicare payment. No Medicare payment is typically made to CRNA involved in such a case, even if the CRNA was the provider actually administering the anesthesia to the patient. Nurse managed units within acute care settings are also both cost effective and provide quality care. For example, nurse managed units are proving to be very successful in managing patients being weaned from respirators. In addition, studies have documented the positive outcomes demonstrated by the use of neonatal nurse practitioners with low birthweight infants. The President's plan would address the problem of artificial restrictions on nursing practice by preempting such barriers to practice, providing incentives for states to adopt a federal model for nursing practice statutes, and by including payment for services of advanced practice nurses. It is our understanding that the Administration plans to shore up these provisions by ensuring that advanced practice nurses do not face exclusion or other discrimination by health plans and by extending Medicare coverage to the services of nurse practitioners and clinical nurse specialists in all settings.

Just as nurses throughout the United States have demonstrated their ability to provide high quality, cost effective and accessible health services, consumers have shown their widespread acceptance of these services and their willingness to continue receiving primary care services from nurses. A recent Gallup poll revealed that the vast majority of Americans (86 percent) are willing to receive everyday health care services from an advanced practice registered nurse that they now must go to a physician to receive. Only twelve (12 percent) percent said they would be "unwilling" to go to a registered nurse. Nurses are currently working with consumer-oriented organizations in order to promote shared principles of health care reform. We are confident that as the American public becomes more familiar with the primary care services that nurses can provide, and as more Americans have an opportunity to receive such care from nurses, that the "unwilling" category will decrease sharply. In fact, we believe that, based on the experiences of advanced practice nurses in HMO, clinic, and private practice settings, more and more Americans will identify nurses as their provider from whom they select to receive primary care services.

QUALITY ISSUES

As health care reform becomes a reality, hospitals and other health care institutions will experience increasing pressure to contain costs. As the focus of the health care delivery site shifts from acute-care institutions to community based care, there will be an increase of hospital mergers and closures of hospitals resulting from an oversupply of beds. It is anticipated that some hospitals will specialize and others will integrate services such as home health and nursing homes.

Nurses have had an opportunity to experience first-hand what many hospitals do when they face pressure to cut costs. In the last few years, nurses have grown increasingly alarmed at the wholesale reduction in quality of care that many hospitals have initiated in the name of cost-savings and cost-efficiency. Numbers of nurses have been cut and nurses have been laid off. In their place, hospitals have hired unlicensed, semi-skilled personnel, often trained by the

hospitals themselves in brief training courses. While the use of unlicensed personnel to assist registered nurses is not new, hospitals in the last few years have greatly expanded the use of these personnel, both in numbers and in the range of functions they perform. This has happened at a time when, due to a number of factors, the severity of illness of the hospitalized patient population has increased significantly. As a result, registered nurses find themselves caring for and supervising care for ever-greater numbers of increasingly sick patients. This has meant a continual downgrading of care for patients, one which poses a real risk to their health and safety while hospitalized.

Many hospitals have openly stated--threatened, if you will--that they will increase the trend toward downward substitution if health care reform is enacted. We consider this not only a threat to nurses, but also to the patients we care for--patients who literally entrust their lives to the hospitals. We believe that hospitals must adhere to strict quality controls if patient care is to be protected. Hospitals should not be permitted to sacrifice patient care in the name of cost efficiency. We have received every indication that the Administration will work to institute mechanisms to protect and ensure safe, quality care both in the long run and in the period of transition to a reformed health care system. These mechanisms will include the development of patient outcome measures as well as, in the immediate period, criteria that monitor changes in hospital staffing and patient care delivery patterns to ensure that patient care is not compromised.

THE HEALTH CARE WORKFORCE

Nursing has been working with the Department of Labor and the White House on their workforce proposals in the health care reform plan. We commend the Department of Labor for developing an initiative that provides assistance to workers before they potentially become unemployed. Nursing supports their concept of developing a National Institute for Health Care Workforce Development in order to have a mechanism to analyze the workforce needs of a new health care system.

Critical workforce issue are raised by the health care reform plan and its effect on employment. Within the health care industry, there will be impacts based on the types of jobs individuals hold. Nurses are the single largest groups of health care providers. It is estimated that fully two-thirds of the nation's registered nurses will need to be retrained to appropriately staff a revised health system. Although we are optimistic that nurse displacement will be short term, it will be essential that a retraining and redeployment plan be designed to facilitate that transition. Nursing believes that the transition plan must include a series of interim quality protections that safeguard patient care and provide for re-training and re- deployment of health care personnel. The decision of hospitals and other institutions to significantly alter staffing levels , mix or re- ploy personnel should be guided by several basic principles:

* Advanced public disclosure of the intention to merge, close, or significantly redeploy personnel;

* Involvement of consumers and affected professional personnel in development and implementation of educational programs and other means for re-deployment;

* Evaluation and report to health care consumers;

* Analysis of the impact of the re-deployment on patient outcomes and other quality care indicators; and

* Assurance that re-deployment plans use professional personnel in accord with licensure laws, educational preparation and assessed competence.

In addition, a national transition plan for the health care workforce should contain, at a minimum:

* Retraining and relocation programs to prepare personnel to assume positions in primary health care, public health, and critical care across a variety of health care delivery settings;

* Use of conversion boards to assess the opportunity for the hospital or institution to be converted to some other use in order to keep the jobs in the community;

* Institution of training programs on "How To Start A Business" and access to small business loans in order to encourage nurses and other providers to establishment small community health care clinics to benefit their communities;

* Pre-notification to providers and the community of any hospital closure or merger;

* Continuation of health and pension benefits for health care personnel;

* Continuation of HIV disability coverage;

* Limits on discounting health care services to prevent cost shifting; and

* Annual public reports about the impact of major institutional changes in staffing levels, mix, or deployment on the quality of care delivered.

The situation of a re-focused health care workforce must be monitored very carefully throughout the transition period and into the enactment of health care reform. Should there be significant increases or changes in morbidity or mortality rates or increases in adverse occurrences (i.e., falls, infections, medication errors) or other indicators of change in the quality of care in hospitals, then more aggressive steps to ensure quality patient care will need to be enacted such as a decertification or fine system for hospitals not complying with quality standards.

We understand that the Administration's health care proposal contains many of these provisions to provide a workforce transition plan for health care personnel. Nursing cautions, however, that training opportunities envisioned for low skilled workers in the health care industry (clerical and administrative support positions) may inadvertently increase the pool of another group of low skilled workers (such as nurses' aides, nursing technicians, nursing assistants). Nursing is concerned that any emphasis on short-term and on-the-job training as well as the use of the term "higher value added health care jobs" without defining such jobs will increase the number of low skilled health care providers. This goal neither meets the health care needs of the nation, or is in the best interest of these workers, most of whom are women.

Rather, increasing the pool of professional health care providers is critical.

Another issue associated with a decreasing demand for hospital based nurses is the possible decline in nursing wages. To minimize this downward pressure on wages, the current and future supply of nursing labor must be channeled away from settings with decreasing demand and into high growth areas. To maximize nurses' earnings and avoid serious imbalance in the supply and demand for nurses, a specific plan to systematically assess, manage and evaluate the recruitment, education and utilization of nurses is needed.

NURSING EDUCATION

Health care reform will require a refocusing of knowledge and skills for nursing faculty and future nurses. With greater emphasis on prevention and early intervention, as well as a decreased need for acute care nurses, nursing education will need to be re-focused on primary health care and the management of acute minor illness and complex chronic diseases. Skills in case management, discharge planning, supervision of health personnel, and financial planning will be essential. Fortunately, many nurses are skills in these vital areas, but many more will be needed.

The trend that will occur in a health care reform environment which is of most significance to nurses is the shift in balance between episodic, high cost, specialty focused, hospital based tertiary care to primary and preventive care delivered in a range of ambulatory care settings by a variety of practitioners. This shift is already occurring, as witnessed by the rapid growth in home care and ambulatory care services.

Since World War II, the majority of nurses have been educated for and employed in hospitals. Significant educational efforts on both the part of individual nurses and the health system are now needed to focus on the delivery of primary health care services. The Administration has included several health provider education initiatives in their proposal. Under their plan, the Secretary of Health and Human Services will determine the estimated need of nurse workforce and advance practiced nurses needed to meet the current health care demands of the nation. This will be based on the workforce estimates developed by the National Council on Nurse Education and its allocated regional councils. To fund nurse education, new programs need to be established to increase the supply of nurses.

According to the National Sample Survey of Nurses (1988), there are approximately 125,000 registered nurses working in physician offices, freestanding clinics, ambulatory surgical centers, health maintenance organizations and other ambulatory care settings. In addition, there are approximately 11,000 registered nurses working in community/public health settings, 48,000 in school health, and another 22,000 in occupational health. With the appropriate funding support this pool of generalists nurses could begin to rapidly increase the nation's supply of primary care providers.

Nursing commends the Administration for its increased focus on nurse education issues.

It is clear that the United States health care system has an increasingly urgent need for primary care providers. Immediate funding must be made available to strengthen existing advanced practice nurse programs and to

establish new programs to prepare the primary care providers so urgently needed.

The Administration's plan would shift the funding emphasis under Graduate Medical Education from specialty physicians to primary care physicians. Advanced practice nurses will be increasingly needed to fill the future gap created in this shift in medical education. For example, a reduction in the supply of physician anesthesiologists will require increased funding to educate a greater number of certified registered anesthetists.

Nursing has specifically recommended that an amount equal to 10 percent of direct Graduate Medical Education (GME) funds be pooled from all insurers and be used in a manner similar to that used in the GUE program for physicians. These funds would be allocated to support the education and training of primary care nurses and specialty advanced practice nurses, such as certified registered anesthetists, who will be needed in greater numbers under the Administration's plan by allowing reimbursement of providers for faculty costs and student stipends through GME. Thus program would enable hospitals to maintain quality service and cost effectiveness within the constrains of the new system. This new program could be funded by a combination of Medicare contributions and a surcharge on health premiums. Because of the importance of advanced practice nurses to the delivery of care, a constant stream of dollars is needed to support the education and training of these providers on a basis similar and equal to resident physicians. Nursing believes that this fund must be in addition to the current Nurse Education Act program.

We applaud the Administration's proposal to also expand The Nurse Education Act for the purposes of retraining nurses to meet the new health care needs of the nation as well as expand the supply of nurses. Increases in the number of graduate programs which focus on primary care as well as increases in the capacity of current graduate funding programs will be necessary under a reformed health care system.

Funds are needed to develop retraining opportunities for nurses who are forced to leave the tertiary care workforce for community, primary and preventive care practice areas including post-master's certificate programs to enhance the primary care skills and abilities of clinical nurse specialists and other master's prepared nurses. BSN programs will need to be expanded to assist the diploma and associate degree nurses employed in acute care settings to rapidly obtain a BSN in order to enhance their community, public health and/or critical care knowledge and skills. In addition, hospitals will need assistance to provide continuing education to acute care nurses for acquisition of community care nursing skills. These BSN assistance programs and continuing educations programs are essential in order to prepare nurses to make the transition from hospital to community based nursing care.

In addition to preparing primary care providers and other nurses, it is also of importance to ensure that there is an adequate supply of nurse educators, both at the undergraduate and graduate levels of education. Existing nursing faculty may need additional training themselves in order to become nurse practitioner and other advanced practice nurse educators.

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

professions and to increase the number of minority faculty and researchers in the health professions.

RESURGENCE OF THE PUBLIC HEALTH SYSTEM

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

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

We applaud the inclusion of a strong public information and education component to mobilize communities and motivate individuals to reduce risks to health. Nursing stands ready to lead community and individual efforts to reduce some of our deadliest and costliest health risks -- tobacco use, drug and alcohol abuse, sexual activity that increases the prevalence of HIV infection and other sexually transmitted diseases, inadequate or poor nutrition, physical inactivity, and the lack of childhood immunizations.

REMOVING BARRIERS TO PRACTICE

One of the key features of the Administration's proposal is the elimination of anticompetitive practices in the health care industry would be to ensure that health providers are treated equitably within the health system by removing barriers to practice. In discussing how this can best be achieved, nursing has stressed aggressive enforcement of anti-trust guidelines and a reiteration of their commitment to encouraging competition in the health care marketplace.

Nursing encourages this Committee to develop a new health system that will compel all business entities to treat all health providers in accordance with the legal scope of their practice and will review all actions taken by corporations working within a health plan, especially when they adversely impact upon one class of health professionals.

ADMINISTRATIVE SIMPLIFICATION AND COST SAVINGS

Nurses throughout the nation breathed a collective sigh of relief when the President outlined the need to simplify the mounting paperwork and other administrative requirements that burden our health care system. We know firsthand what a waste of professional time these requirements can represent. Too often, nurses are forced to take time away from patient care and devote it to filling out forms. It has been estimated that a staff nurse fills out an average of 19 forms per patient. Thus, we applaud the President's proposals to pare down and simplify paperwork and other wasteful administrative requirements.

However, we need to draw a distinction here between completion of insurance forms and other activities that serve little other than facilitating the flow

of paperwork and bureaucracy, and efforts that do facilitate maintaining and improving quality and patient care standards. The Administration's proposal would emphasize data collection that is related to quality of care, development of outcomes criteria and other activities that are directly relevant to patient care. As health care professionals, we regard this as important and necessary. The distinction we make is between needless and endless paperwork and the collection of patient care information that leads to continuous improvement in the quality of care. We are more than happy to give up the former and opt for the latter.

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

CONCLUSION

Mr. Chairman, we commend the Committee for holding this hearing and for working so diligently to find solutions to the health care crisis. We appreciate this opportunity to share our views with you and look forward to continuing to work with you as comprehensive health care reform legislation is developed.

Thank you.

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HEADLINE: Beyond four walls: case management evolves into management of a continuum of care; medical case management; includes related article

BYLINE: Lumsdon, Kevin

BODY:

If the future of health care is the hospital wihtout walls, Carondolet St. Mary's Hospital is well on its way. More than a decade ago, executives at the Tucson, AZ, facility took the progressive step of reorganizing the nursing staff under a professional practice model that mirrors the structure of the medical staff. Their aim was to give nurses more autonomy and accountability.

To support the change, St. Mary's management developed a peer-reviewed credentialing system with four levels of competency that nurses could attain. They were so serious about the new model that they also changed the billing system to break out a seperate nursung charge, which varies according to patient acuity.

But within three years, nursing staff satisfaction had instead declined. Physicians also were complaining.

The reason? They were increasingly frustrated that the same patients--most of them chronically ill--were being sent home under the early discharge incentives of Medicare DRGs, only to be readmitted in two or three weeks.

The new model, while important within the hospital, did not allow the staff to manage the care of patients whose conditions frequently worsened at home--often requiring expensive emergency and impatient resources.

St. Mary's pushed traditional boundaries further, decentralizing its home health unit and rolling out an extensive case management program.

Today, 22 nursing case managers track and make annual home visits to 7,000-8,000 patients. Case managers serve as the primary link between patients and their physicans, in addition to providing ongoing care, education and assessment.

Case management continuum

"This is case management on a continuum--beyond the walls and not limited to the hospital, " says Phyllis Ethridge, R.N., the hospital's vice president of patient care services. "these are high-risk patients who need to be case-managed into the community. If we just case-manage them at the hospital, that doesn't prevent them from coming back in--or help them identify what the exacerbations of their illness are."

Knowing that it's one thing to build a continuum of care and quite another to behave like one, hospitals and health networks are developing new models of care delivery. In the process, they're finding ways to enhance communication across care settings, improve the satisfaction of staff and patients, and prevent or delay the progression of chronic illnesses.

In keeping with the new model, St. Mary's pursued capitated contracts through the state Medicaid program and senior HMOs, which Ethridge says enable the hospital to better tailor services that fit the changing needs of the elderly and other at-risk patients. Under those contracts, she added, patient days per 1,000 enrollees have ranged from 1,100 to 1,300--typically 700-800 fewer than the overall Medicare average and 300-400 fewer than the average ofr Medicare HMOs.

Recently, St. Mary's was one of four sites that HCFA named as part of a three-year, $ 5 million Medicare demonstration project that will pay the Carondolet nursing network a capitated rate that varies by age, sex, previous home care visits, and limitations in activities of daily living.

Nationally, the demonstration will enroll 10,000 patients, most of whom will recieve care under integrated models, with the remaining control group recieving current Medicare-approved services.

"Where capitated financing is involved, where the management of resources is integral to an organization's botton line, case management neeeds to be part of the provider system in a more integral way," says Richard Bringwatt, president and CEO of the NAtional Chronic Care Consortium, Bloomington, MN. "When someone has the need for services in multiple settings, either at once or in sequence, it makes sense to have an internal team manage the total plan of care, rather than leaving a fragmented system in place."

The consortium's members include St. Mary's and 20 other health systems that are experimenting with care delivery models and tools.

More staffing flexibility

Executives are finding that cross-continuum-care models can also provide more staffing fexibility--and boost morale. In Lebanon, PA, Good Samaritan Hospital has integrated acute and home care, with the same care team following patients from hospital to home--and back again.

By cross-training 70 inpatient nurses in home care procedures, the hospital offset a shortage of nurses at its home care agency and reduced the number of times that inpatient nurses are asked to take time off because of declines in hospital census. The primary care nursing model also is being expanded to include home visits from respiratory therapists, dietitians and other allied professionals.

"Our doctors are excited and want to develop a package for every patient," says patient care vice president Jeanne Donlevy, R.N., noting that the program so far has focused on Medicaid patients but will be broadened.

"Under this model, you don't need case managers anymore," adds Karen Zander, a principal with the Center for Case Management, South Natick, MA. "The people

giving the care are also managing the care." Zander, a pioneer in developing operational care tools known by various names, including CareMaps and critical paths, says case management efforts are leading toward delivery models that don't require a new plan of care to be developed each time patients move from setting to setting.

Gaining a community focus

As case management focuses on what happens to patients out in the community, its scope is expanding beyond health care providers. To better identify potential cases of child abuse and manage patients who've attempted or tthreatened to commit suicide, the emergency department at Lakes Region Gerneral Hospital, Laconia, NH, brought in representatives from various community agencies to talk about potential solutions.

Various hospital staff members invited mental health and social service providers, police, the local prosecutor, and others to crituqe specific cases and discuss improvements. All of them showed up, and from those discussions pathways are bieng developed that will help the agencies share critical information.

"One of the first issues we addressed is confidentiality," says Mary Lee-Bickford, R.N., the hospital's emergency services director. "In some cases, what's in place to protect confidentiality and patient rights ends up not helping, and perpetuates the fragmentation of care."

With legal input from the prosecutor, victim/witness coordinators and others, the group decided that information directly relevant to a patient's treatment at each stage could be shared. "We don't have acess to all of the information about a particular patient, but we know what the rules are," adds Bickford. "You have to work through the baggage of these intra-agency issues. The old view is to protect and defend without finding a better system."

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NEWS RELEASE

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May 16, 1994

PRESIDENT CLINTON SAYS RN CARE HAS POSITIVE IMPACT ON PATIENTS, LOWERS HEALTH CARE COSTS

ANA commissions study to examine impact of cost-cutting measures

WASHINGTON, DC -- President Clinton joined the American Nurses Association in its concern about the negative impact of registered nurse layoffs on the quality of patient care and reaffirmed his commitment to health care reform that assures appropriate insurance reimbursement for all qualified providers.

"One of the things that amazes me is how many nurses have been laid off in recent months and then told that is because health care reform is coming," Clinton said.

"What's going to happen is we're going to continue to see these trends occur unless we find a way to get 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 and fewer complications whether you're dealing with low-birth-weight babies or older people. You don't have to work for the Congressional Budget Office to realize that healthier patients and shorter stays means lower health care costs," the President said.

Clinton delivered the remarks here on May 10 during a "Salute to Nursing," a celebration to honor 16 registered nurses who serve in Congress and the executive branch. The event was held in recognition of National Nurses Week, May 6-12.

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In light of increased reports of registered nurse layoffs as an approach to cost-cutting, American Nurses Association President Virginia Trotter Betts, JD, MSN, RN, called quality "the single most overlooked issue" in the health care debate and said that preserving patients' access to professional nursing care is the critical link to maintaining and improving quality.

"Patients enter a hospital to be cared for. And the people who do the caring – hour after hour, day after day -- are registered nurses," she said.

"Patients need reassurance that there will always be professional nurses there to take care of them. We believe that ensuring the continued availability of professional nurses is at the heart of maintaining a high level of quality in a restructured health care system.

"Over the past year there are increasing reports of nurses being laid off. Too frequently, nurses are being replaced with less experienced, lower-paid workers."

According to Modern Healthcare's 1993 human resources survey, 27 percent of hospitals had begun downsizing their workforces. Additionally, a 1993 study of 281 hospitals conducted by E.C. Murphy Ltd., found those that reduced their staffing by 7.75 percent or more were 400 times more likely to see an increase in patient illness and mortality rates.

Well-documented research indicates that a higher proportion of RNs in the skill-mix is directly linked to fewer patients deaths, fewer complications, shorter lengths of stay and increased patient/consumer satisfaction.

Betts announced that ANA has commissioned a study to look more closely at the effects of various cost-cutting practices, such as down-sizing of RN staff and greater use of unlicensed assistive personnel, on the quality of care.

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"I am concerned that policymakers are focusing only on how to finance reform and are not addressing how to improve the way we deliver care," said Betts. "Cost-containment efforts without consideration for quality and safety are a poor investment for the nation."

For example, a recent story in The Washington Post (May 8) reported that local hospitals are investing in capital improvements, new technology, and advertising in order to compete in a changing marketplace, yet are simultaneously reducing staff. The story, however, did not address how this trend is impacting the quality of patient care.

According to ANA reports, during the past 18 months two D.C. hospitals, Georgetown University Hospital and Children's Hospital, and Fairfax County's INOVA health system reduced their RN staff.

ANA is concerned that labor costs are being singled out as an easy target for cost-cutting. Labor as a percent of total hospital expense actually declined between 1985 and 1992, while capital costs soared and excessive tests and procedures became more widespread. RNs made up an average 22 percent of hospital staff in 1991-92, essentially unchanged from the 21 percent of 1985, even as the hospitalized patient population as a whole grew "sicker" and services became increasingly intense.

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