Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	To Rosalyn from Linda Minick re: meeting participants (partial) (1 page)	10/13/93	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Carol Rasco (Meetings, Trips, Events)
OA/Box Number: 4593

FOLDER TITLE:
American Nurses Assn. 10-14-93 10:00 - 10:30

rw152

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker
Clinton Library

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This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

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

CONFIDENTIAL

To: Rosalyn in Carol Rascoe's Office **Fax:** 202 456-2878

From: Linda G. Minick - Office of Virginia Betts, ANA **Phone:** 202 554-4444 x104

Date: October 13, 1993 **Total Pages with Cover:**

This fax will serve to confirm:

1. 10:30 am - 10/14 meeting with Carol Rascoe.

Cleared 10/13/93 kam

Participants:

A. Virginia Trotter Betts - SS# [redacted] DOB P6/b(6)

B. Donna Richardson - Director of Government Relations

2. Agenda is attached.

Nurses: Charting the Course for a Healthy Nation

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

Susan Johnson-Cook
Nov 15/16
ANA Session / Dem Visit

AMERICAN NURSES ASSOCIATION

A G E N D A
Thursday, October 14, 1993
10:30 am

1. **Medicaid/Medicare policies before reform enacted**
   - a. **Reimbursement of advanced practice nurses**
   - b. **Provider taxes**

2. **Labor Issues and Health Care Reform**
   - a. **Hospital layoffs** – Hosp. / others laying off nurses in name of health reform, no quality control being promoted. See 2 pieces on State Health Plans & Transition Phase...
   - b. **Down substitution**

3. **Transition Plan for Health Care Reform**
   - a. **Quality assurance**
   - b. **Professional Security**
   - c. **State Health Plans**

Get back w/ Linna on person to visit w/

- HCFA: Provider taxes > CHR contact Bruce V.
  Staff nurses/LPN's can be taxed?
  ANA feels institution/indep. prac. only was intend

- Nurse appts. needed in HHS
- Bills going thru Congress now which support reimbursement of 1a.
  CHAMPUS/~~FE~~HBE

CHR visit w/ Leon, get back to them

Get back to them: Who is working on NAFTA labor issues?
Linna got call from Mex. nurse person, wanted to meet w/ Canadians

2 prom. deal w/ prof. issues

THE WHITE HOUSE

WASHINGTON

~~Rob~~ Roz

410

10-14-93
10-10:30

Jaclyn

A Nurses Assoc

554-4444

x 442

Pls. call

Accept
10-14-93
10:00-10:30?

AMERICAN NURSES ASSOCIATION
AMERICAN NURSES FOUNDATION
AMERICAN ACADEMY OF NURSING
AMERICAN NURSES CREDENTIALLING CENTER
AMERICAN NURSES POLITICAL ACTION COMMITTEE
600 Maryland Avenue, SW, Suite 100 West
Washington, DC 20024-2571

Phone: (202) 554-4444 Fax: (202) 554-2262

~~CONFIDENTIAL~~ RW

To: Roralyn (C. Rance) Fax: 456-2878

From: Donna Richardson Phone:

Date: 10/04 Total Pages with Cover: 1

Roralyn,

Donna Betts could be available on the 8th of Oct. She is free ~~after~~ on the 14th after 8:30 a.m. until 1pm. I know it's not much.

Thanks

Donna
ext 440

Nurses: Charting the Course for a Healthy Nation

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

Donna Richardson American Nurses Assoc. 202-554-4444 Ext. 442 or 440	9/9 9:05am	Returning Roz's call re. a meeting with CHR		

Need new dates:

THE WHITE HOUSE

WASHINGTON

August 3, 1993

MEMORANDUM FOR DR. PHIL LEE
BRUCE VLADECK

FROM: Carol H. Rasco, Assistant to the President for Domestic Policy

SUBJECT: American Nurses Association

Per the attached request, I have asked my assistant, Rosalyn Kelly, to contact Donna Richardson to say that we will try to arrange for the three of us to meet with this group. However, my schedule will not allow me to meet with them before August 24. Other dates that I am available are August 25, 26 and the week of September 13.

Rosalyn will contact your office soon for your availability and then coordinate with ANA.

ANA has conflict with August dates — will try for Sept. per conversation w/ Jocelyn @ ANA

Roz

Call re: office as outlined in last ltr, tell them we'll try to set for all 3 of us to meet w/her. Then fax ltr. to Lee and to Vladeck - start working w/their offices to set up for Aug. 24, 25, 26 or after Sept. 9th. 30 min. is enough. Meeting in my office.

Lee 10:00 ~~2:00~~	~~2:00~~ 4:00	3:00
Vladeck 10:30 ↓ 3:30	3:00 ↓	X

American Nurses Association

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

Virginia Trotter Betts, JD, MSN, RN
President

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

AUG -2 REC'D

July 22, 1993

Carol H. Rasco
Assistant to the President for Domestic Policy
The White House
Washington, DC 20050

Re: Request for Meeting

Dear Ms. Rasco:

On behalf of the American Nurses Association (ANA), I am writing to request a meeting to discuss issues surrounding health care reform and related issues. Roy Neel has suggested that meeting with you, Phil Lee and Bruce Vladeck (either jointly or individually) could be beneficial. As you know, ANA has been a strong supporter of the President's domestic policy agenda, particularly as regards health care and workplace issues. We would appreciate the opportunity to discuss with you some of our current and ongoing concerns in this area.

We will be contacting you shortly to arrange a meeting. In the meantime, please feel free to contact Donna Richardson, Director of Governmental Affairs for ANA, at (202) 554-4444, extension 440.

Thank you.

Jocelyn, AK
x442

Yours sincerely,

Virginia Trotter Betts/jr

Virginia Trotter Betts, JD, MSN, RN
President

AMERICAN NURSES ASSOCIATION

A G E N D A
Thursday, October 14, 1993
10:30 am

1. Medicaid/Medicare policies before reform enacted
   a. Reimbursement of advanced practice nurses
   b. Provider taxes

2. Labor Issues and Health Care Reform
   a. Hospital layoffs
   b. Down substitution

3. Transition Plan for Health Care Reform
   a. Quality assurance
   b. Professional Security
   c. State Health Plans

American Nurses Association
600 Maryland Avenue SW
Suite 100 West
Washington, DC 20024-2571
TEL 202 554 4444
FAX 202 554 2262

NEWS RELEASE

FOR IMMEDIATE RELEASE
October 13, 1993

CONTACT: Kim Smith, ext. 243
Lisa Wyatt, ext. 240
Kathryn Scott, ext. 242

NURSES WIN GREATER ROLE UNDER CLINTON HEALTH PLAN

WASHINGTON, DC – Under the Clinton health plan, registered nurses will play a larger role in delivering health care services, according to the American Nurses Association (ANA). In particular, advanced practice nurses, those with 2-4 years post-graduate education, will be able to provide a full range of health care services to patients, unrestricted by barriers at the federal and state level.

"We were successful in convincing the health care task force that nurses are part of the solution. The goals of universal access, cost containment and a greater emphasis on primary health care services cannot be achieved unless you remove the shackles that hobble thousands of front-line providers," said ANA President Virginia Trotter Betts, JD, MSN, RN. "This is a major victory for nurses and consumers."

ANA believes consumers will benefit greatly by increasing the number and range of qualified providers. It is widely acknowledged that the existing pool of some 200,000 primary care physicians is insufficient to address the primary care needs of Americans. This shortage of primary care providers will escalate with the phase-in of universal insurance coverage.

More than 100,000 advanced practice nurses, such as nurse practitioners, certified nurse-midwives and clinical nurse specialists currently provide primary health care services, frequently as the only caregiver to underserved communities in rural and urban America.

MORE...

Specifically, the following provisions in the Clinton health care plan recognize a greater role for nurses in a reformed health care system:

- federal preemption of artificial barriers to nursing practice;
- mandated reimbursement of nurses from public and private payors;
- consistent recognition of advanced practice nurses under the Medicare program.

Currently, advanced practice nurses must navigate a patchwork of laws and regulations that vary from state to state and within the Medicare program. For example, in some states, such as Alaska and Oregon, advanced practice nurses can provide a full range of health care services within their scope of practice. They may write prescriptions, receive direct third party reimbursement for their services and apply for admitting privileges to hospitals. In other states, such as Arkansas and New Jersey, advanced practice nurses have little autonomy due to barriers that restrict their practice, thereby reducing the number of accessible primary care providers in those states.

Other changes that ANA was able to negotiate include:

- antidiscriminatory language for inclusion of nursing services in the benefits plan;
- inclusion of nurse providers in the accountable health plans.

Including nursing services in the covered benefits plan and nurse providers in the accountable health plans will ensure that consumers have access to nurses, who are proven cost-effective providers.

"These changes are important because they level the playing field and increase choice of providers for consumers," explained Betts. "The current system is structured toward illness care delivered by physicians. In order to change the focus of the health care system from illness and cure to prevention and care, nurses' services must be covered and nurses must be recognized as qualified providers."

According to a recent Gallup poll, the vast majority of Americans are willing to receive their everyday health care services from an advanced practice nurse. There is significant research that shows that advanced practice nurses spend more time with patients and provide primary care that is as good or better than physician care in many important measures of quality and patient satisfaction.

MORE...

To increase the pool of both generalist registered nurses and advanced practice nurses, the Clinton plan contains increased funding for nursing education. This includes funds to double the number of graduates annually from advanced practice nursing programs and a 10 percent redistribution of Graduate Medical Education funds, monies pooled from all insurers to reimburse providers for the costs of academically based, advanced practice, primary care nurse education programs.

This funding would enable many of the 300,000 registered nurses currently working in community-based settings to pursue an additional 12-18 months of graduate education in order to quickly increase the nation's supply of primary health care providers.

Other measures to increase the pool of registered nurses include loan forgiveness for primary care providers, support for baccalaureate and master's level nursing programs, support for retraining of nurses who are displaced from acute care settings, and an emphasis on recruitment of health professionals from culturally diverse, underserved populations.

ANA also convinced the administration of a multidisciplinary approach to: 1) quality assurance mechanisms; specifically, nursing care will be included in the evaluation of the effectiveness of care, practice standards and guidelines; 2) malpractice reforms; specifically, nurses will be covered in all reforms; 3) anti-trust remedies; specifically, anti-trust guidelines will be aggressively enforced and clarification of regulations will facilitate nurses as well as physicians and institutions to form provider alliances.

"The level of recognition by the White House of nurses' contribution to the health care system is historic. Each and every nurse in America, regardless of what they do or where they practice, should take pride in these victories."

ANA, which has declared its strong support for the Clinton health care plan, actively promoted nursing's reform plan, ***Nursing's Agenda for Health Care Reform***, since 1990. ANA will continue to support and advocate for key principles included in ***Nursing's Agenda*** as health care reform moves through the legislative process.

MORE...

"Over the past months we have provided input to the health care task force and we will continue to press for the provisions that nursing believes are fundamental to achieve true reform. To that end, we pledge the support of the nation's 2.2 million nurses to keep the reform train running on track, on time and with no unscheduled stops. We will stoke the engines of reform until this train reaches its destination."

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

###

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 advanced 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.

g:\releases\clinton.apn

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

Virginia Trotter Betts, JD, MSN, RN
President

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

May 13, 1993

Via Hand Delivery

The Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
Washington, DC 20201

Dear Secretary Shalala:

Thank you for meeting with Gwendylon Johnson, Judith Huntington, Linda Shinn, Donna Richardson, and me on April 29. We appreciate your openness to our discussion about nursing priorities and issues related to health care reform as well as your clear understanding of the complexities involving the implementation of health care reform.

We are including the following information in response to your request on redirecting some of the graduate medical education funding for nurses and the structure and direction of public health services. We will forward additional information on hospital restructuring as soon as we finalize it.

ANA is pleased that you share our belief that a restructured health care system must address universal access, quality and cost containment simultaneously in order to be successful. Nursing is committed to ensuring that health reform goal.

Redirection of Federal Graduate Medical Education Funds

ANA recommends that the Administration increase Federal funding and support for preparation of primary care providers. Specifically, Graduate Medical Education (GME) funding should be redistributed (preferably through the Nurse Education Act (NEA)) to increase the number of qualified nurses to be primary care providers. Based on data from the National Sample Survey of Nurses (1988), there are approximately 125,000 RNs working in physician's offices, freestanding clinics, ambulatory surgical centers, health maintenance organizations, and other ambulatory care settings. Additionally, there are approximately 111,000 RNs 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.

ANA specifically recommends the following actions:

- Allocate 10 percent of the direct funding for GME to NEA, in addition to the approximately $ 300 million federal funds which presently go for nursing education, be allocated to NEA. These funds should be in addition to the current funding levels of NEA.

- Increase the number of graduate programs which focus on primary care as well as increase capacity in current graduate funding programs.

- Fund post-master's certificate programs to enhance the primary care skills and abilities of clinical nurse specialists and other master's prepared nurses.

- Fund BSN nursing education programs especially those which assist the diploma and associate degree nurses employed in acute care settings to rapidly obtain a BSN to enhance their community, public health, and/or critical care knowledge and skills.

- Assist hospitals which seek to provide continuing education to acute care nurses for acquisition of community care nursing skills.

The BSN assistance programs and continuing education programs are necessary to prepare nurses to make the transition from hospital to community based nursing care. We must stress that the continuing education programs must allow credits earned to be transferred to BSN or graduate programs. Nursing is all too familiar with institutional programs which, if not affiliated with institutions of higher learning, do not allow nurses to later articulate within the university setting and thus hamper upward career mobility.

Nursing Care for Minority Populations

ANA agrees with you about the need to address the health care needs of the minority communities. Historically, nursing has consistently been an advocate for the underserved and under-represented. Many of the underserved and disenfranchised in America's health care system are ethnic/racial minorities. A health care system that does not address the needs of minorities will not be effective in improving the health status of Americans. Providing culturally competent health care to all Americans is an essential component of universal access, quality and cost containment. Many minority nurses (both advanced practice and generalists) are needed to meet the health care needs of the growing minority population. The ANA has supported education and leadership development for minority nurses for over 25 years. Still there is much to be done.

Minority nurses represent only 8.8 percent of all employed registered nurses while minorities represent almost 25 percent of the U.S. workforce. Of the 8.8 percent of minority nurses,

4.0 percent are African American, 1.4 percent are Hispanic, 2.7 percent are Asian and 0.4 percent are Native Americans. Most African American and Asian nurses are baccalaureate prepared, while most Hispanic and Native American nurses are associate degree prepared.

Access to care for the minority populations will be improved by providing relevant and competent professional nurses. A cadre of bilingual and bicultural nurses are needed to successfully deliver primary health care through public health and community outreach services. Research has shown that minority nurses are more likely to work in agencies that serve minorities.

ANA has identified several actions that can be employed by the federal government to increase numbers of providers from the minority populations, for example:

- Target funding for education programs that will move minority nurses from ADN to BSN and/or MSN preparation.

- Continue support for doctoral education and faculty development are necessary to provide minority nursing leadership, in health delivery, research, and health care policy for minorities across America.

- Establish state-wide partnerships between health science centers and nursing centers of excellence and schools who have been successful in nurturing minority students. In addition, universities can share faculty, laboratories, and research facilities. Everyone will gain from this kind of partnership. This would facilitate sharing techniques and strategies for recruitment and retention of minority students and faculty. Knowledge of minority health care behavior, cultural competency, research and leadership development could also be shared.

Rebuilding the Public Health Infrastructure

A health care system cannot succeed in building a healthier America unless it addresses health promotion and disease prevention for the total community or geographic area. This requires support for both public health and personal health services. Since many people are currently without access to traditional medical and clinical preventive services, there is considerable overlap between existing public health systems and personal health services. Resources once used for core public health programs have been drained into medical care services provided by the public sector.

In a reformed system, we anticipate that clinical preventive and curative health services will be provided by Approved Health Plans (AHPs) and not public health agencies. Maternal and child health clinics, immunizations, family planning, breast and cervical cancer screening, clinical STD care, and handicapped children's programs are examples of clinical services currently provided (although sparsely) by public health nurses in public programs that need to be integrated into a basic health benefit plan.

The transition from the existing system will take time as public health agencies move away from clinical services and return to the core functions of public health. The focus of state and local health departments will necessarily change to better meet the broader public health needs of the community. Non-insurable components of the public health system such as the capability to respond to health emergencies, the enforcement of regulatory measures to protect personal and environmental health, the assessment of health conditions and services in a community, and measures to ensure the quality of both personal and population based services are critical to ensure a healthier population and contain costs.

The core public health functions that need strengthening in public programs include the following:

- Assessment of the health status of communities to identify the unique and most pressing health problems of each community, thus enabling rational, effective and efficient deployment of resources through adequate planning and policy development.

- Monitoring and action to ensure prevention of infectious and chronic diseases, control of epidemics as well as the safety of air, water, and food supplies.

- Health education to provide individuals and families with knowledge and skills to maintain and improve health behavior.

- Outreach, screening and linkage to ensure that individuals needing health care are identified and receive appropriate services.

All of the core public health functions are reliant on public health nurses who are knowledgeable about families in their communities and who can apply scientific and technical knowledge to promote health and prevent disease. Activist home visiting by public health nurses can ensure families appropriate care, whether provided directly by the nurse or through private programs. Regional and local differences will be significant in determining specific public health programs, but public health nursing, with increased capacity for community outreach, assessment and intervention, is going to be needed to integrate services and ensure that vulnerable populations don't "fall through the cracks".

Data systems are another critical component of a revitalized public health service. Public health agencies will need consistent reporting on personal health, environmental health, community concerns and resources, and the quality and range of services available in a community. Public health agencies will need to gather data through ongoing surveillance on the effectiveness of community health services such as high blood pressure prevention education programs as well as to monitor the impact of Accountable Health Plans (AHPs) on public health indicators such as low birth rates, immunization rates, and prevalence of tuberculosis.

Estimates of the resources required to revitalize our public health infrastructure are approximately $30 per capita per year, exclusive of funding for personal health services. The precise allocation across levels of government, and the identification of revenue sources to generate these funds, will need further development. Finally, the development of ongoing strategies that allow for flexible funding mechanisms are essential to address local and regional diversity.

Conclusion

We hope that the above addresses many of your questions. We welcome further opportunity to discuss health reform from a nursing perspective. We also enclose the ANA's recent testimony before the Senate Finance Subcommittee on Medicare and Long-term Care on Anti-Trust Issues in the Health Care Industry. It will both highlight and detail the intense efforts that abound in the environment to prevent nurses from practicing and offering cost-effective services in every community.

ANA looks forward to working with you to develop a transition plan for health care reform and assist in its implementation. If you have questions or need further information please feel free to contact me.

Donna, it is always a pleasure meeting with you, and I especially want to thank you for your graciousness at the Rose Garden event. That was a Nurses Day to remember!

Sincerely,

Virginia Trotter Betts, JD, MSN, RN
President

Enclosure

k:/grel/drr:lm/meetings/shalala.429
5/13 -- 6:53 pm-corrected jec 5/26

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

Virginia Trotter Betts, JD, MSN, RN
President

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

September 30, 1993

Mr. Bernard Truffer
Director, Payment Policy Division
Office of Medicaid Policy
Health Care Financing Administration
233 East High Rise Building
6325 Security Boulevard
Baltimore, MD 21207

Re: Medicaid Provider Taxes--Nursing Services

Dear Mr. Truffer:

This is to follow up on our telephone conversation of September 28. I am seeking clarification of a provision in the final rules regarding Medicaid provider taxes recently issued by the Health Care Financing Administration and effective as of September 15, 1993. My questions pertain to the regulations as they apply to taxes on "nursing services" (42 CFR 433.56(a)(16)).

1. The regulations identify three examples of nurses whose services may be taxed--nurse midwives, nurse practitioners and private duty nurses. These are nurses who often (although not always) practice as private practitioners, not as employees who work for a salary or a wage. Did HCFA intend that Federal Financial Participation (FFP) be limited to taxes on nurses who practice independently, or may nurses who are employees also be taxed?

2. If employed nurses may be taxed, do these include nurses who work for institutions on which a Medicaid provider tax is also imposed? If so, may a state choose to exclude such nurses from a provider tax and still meet the qualifications that provider taxes be broad-based and apply in a uniform manner to all providers in a class?

3. If employed nurses may be taxed, does this include nurses other than the three examples (nurse midwives, nurse practitioners and private duty nurses) cited in the regulations? For instance, would it include staff nurses in hospitals or nursing facilities? Is the tax limited to registered nurses, or may taxes on licensed practical nurses and nursing assistants also qualify for FFP?

4. May the state decide to limit its tax to nurses in private practice, or does the requirement that the tax be broad-based and apply in a uniform manner mean that all individuals who provide nursing services must be taxed?

5. Must a state tax on "nursing services" be imposed on individual nurses, or may it be imposed on the institutions through which such services are provided? Are there any federal restraints on the manner in which a tax on individual nurses may be imposed?

6. As a result of the regulations are the states in any way "required" to tax nursing services? Our understanding of the regulations is that it outlines the circumstances under which FFP may be available, but that the states retain the sole authority to determine which groups they choose to tax. Could you provide any clarification on this issue?

I very much appreciate any clarification or additional information you may provide on these issues. I may be reached at the above address, by telephone at (202) 554-4444, extension 451, or by fax at (202) 554-0189.

Thank you.

Yours sincerely,

David Keepnews, JD, MPH, RN
Assistant Director, Governmental Affairs

g\grel\dk\hcfa\prtx\clar.ltr

AMERICAN NURSES ASSOCIATION

EDUCATION OF NURSES

Determination of Nurse Workforce

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

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

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

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

nurses to meet the workforce needs.

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

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

Funding for Nurse Education

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

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

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

Funding for Nurse Education:

* Develop retraining opportunities for nurses who are forced to leave the tertiary care workforce for community, primary and preventive care practice areas. Included among these opportunities will be programs for continuing education, faculty development, incentives for linkages of diploma schools with baccalaureate and masters nursing programs as well as incentives for these facilities to develop linkages with primary care, schools and public health networks.

* Collect and evaluate data related to workforce surveillance, including shortage areas, recruitment and retention strategies and needed nurse education programs as well as current regional distribution of baccalaureate and masters nurse education programs.

* Development innovative demonstration programs to enhance the cost effectiveness of the delivery of nursing care and the development of educational programs to prepare nurses to meet those workforce needs. In addition, technical assistance will provided to states for the enhancement of state utilization of nurse providers.

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

* Ten percent of GME funds pooled from all insurers will be available for reimbursement to providers for the costs of academically based, advanced practice, primary care, nurse education programs according to the following formula

    - A formula should be determined by the Secretary to provide a prorated annual stipend for each full time, graduate nursing resident-student who provides patient care at the provider site;

    - The costs of clinical nursing faculty supervision at the provider site based on the average annual salary for clinical faculty; and

    - Other related teaching expenses.

AMERICAN NURSES ASSOCIATION

TRANSITION PHASE HEALTH CARE REFORM

HOSPITAL REFORM

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

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

Hospital Reform

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

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

The decisions of hospitals and other institutions to significantly alter staffing levels, mix, or re-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 via educational programs and other means for re-deployment, evaluation and reporting to consumers, certifying bodies and professional providers the impact of re-deployment on patient outcomes and other quality of care indicators, and assurance that re-deployment plans use professional personnel in accord with licensure laws, educational preparation and assessed competence.

A national transition plan should contain at a minimum:

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

- Use of conversion boards to assess the opportunity for the hospital to be converted to some other use thereby keep jobs in the community.

- Training programs on "How to Start a Business" and access to small business loans.

- Pre-notification of hospital closure or merger.

- Continuation of health and pension benefits.

- Continuation of HIV disability coverage.

- Limits on discounting health care services to prevent cost shafting.

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

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

- Wage pass through for providers of direct care.

- De-certification or fines of hospitals.

- Protection of hospitals that are sold providers or provide a high percentage of uncompensated care by establishing uncompensated care pools until all citizens have universal access.

The Impact of Competitive Financing Policies on Nursing Practice and Patient Care in Massachusetts Hospitals

A Report of Preliminary Findings

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Abstract

In anticipation of health care financing reform, there has been a renewed debate of the merits of regulatory or single-payer models versus free-market approaches such as managed competition. Massachusetts provides a unique laboratory for comparing the two approaches. This article traces the impact regulatory financing policies had on nursing practice and patient care in the 1980s. The results of studies conducted by the author in the 1980s are compared with a recently completed pilot project evaluating the effects of competitive financing policies on patient care and nursing practice. While acknowledging the preliminary nature of the findings, and the difficulty generalizing the results to other parts of the country, several important differences and trends were noted. Specifically, under competition: (1) downsizing of the hospital sector has occurred much more rapidly with much larger lay-offs of registered nurses; (2) many hospitals are replacing registered nurses with unlicensed assistive personnel; (3) nurse managers are spending inordinate amounts of time drafting and negotiating managed care contracts; and, (4) there has been a dramatic rise in rationing of hospital services for patients in managed care groups. The author concludes by discussing the implications of these findings for national health care reform.

Impact of Competition and Regulation on Nursing Care in Massachusetts Hospitals

A Report of Preliminary Findings

Introduction

As a new administration in Washington is poised to propose reform of the American health care system, cost-containment is receiving renewed attention. Constraining American health care costs is critical if resources are to be reallocated to the 37 million Americans locked out of the health care system. Any new financing arrangement will have a profound impact on hospitals where the bulk of the health care resources are spent. Because staff nurses are the backbone of the labor force in hospitals, changes in financing arrangements can have a profound impact on the quality of nursing care. This article traces the relationship of regulatory and competitive financing models on staff nurses in Massachusetts. Massachusetts is an ideal laboratory to contrast these two approaches as it has shifted from using regulatory controls during the 1980s to competitive financing policies in the 1990s. Results from surveys, forecasts, and pilot data conducted by the author in the 1980s on the quality of nursing care in Massachusetts hospitals will be compared with the results of a more recent pilot project using focus groups and individual interviews.

Nursing Supply and Demand Under Prospective Payment

During the 1980s, four states (Maryland, Massachusetts, New York, and New Jersey) established prospective payment programs that included Medicare and all other private health insurers (1). These all-payer regulated states were effective in slowing increases in hospital costs and insuring access to care (2). Three states (Massachusetts, New York and New Jersey) used pooled funds to reimburse hospitals for debts incurred to provide indigent care (3). Yet despite the success of these regulatory approaches in insuring adequate access to care while constraining health care costs, currently, only Maryland continues to use an all-payer system. The fact that three states have abandoned or radically redesigned hospital financing toward more competitive models, suggests regulatory approaches are not viable cost-control mechanisms. Certainly the argument over which model is "better" in controlling costs while simultaneously maintaining quality of care is not new. However, largely absent from this debate is an analysis of how either approach affects staff nurses and the quality of patient care. Massachusetts is the only state where one can compare how financing models influence the delivery of nursing care in acute care settings because of the stark contrast in policies to control health care costs.

In 1975, Massachusetts was by far the most expensive state in the country to be sick: Massachusetts' hospital costs were 50 percent above the national average; there were between 5,000 and 9,000 excess hospital beds; and, the ratio of registered nurses

and physicians to the population was the highest in the country. To constrain skyrocketing health care costs, Massachusetts enacted an all-payer prospective payment program in October 1982. Labeled Chapter 372 after the enacting legislation, hospital administrators anticipated sub marginal cash flows, lack of capital for structural maintenance and equipment, under utilization and employee layoffs (4). Almost immediately anecdotal reports in the press detailed the termination of specialized nursing services (5). Between 1982 and 1983, positions for registered nurses only increased by .1 percent (6). By 1984, approximately 3,000 of the 145,000 jobs in hospitals had been cut and hospitals were generating savings of between $60 and $90 million a year (7).

The impact Chapter 372 had on access and quality of care is controversial. A study by the Massachusetts Executive Office of Human Services stated that aggregate statewide data did not contradict the anecdotal evidence of increased transfers of uninsured patients to public hospitals. The report concluded that essentially Chapter 372 "neither enhanced nor diminished" a hospital's willingness to care for Medicaid or Medicare patients (8). As for the impact Chapter 372 had on quality of patient care, a report by the Boston Foundation (9) concluded that there was no documented evidence that C. 372 adversely effected hospital care. However, many populations at risk, including the elderly, faced significant problems accessing primary health care and other outpatient services.

During this time, a substitution trend began to emerge that would continue throughout the 1980s. Because the difference in salary between unlicensed nursing personnel, licensed practical nurses and registered nurses was so narrow, hospitals began to cut unlicensed nursing positions and increase registered nurse positions. From 1981 to 1985, there was a 7.6 percent increase in registered nurse positions, and a 14.6 percent decline in licensed practical nurses' positions or ancillary personnel (10). Thus, for every 2 unlicensed or L.P.N. positions cut, 1 registered nurse position was added. Similarly, for every two middle-management or nurse supervisor positions cut, one associate director of nursing position was added.

The study conducted by the author on the "Future of Nursing Education and Employment in Massachusetts" in 1985, concluded that prospective payment was impacting nursing labor in two ways (10). First, flattening the hierarchy in the nursing department improved the quality of work life for staff nurses who felt more empowered and autonomous. Second, the mix of nursing staff shifted to an all R.N. model. Although there were fewer nursing personnel, the mix of staff was both efficient and cost-effective. Registered nurses were no longer accountable for supervising unlicensed personnel who changed jobs more frequently than registered nurses and had a wide range

of clinical expertise and interest in their job. Research by Clifford (11) and Christman (12) documented that by consolidating the patient's nursing care needs with registered nurses, the quality and cost-effectiveness of nursing care increased, turnover declined and the morale of the nursing staff greatly improved.

In 1985, Massachusetts lost its Medicare waiver and reimbursement became tied to Diagnostic-Related Groups (DRGs). All other payers in Massachusetts continued under a prospective payment program. The impact of DRGs on hospital workers was immediate and dramatic. During the first year and a half, lay-offs totaled 1,300 hospital workers (13). The most severely affected were LPNs and nurses' aides who several hospital spokespeople predicted would be an "obsolete occupation in hospitals" by the end of the decade (13). A preliminary survey, conducted by the Massachusetts Nurses Association on the impact of DRGs, found that the severe cutbacks in ancillary personnel required nurses to spend much of their time doing non-nursing tasks such as getting supplies, answering phones or picking up dinner trays (14).

Regulatory hospital financing mechanisms in place in the early 1980s had a clear downsizing effect on the numbers and mix of nursing personnel. Initially, efforts toward reorganizing the delivery of nursing care according to a primary nursing model had a positive impact on nursing care and job satisfaction. However, with the introduction of DRGs in the mid-1980s, there were additional cuts in ancillary personnel. Registered nurses performed far more nursing and non-nursing tasks with patients who were sicker and discharged faster than ever before. Nurses expressed intense frustration about performing these non-nursing tasks that removed them from the patient's bedside (14). A public hearing on DRGs sponsored by the Health Planning Council of Greater Boston and testimony from the Attorney General's Office confirmed that DRGs had an adverse impact on quality and access to care (15).

Given the constant shortage of skilled nursing personnel in long-term care it was presumed that unemployed LPNs and nurses aides would seek employment in nursing homes. However, few nursing staff made this transition. In a survey conducted in September 1986, 90 percent of all Massachusetts nursing homes reported a shortage of nurses' aides creating "near crisis" conditions for both employees and residents (16). Lower wages, increased patient loads and acuity, coupled with staff shortages, were all blamed for deterring nursing staff previously employed in hospitals from seeking positions in long-term care (13).

The failure of LPNs and nurses' aides to make the transition from acute-care settings to long-term care facilities has implications for the anticipated need to transition registered nurses from hospitals to more community based settings under managed

competition. Clearly, if the economic and professional incentives are insufficient, unemployed hospital workers will avoid alternative employment opportunities in other sectors of health care delivery. As the health care system is restructured, it is important to remember that simply retraining displaced staff nurses will not guarantee there will be an adequate labor supply to meet the increasing demands in community care. Cyclical labor shortages of staff nurses in hospitals provides ample evidence that when salaries and professional rewards are inadequate, nurses will withdraw from the labor market.

By May 1987, two years later than the rest of the country, Massachusetts hospitals faced a critical shortage of registered nurses. In a survey of 63 Massachusetts hospitals, the Massachusetts Hospital Association found that 70 percent had RN vacancy rates that exceeded 10 percent and over 25 percent had vacancy rates more than 15 percent (17). The highest registered nurse vacancies were in skilled nursing or in areas that provided care to the aged such as medical-surgical units and acute rehabilitation units (17). Most hospitals used scheduling innovations (52.4%) and special salary upgrades (46%) as a ways to retain nurses. Although the Massachusetts Hospital Association acknowledged that salary and working conditions were key ingredients to retaining registered nurses, they argued that cost-containment programs -- primarily DRGs -- severely limited the amount of salary improvements they could offer nursing staffs.

Financial data refute the argument put forth by hospital administrators that limited financial resources severely constrained their ability to upgrade nurses' salaries. Certainly the hospital financing formula in place between 1982 and 1987 created strong incentives for hospitals to reduce the volume and intensity of services. However, profits realized by Massachusetts hospitals increased from $62 million in 1981 to $127 million in 1986 (18). The Rate Setting Commission report concluded that despite declines in patient volume, "the financial position of the industry under current regulation is strong and generally improving" (18). The artificial depression of nurses' salaries after the introduction of DRGs appeared to stem more from the *perception* of hospital administrators that there needed to be more belt-tightening as hospital utilization declined rather than actual fiscal constraints.

Anecdotal newspaper reports indicated that the nursing shortage was having a "chilling effect" on the quality of care delivered in Massachusetts hospitals (19). Boston City Hospital temporarily closed understaffed wards and other hospitals were diverting ambulances to other emergency rooms. One nurse, working in a Boston hospital noted that she "goes down a list doing what's most important to get done and hoping to God you don't make a mistake" (19). In the face of these conditions, the Boston Redevelopment Authority did a study of the health manpower needs of Boston hospitals and found that in

Boston alone, there would be a need for an additional 1,381 nurses by 1992 (20). At the same time, the Massachusetts Board of Registration in Nursing reported that from 1983 to 1987 the number of graduates of nursing programs was down 25.9 percent and admissions declined by 39.8 percent (21). By 1987, the combination of tight regulations on hospital costs at both the federal and state level created a severe depression in nursing salaries and a concomitant rise in the vacancy rate to 10.9%.

Between 1987 and 1991 state regulations in Massachusetts governing the reimbursement formula were reversed and hospitals were given a 100% volume variability. Representatives of the Massachusetts Hospital Association were successful in lobbying for an additional $95 million for low cost hospitals and a Medicare "shortfall fund" equaling $70 million. The Massachusetts Nurses Association had lobbied for a wage pass-through for nurses since prospective payment financing began in Massachusetts in 1981. The severe labor shortage prompted state officials to include a wage pass-through for direct care providers in its new hospital financing bill enacted in 1987. Also included was a surcharge of .15% on the hospital bed rate to fund a Labor Shortage Initiative targeting minorities and second career individuals who sought employment and training in areas where there were critical shortages of hospital personnel.

Revisions in the hospital financing formula and the wage pass-through had a substantial impact upon nurses' salaries. Until 1988, hospitals were content to hold nursing salary increases to 5 to 10 percent -- roughly the equivalent of inflation. In a remarkable turnabout, hospitals began granting increases of up to 30 percent, and added incentives such as daycare and more flexible schedules (21,22). Between 1987 and 1989 nurses' salaries doubled from $26,200 to $45,000. Simultaneously, the vacancy rate was cut in half from 10.9% to 5.8%. Consistent with these trends, nursing enrollments for the fall 1989 semester rebounded by 5.9 percent -- the first increase reported since 1984 (23).

In 1989, 927 staff nurses in Massachusetts hospitals responded to a 10-page questionnaire that measured a variety of factors related to nursing care (24). The sample represented a wide array of staff nurses working in hospitals across Massachusetts. The most significant change prospective payment had upon nursing practice was an increased emphasis on documentation in the patient chart and patient teaching. Although the ratio of registered nurses to patients and the number of available nurses had remained about the same, nurses felt the demands of the work schedule had increased. The increased demands on the nursing staff were associated with added responsibilities that were previously assumed by LPNs or nurses' aides and increased patient acuity. Despite the

increased demands on nurses, overall, nurses felt that the quality of patient care had remained about the same (25).

Regulation clearly forced the hospital industry in Massachusetts to downsize during the 1980s. It is important to note that the actual number of hospitals closing or merging was gradual -- approximately one to two a year across the entire decade. When large loss of registered nurse positions did occur, it was associated with the closures of hospitals. Lay-offs were sporadic and tended to involve less than 50 registered nurses. Although there was an acute labor shortage of registered nurses in the mid-1980s, overall the number of registered nurse positions decreased gradually over the decade from a high of 23,039 in 1980 to 21,096 in 1991. Declines in RN vacancy rates from a high of 10.1% in 1988 to a low of 2.1% in 1991, coincided with a decrease in demand for registered nurses as well as marked improvements in nursing salaries (26).

Competition as a Model to Constrain Hospital Costs

By the end of the 1980s, the change in the hospital volume incentives triggered a dramatic increase in costs. Between 1987 and 1989, Massachusetts hospital costs rose by 23.4% -- compared to 18.8% nationwide, and 10.2% in the previous two years (27). The backlash that ensued splintered the Massachusetts Hospital Association, labor, and the insurance industry into various factions (28). The failure of key players in the health care arena to agree on a cost-effective regulatory approach to hospital financing, burgeoning costs, and a looming state deficit, prompted one frustrated state official to say: "I favor putting the scorpions in the same bottle, and letting them fight it out" (29).

Insurers in Massachusetts complained that historically they each competed according to different rules and there was a concerted effort to finally "level the playing field". Throughout the 1980s, health maintenance organizations (HMOs) were allowed through state law to negotiate unlimited discounts with Massachusetts hospitals while the discount rate between Blue Cross, the insurer of last resort, and the commercial insurers was fixed at 7.5%. HMOs negotiated huge discounts with Massachusetts hospitals averaging between 15 and 20 percent. Because of their clear price advantage, the HMO share of the Massachusetts insurance market grew from 3% in 1980 to almost 37% in 1993.

Under Chapter 495 enacted in December 1991, all insurers were given unlimited authority to negotiate discounts with Massachusetts hospitals. In a letter to state legislators, Governor Weld described Chapter 495 as, "*emphasizing managed care .. and encouraging payers and providers to control costs by negotiating mutually beneficial payment arrangements.*" Chapter 495 also included a systematic charge cap based on

case mix and disproportionate share differences rather than a hospital's historic level of costs.

Since the enactment of Chapter 495, 6 Massachusetts hospitals have either closed or merged and the Massachusetts Hospital Association anticipates an additional 5 to 6 hospitals will close in the next 12 months. Over 1,000 registered nurses have been laid-off, many replaced by unlicensed personnel. In the teaching hospitals where nurses in advanced practice are among the highest paid hospital workers, there has been a substitution with less expensive providers such as medical residents or social workers. In effect, the downsizing and labor loss that has occurred under 18 months of competition is roughly equivalent to what typically transpired over a 5 year period under regulation. A critical difference is that the lay-offs are in far greater numbers and they occur much more precipitously than the lay-offs of registered nurses in the 1980s.

Under competition, there has been a rapid decline in hospital volume. Data from the Massachusetts Hospital Association show that between 1991 and 1992, the total number of patient days decreased by 2.6%. Nine Massachusetts hospitals were particularly hard-hit with volume declines of between 10 to 14.99%, and another 26 hospitals reported declines of between 5 and 9.9%. Since January 1993, the decline in the total number of patient days has doubled to 6%. Clearly, competition has resulted in far fewer hospital admissions and a substantial decrease in the length of stay . Predictably, the severe decline in hospital volume has been accompanied by a concomitant decrease in the demand for staff nurses in Massachusetts hospitals.

In essence, competition has adversely effected staff nurses in Massachusetts hospitals because of two trends triggered by managed care. First, the demand for staff nurses has rapidly decreased as hospitals have fewer patients who are discharged faster than ever before. Secondly, staff nurses and nurses in advanced practice are being replaced in record numbers by less expensive personnel as hospitals attempt to hold down their labor costs to improve their competitive advantage. Those hospitals who can not hold down costs, are those who lose managed care contracts and are quickly threatened with large revenue losses.

Research Design

In February 1993, the author began a pilot project to determine how nursing care in acute-care hospitals and in state and private psychiatric facilities had been affected since the implementation of competitive models of hospitals financing in 1991. Ten focus groups were conducted in three sites across Massachusetts. The participants in nine of the focus groups were Unit Chairpeople, (the leadership of the collective bargaining units represented by the Massachusetts Nurses Association). One focus group was with

members of the Cabinet of Nursing Administration at the Massachusetts Nurses Association. Other interviews with nurse administrators were obtained though convenience sampling.

A total of 29 health care professionals participated in the study, each from a different Massachusetts hospital. The average age of the participants was 45 (M= 45.1, S.D.= 7.5). Most of the nurses had a baccalaureate or higher degree (58.4%), were working full-time (65.5%) and had been a registered nurse for 20 years (M= 20.6, S.D.=9.4). Most were staff nurses (44.8%), 27.5% were nurse administrators, 13.7% were assistant or head nurses and 13.7% were nurses or other health care professionals who worked in various clinical specialties such as psychology or medicine. It is important to note that the nurses in this study had been working at their present hospital an average of 15 years (M=15.0, S.D.=7.6). Because nurses in this study worked at their present hospital during the 1980s, they were able to compare and contrast the effects of regulation and competition on nursing care from a consistent frame of reference.

The size of the hospital where the participants worked was evenly divided among hospitals with 300 or more beds (24.1%), beds between 200-299 (34.5%), and 100-199 beds (24.1%) with a small number of nurses working in hospitals with between 50 and 99 beds (6.9%). Almost equal numbers of respondents worked in teaching (51.7%) and non-teaching hospitals (48.3%) and almost equal numbers of nurses worked in hospitals located in urban (44.8%) and suburban (41.4%) areas with the remaining respondents working in hospitals located in rural parts of Massachusetts (10.3%). The distribution of the hospitals is important because it is theorized that competition will be most intense in geographic areas where hospitals are clustered together.

Participation at some of the focus groups was sparse because of severe weather. Follow-up telephone interviews to non-participants were conducted by the principal investigator and two research assistants. Convenience sampling of nurses administrators was used to increase the number and representativeness of nurse managers in the study. The interview protocol for both the focus groups and the telephone interviews was the same. Interviews averaged thirty minutes -- some were as long as two hours, others as short as 10 minutes. Tape recordings and hand written notes were taken during each interview and focus group. Debriefings between the research assistants and the principal investigator occurred after each focus group. During the debriefing, impressions, interpretations, and clarification of the information shared by the participates was reviewed, discussed and noted. Similarly, the principal investigator reviewed tape-recorded telephone interviews and hand-written notes conducted by the research assistants.

Results

Several trends regarding the demand for hospital services were consistently noted by all participants. First, nurses noted that there has been a marked decrease in the patient census which is supported by the volume declines documented by the Massachusetts Hospital Association. Nurses attribute the decline in volume to two factors: (1) failure of their hospital to successfully secure managed care contracts; and, (2) improved medical technology which has hastened patient's recovery from a variety of medical procedures. For example, one nurse from a hospital in western Massachusetts noted that hospital treats approximately 50 to 60 patients in day surgery and plans are underway to double that capacity. Fairly typical is the response of a nurse from a teaching hospital in Boston who noted that because the hospital lost its bid for a Medicaid managed care contract, its pediatric psychiatric unit will close. A small number of nurses reported that the hospital where they work may merge with another facility, however no nurses in the study stated that their hospital faced imminent closure. It is important to note that in the nurses' view, downsizing of the hospital sector is a function of incentives in the financing model as well as advances in medical treatment that facilitate rapid recuperation and discharge. Thus some of the declines in hospital volume probably would have occurred regardless of the financing model.

From the staff nurses' perspective, competition has accelerated some of the inefficiencies in the health care delivery system. Several staff nurses stated that beds are being kept open on underutilized units, (such as pediatrics), to maintain certification and attract managed care contracts. As pressures to economize escalate under competition, nurses are frustrated by the inappropriate allocation of the hospital's scarce financial resources or the failure of hospital administrators to heed suggestions by nursing staff. Inappropriate purchase of supplies and the lack of productivity of ancillary staff are two of the most frequent complaints cited by staff nurses regarding hospital inefficiencies. In two instances, hospitals in serious financial difficulty were upgrading the physical plant in a deliberate effort to improve the hospital's image while simultaneously cutting nursing positions. Although such aesthetic improvements have little relationship to quality, they are a powerful marketing tool that hospitals hope will give them additional leverage when negotiating managed care contracts.

In all the interviews, nurses note that the acuity level of patients has greatly increased while the ratio of registered nurses to patients has declined. Specifically, nurses in teaching hospitals report that the ratios in ICUs have doubled from one registered nurse to one patient, to one registered nurse for two patients. Staff nurses in teaching hospitals perceive a 1:2 nurse/patient ratio as reasonable and anticipate no

adverse impact on patient care. However, in community hospitals, staff nurses report 1:3 or 1: 4 nurse-patient ratios in ICUs and are adamant that such changes have adversely impacted the quality of patient care. Although there is considerable hospital to hospital variability in terms of actual numbers of registered nurses on general medical-surgical units, nurses consistently report that there are fewer registered nurses responsible for providing care to greater numbers of patients.

From the staff nurses' perspective, changes in the number and mix of nursing personnel will actually increase hospital costs. Because of insufficient registered nurses on general medical-surgical units, frequently patients are transferred to the ICU or step-down units. Short-staffing the less costly general medical-surgical floor has therefore had the perverse effect of increasing transfers to the most costly units in the hospital. Where nurses in discharge planning or continuing care have been replaced by less costly social workers, staff nurses claim that incomplete or inappropriate assessments of patients' medical and nursing care needs have resulted in increased recidivism.

Most nurses report that hospitals are replacing nurses with unlicensed assistive personnel or registered nurses from a float pool or per diem agency. Although the use of unlicensed assistive personnel and per diem nurses may generate short-term savings for hospitals, in the long-term it could be anticipated that the fragmentation and high turnover inherent in such staffing could add costs. One staff nurse noted that, "Per diems only get two day of orientation to work in an ICU even if they've never had to work in a unit". The use of supplemental nurses is considered fiscally sound so long as the number of such personnel never exceed 30 percent of the total positions in the nursing department (30). However, staff nurses believe hospitals are relying more heavily on float or per diem staff to save money on benefits and provide more flexible scheduling. "They can call them 5 minutes before the shift is supposed to start and tell them not to come in if the census is down".

Staff nurses uniformly felt it was inappropriate to delegate professional nursing responsibilities to unlicensed assistive personnel (UAP). Typical was the response of a staff nurse in a teaching hospital who noted that the UAPs are only required to have a high school diploma and six weeks of training and perform such nursing procedures as suctioning vented patients and drawing bloods. Complaints about the UAPs fall into two categories -- "they do too much", or "they do nothing at all". Several nurses stated that the UAPs are unproductive, "watch T.V.", have to be constantly supervised, and turnover quickly. Conversely other nurses note instances where the UAP performed duties clearly not within their responsibilities such as intubating patients or giving medication. In one instance a respondent noted that all the nursing staff in an ICU simply refused to delegate

any nursing functions to a UAP and eventually the hospital administrators removed the UAP from the unit.

Interestingly, a consistent pattern emerged differentiating these changes in staffing ratios between community and teaching hospitals. Staff nurses in community hospitals consistently dated the downsizing and replacement of registered nurses with less skilled and less costly personnel to 1989, while nurses in the teaching hospitals dated the onset of such changes to 1993. Nurses in the community hospitals attribute the earlier economic pressure on community hospitals to a change in the Medicare reimbursement formula for graduate medical education which occurred in 1989. Although at that time teaching hospitals were given a different reimbursement rate for graduate medical education, officials at the Massachusetts Rate Setting Commission question whether this financing change prompted community hospitals to aggressively constrain labor costs. A more plausible explanation is that under Chapter 23, teaching hospitals were given considerable latitude in their hospital caps, while conversely, the caps on community hospitals were severely constrained. The timing of the cuts and substitution effects is important because it would appear that regulatory changes were largely responsible for the changes in number and mix of nursing staff in community hospitals, while the changes in staffing patterns in teaching hospitals was effected more by competitive or market forces.

Nurses consistently stated that under competition the quality of patient care has been adversely effected. Specifically, nurses cite the pressure to discharge patients quickly as increasing recidivism and infections among patients who are medically unstable are discharged with poor or inadequate after-care. Further, because managed care groups seek to negotiate the least costly services from year to year, subscribers may be forced to frequently change physicians and hospitals. The discontinuity of care that has resulted from such practices is a major problem cited by nurses that simply did not exist under regulatory approaches to hospital financing. One nurse noted that, "it's a mess ... there is no continuity of care. I know we wouldn't have had to admit him (a patient) five times in three months". Although managed care purportedly will improve continuity of care, many nurses note just the opposite happens. "We have to send patients where MHMA has a contract. Patients have to go 60 to 75 miles away for care. No one is making connections, the care is very fragmented".

Advocates of managed care believe that subscribers will be cost-conscious and quality sensitive consumers. However, a significant number of nurses stated that family and patient complaints about inadequate care have greatly increased over the past two years. While acknowledging there are a lot of patient and family complaints one nurse belated noted:

> " There's just no time. It really bothers me ... the lack of nursing care. In the past two years it's just getting worse and worse because they keep cutting nursing staff".

A Unit Chairperson in another community hospital recalled that nurses were so understaffed on one of the medical-surgical units they were triaging care and not giving patients baths. Hospital administrators were not responsive to the pleas of nurses for more staff so physicians began to order bedbaths for their patients. Writing an order for a bedbath obviously didn't solve the problem -- in fact it just increased animosity between the doctors and the nurses. Finally, complaints by patients and their families reached the Board of Trustees. The Board of Trustees responded by establishing a committee for nurses to inform the Trustees and physicians about problems with nursing care within the hospital. To date the nursing staff complement remains unchanged.

Nurses in middle or upper management who were interviewed expressed intense frustration over the exorbitant amount of time they spend drafting and negotiating managed care contracts. Nurses in advance practice in hospitals are under increasing pressure by managed care groups to document the cost-effectiveness of nursing outcomes, yet few have the time or resources to conduct such studies. While advocates argue that competition will force hospitals to enhance quality of care, in the absence of widely accepted outcome measures, one Director of Nursing noted that "quality of care decisions are based only on money". These additional administrative demands are felt most acutely by nurse managers or clinical specialists in community hospitals or state owned and operated facilities. Entire cadres of specialized personnel appear to assume these new responsibilities in the teaching hospitals in Massachusetts.

When discussing the issue of laying-off large numbers of staff nurses, nurse managers portray themselves as forced into draconian action and use "war-like" analogies when describing the relationship of the hospital to managed care groups. Typical was the response of one Director of Nursing who stated she, "took a great deal of heat" but that she, "did what I had to do to save the hospital". "Battles" are waged between the hospital and insurers to get patient's necessary services. "Tough fights" erupt around the negotiation of managed care contracts and the "casualties" are jobs in the nursing department. Nurse managers are exuberant when they have "won" a managed care contract. Others nurse managers, faced with growing hospital deficits and additional cuts in their department, are apprehensive, emotionally drained and, in some cases, have left nursing administration.

Both staff nurses and nurse administrators are troubled by the apparent contradictory effects competition has had on hospital costs. Some nurses firmly believe

that managed care contracting has had the perverse effect of actually increasing costs. "We have to put patients in cabs to go to approved sites that are miles away. The cab drivers wait. How can that control costs?" Several nurses from Boston area hospitals noted the wastefulness of obstetrical units opening in two Boston teaching hospitals while existing obstetrical beds remain underutilized. A nurse administrator in a rural hospital related an incident where the hospital was requesting counseling for the children and husband of a young mother dying of cancer. The HMO would pay for only one counseling session and informed the hospital it could be before or after the mother died. The hospital, facing a 2 million dollar debt, nonetheless provided all the counseling the family needed -- both before and after the mother's death -- and simply absorbed the cost.

The competitive pressures upon hospitals have had a devastating impact on morale in nursing departments across the state. Regardless of the nurses' position in the hospital hierarchy or the length of their employment, all the nurses interviewed expressed considerable anxiety over their job security. These responses are in marked contrast to research conducted by the author in the 1980s when nurses voiced little concern about potentially loosing their job. A nurse in a community hospital stated bluntly, "Nurses' morale is horrible. Nurses don't feel they can do a good job in our hospital".

Interestingly, the uncertainty and anxiety about a hospital's very survival appears to have two opposite effects. Either the staff nurses and hospital administrators become embittered and polarized, or in rarer situations directly involving patients, both groups coalesce to fight the "managed care" enemy. Both staff nurses and nurse managers seriously question the cost-effectiveness of prematurely discharging patients who simply return in a more compromised medical state. As one staff nurse noted:

> "Nursing administration is just as powerless as the staff nurses. Hospitals are a business now. To run a business you have to run a profit. Nurses are so exhausted and burnt-out they can't work. Administration doesn't care as long as there's a body there. That's what's out there for the little community hospital".

More typically, staff nurses "pull together" though collective bargaining to "take stands" in opposition to hospital administrators. While acknowledging their overwhelming odds, staff nurses frequently find strength in "getting in touch" with their "personal" and "collective power". Older nurses are heartened by the renewed involvement of their younger counterparts in collective bargaining and their energetic interest in the overall operation of the hospital. Currently, staff nurses are engaged in job actions at six Massachusetts hospitals. At no time under regulatory approaches to hospital financing were so many job actions by registered nurses simultaneously taking place.

From the perspective of staff nurses, high hospital costs are rooted in administrative waste and the intensity of medical care. Nurses cite a number of reasons

hospital costs have escalated out of control including: increased documentation required to justify continuing a patient's hospitalization; shoddy fiscal planning; and, poor management. Interestingly, nurses in community hospitals were more critical of physicians ordering and performing unnecessary procedures than their counterparts in teaching hospitals. In part this may be a function of the quality of the professional relationship between physicians and staff nurses. Staff nurses in community hospitals were more apt to complain of feeling powerless in their negotiations with physicians than staff nurses in teaching hospitals. A nurse in a community hospital summed up these sentiments:

> "They should take a look at the amount of money spent on 90 year old patients on a full vent and full code. I've put N/G tubes down patient who didn't want it who knew they were going to die. Nurses don't have any autonomy or power to say to doctors -- enough!"

Discussion

The impact of prospective payment and DRGs on Massachusetts hospitals may best be described as a slow squeeze. Under regulation, the Massachusetts Rate Setting Commission set revenues and formulas and hospitals could anticipate a stable, albeit restricted, income. During the 1980s, the number of registered nurse positions in Massachusetts hospitals slowly declined by roughly 2,000 full-time jobs; approximately 1 to 2 hospitals closed or merged each year; and, the number of beds in Massachusetts per 1,000 population dropped below the national average (27). The downsizing and concomitant loss of nursing positions begun under prospective payment have continued under competition with one important difference -- these effects occur more quickly, are harder to anticipate, and are greatly intensified. In the past two years, the Massachusetts Nurses Association estimates over 1,000 registered nurses have lost their jobs, five hospitals have closed or merged and the Massachusetts Hospital Association anticipates another 5 to 6 hospitals will close or merge in the next 6 months.

The rapid pace of the downsizing and loss of hospital jobs is related to some factors inherent in competition, and others unique to Massachusetts. Under any managed care arrangement, hospitals can anticipate substantial declines in patient days. When managed care groups are allowed to negotiate unlimited discounts, both purchasers and providers aggressively attempt to hold down costs. In Massachusetts, managed care groups have penetrated 40% of the health insurance market -- the second highest in the nation. Because managed care groups have captured close to half of the subscriber pool, insurers wield considerable market power and have become notorious for driving hard bargains with the hospitals. Hospitals have no guarantee they will keep their managed care contracts, fill their beds, and maintain their revenues. Downsizing of hospitals is

difficult to anticipate because the number of potential patients varies significantly depending upon the year to year success of the hospital in securing managed care contracts. Where hospitals in Massachusetts are concentrated in a particular location, the effects have been particularly severe.

The uncertainty creates tremendous anxiety in the system and hospitals, to improve their competitive advantage and realize immediate savings, have targeted labor costs. Will the job loss experienced by registered nurses in Massachusetts be replicated across the nation under managed competition? The number of beds in Massachusetts hospitals per 1,000 population is below the national average, so the current downsizing is not a function of ridding the system of excess capacity. One might anticipate that in states with greater hospital capacity than Massachusetts, the number of hospitals forced to close or merger may surpass Massachusetts. However, two factors -- the greater numbers of health care professionals than the national average, and high infiltration of managed care groups -- may make the job loss in Massachusetts more acute. Even allowing managed care groups considerable competitive advantages, it took 10 years for HMOs in Massachusetts to penetrate almost half of the insurance market. Limited penetration by managed care groups in other states could be a significant mitigating factor slowing the impact of managed competition.

Clearly, competition is ratcheting down hospital capacity and employment in the hospital sector but has there been a concomitant decrease in costs? This pilot project did not attempt to measure the ability of competition to constrain hospital costs as compared to regulatory approaches. One indicator that managed care groups have had a significant impact on constraining costs is that for the first time in a decade, premium increases will be in the single-digits (31). However, as stated previously, nurses identified several instances where they felt competition had a contradictory affect on costs. Some practices that may escalate costs include: the opening of redundant and unnecessary services; the continuation of only marginally functional services; and, an escalation in the number of non-direct care personnel and resources devoted to rationing patient care and negotiating managed care contracts.

Theoretically, the free-market should reward the most cost-effective providers, and weed out costly competitors. However, in Massachusetts it appears the opposite is occurring. To date, hospitals that have closed or merged have been the cost-efficient community hospitals while the costly, medically intensive teaching hospitals are aggressively maneuvering to strengthen their control of the managed care market (32,33). Recently, five of the Harvard-affiliated teaching hospitals agreed on the unprecedented action of forming a "mega-hospital network" to compete for patients (34). In 1992,

operating income for the 12 teaching hospitals in Boston totaled close to $100 million -- the highest in nine years (33). These trends suggest that in a free-market, the hospitals who survive are not necessarily the most cost-effective.

Proponents of managed competition fervently argue that contracts will be awarded on the basis of cost *and* quality (35). However, in the absence of widely recognized quality outcomes, it is inescapable that cost becomes the overriding factor when awarding and negotiating managed care contracts. At some future date should data become available regarding quality of care outcomes, presumably the quality of care vacuum currently in place in Massachusetts would ease to exist and there would be more measured consideration of the impact on patient care. In the interim, it is undeniable that the overriding factor governing the direction and distribution of hospital care in Massachusetts is cost. Similarly, it seems absurd for proponents of managed competition to claim managed care groups will give equal consideration to quality factors when no such widely accepted measures exist.

In a vacuum of quality measures, the driving force behind managed care -- the rationing or denial of hospital services -- continues unencumbered. It is the perception of the nurses in this study that competition for managed care contracts has increased premature discharges, recidivism, and denial of services. Although theoretically managed care should improve continuity of care, nurses in the study believe that just the opposite has occurred. Specifically, because managed care groups seek from year to year to find the least costly care for their subscribers, patients have to change providers more often then under regulatory models of hospital financing. Access to care becomes problematic when patients have to travel increased distances to approved sites and physicians. Reports by nurses of an increase in patient and family complaints lend credence to the nurses' perceptions. The experiences of nurses in the pilot project support the views of Relman (36) that the cost- conscious policies by private insurance companies have distorted altruistic concerns for a concern for the bottom line. However, only with larger quantitative studies will there be a definitive answer to the question of whether quality of care is compromised under managed care contracting.

Implications of Findings for National Health Care Reform

The experience of Massachusetts under regulatory financing mechanisms was not identical to the five other states who used prospective payment to control hospital costs in the 1980s. Nor can it be assumed that if managed competition becomes a national financing model, staff nurses in hospitals across the country will all experience effects equivalent to nurses in Massachusetts. While acknowledging state to state variations in terms of the intensity and distribution of health care services, consistent trends did

emerge among the states using regulation, particularly as it related to the supply and demand of nursing personnel. Similarly, it is reasonable to assume that some commonalties would transcend state to state variations under competition.

Chapter 495 in Massachusetts and managed competition have key features in common. Both promote the development of managed care groups and allow insurers the authority to negotiate unlimited discounts with providers (37, 38). Both set a ceiling on hospital costs either through a cap, (as is in the case of Chapter 495), or nationally through global budgets and perhaps wage and price controls. These are the central elements which nurses in this pilot project associated with rapid changes in the quality of patient care and precipitous declines in the numbers and mix of nursing staff in Massachusetts hospitals. Already, other industrialized states who are anticipating managed competition, are laying-off significant numbers of registered nurses and replacing them with unlicensed assistive personnel (39).

The model of managed competition envisioned in a national health care plan would include regional health alliances to oversee the financing and disseminate information regarding quality. In it's purest definition, managed competition has never been tested for its ability to constrain costs, or to determine how quality and access to care may be adversely effected. Conversely, effects on cost, quality and access have been thoroughly evaluated in other industrialized countries with national health insurance and in states who have had success with other models such as regulation (Maryland) and "pay or play" (Hawaii). Studies conducted on the experience of selective contracting in California demonstrate measurable cost-containment, but still no good evidence of the effects on quality of care (40). Several studies in California have reported serious problems related to access health care services (41,42). A report on price-competitive health plans in Minneapolis-St. Paul identified many of the same inefficiencies cited by staff nurses in the pilot project (43).

Although the Massachusetts model is not identical to managed competition, it the absence of any evaluative research, it is prudent to carefully examine the experience in Massachusetts with regard to quality, access and the cost of hospital care. It seems reasonable to assume that some of the changes in hospital care articulated by nurses in this pilot study, would occur under a national model structured according to the principles espoused by the proponents of managed competition (37, 38). In light of anticipated loss of registered nurse positions in hospitals, since the spring of 1993, the author has made several recommendations to the American Nurses Association (44).

The author has urged the American Nurses Association to lobby for federal policies which would establish retraining and relocation programs for displaced hospital

workers. Retraining and redeployment programs will assist nurses facing job loss to transition primary care settings where there may be anticipated increased demand for nursing personnel. In addition, regulations need to be devised regarding pre notification of lay-offs, continuation of health and HIV disability insurance and the establishment of hospital conversion boards. Policies regarding conversion boards and lay-off language were enacted in Massachusetts under Chapter 23 and will be essential to assist the large numbers of highly educated and trained hospital workers who will be facing job loss and communities where the hospital may be the primary source of employment.

It is also important to acknowledge that with competition there is a threat to under serve patients and it is necessary to have *more* regulations to maintain quality and access to care. Regulations to slow down the pace of downsizing, such as placing a ceiling on the discount rate insurers can negotiate with providers, will rein in the cut-throat competition that has pitted hospitals against each other and precipitated rapid declines in hospital revenues. Further, there must be some regulatory mechanism to protect hospitals that are sole providers or provide a high percentage of uncompensated care who are at a competitive disadvantage. Theoretically, if national health care reform includes universal coverage this issue will be moot. But if there are gaps, especially for the underinsured, some mechanism must be in place to provide reimbursement to hospitals and maintain necessary services. Otherwise there will be a marked increase in patient dumping and public, city or nonprofit hospitals who serve large numbers of indigent patients will be incapable of competing under a national financing model designed under managed competition.

No health care financing model -- either regulation, competition or some combination -- is without flaws. Nor is it reasonable to assume that even the most carefully crafted policy will survive the political vicissitudes of Congress after special interest groups, intent on preserving their own economic self-interest., intercede. It is incumbent upon those who analyze policy and those who enact it, to anticipate some of the unintended effects of public policies and put in place mechanisms that will protect those individuals who are most vulnerable. If administrative waste and the intensity of medical care are not directly targeted as a means to hold down health care costs, than it is inevitable that cost savings will be realized by cutting labor or rationing care. Surely no-one can advocate for a reform where the pernicious effects are felt most intensely by patients who seek care, and those who provide it.

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WORK CATEGORY CODES:

1.0	=	Assessment
1.1	=	Assessment: interpretation
1.2	=	Assessment: data collection
2.0	=	Planning
2.1	=	Planning: individual patient
2.2	=	Planning: group of patients/unit
3.0	=	Physical treatments and care
3.1	=	Medication
3.2	=	A.D.L.
3.3	=	Other
4.0	=	Psychosocial/teaching (patient and family)
5.0	=	Documentation
6.0	=	Evaluation
7.0	=	Environmental
8.0	=	Unit Activities (includes staff education)

\bc

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October 16, 1992

TO: **Operations Improvement**
Patient Care Task Force, Care Delivery Model Subgroup

Joyce Roberts, CON	Donna Rice, PICU
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FROM: Mary T. Sheehan, Subgroup Leader MTS.

Attached, please find the Task Inventory List we've just completed. As you can see, we have:

1) identified the **current position** completing the task;
2) the * **category of work** to be done; and
3) the **minimal skill level required** to perform each task.

Please review the list before next Thursday's 9:00 a.m. meeting. Share it with your colleagues and bring (or send) suggested revisions to the meeting.

Call if you have questions.

* A list of the work categories follows.

MTS:bc

P.S. I've also attached information for our Task Force presented at the 10/08/92 Steering Committee meeting.

Attachments

a:cdmgrp.oi

TASK INVENTORY LIST

	CURRENT POSITION	WORK CATEGORY		TASK	REQUIRED SKILL LEVEL	REGULATORY CONSTRAINTS (Y/N)	TRAINING REQUIRED (Y/N)	DEFERRABLE (Y/N)	EVENT DEPENDENT/ ON DEMAND (Y/N)	TIME DEPENDENT (Y/N)
	RN	1.0	2.0	Admit new patient	RN					
	RN	1.0		Classify patients	RN					
	LPN	1.0		Patient Classification	RN					
	LPN	1.0	2.0	Admissions	RN					
•	RN	1.1	1.2	Fetal heart tones	NA					
	LPN	1.1		Assess simple/basic EKG problems, troubleshoot	NA					
	RN	1.1		Assess VS	RN					
	RN	1.1	1.2	Assessment of body systems	RN					
	RN	1.1	1.2	Re-assess patient	RN					
	RN	1.1		Triage EENT patients	RN					
	RN	1.1	1.2	Neuro assessment	RN					
	LPN	1.1		Triage Functions	RN					
	LPN	1.1		Assess VS	RN					
	LPN	1.1	1.2	Assessment (body systems)	RN					
	NA/NT	1.1	1.2	Assessment	RN					
	RN	1.2		Order lab tests	CLERK					
••	RN	1.2		Swan ganz readings	LPN					
•	RN	1.2		Take VS	NA					
	RN	1.2		Braden-scale (skin care) every A.M.	NA					
	RN	1.2		Weigh patients	NA					
••	RN	1.2	1.2	Fetal Monitoring	NA					
•	RN	1.2		Measure chest tube drainage	NA					
•	RN	1.2		Check PH of gastric contents	NA					
	NA/NT	1.2		Monitor patients for safety (i.e. tubes)	NA					
	NA/NT	1.2		VS without B/P (NA)	NA					
	NA/NT	1.2		VS with B/P (NT)	NA					
	NA/NT	1.2		Obtain patient' height/weight	NA					
	LPN	1.2		Obtain patient's weight/height	OTHER					
	LPN	1.2	1.2	Telemetry monitoring	OTHER					
	LPN	1.2		Braden scale	RN					
	RN	2.1	2.2	Multi disciplinary conferences	ALL					
	RN	2.1		Contact discharge planner	CLERK					

CURRENT POSITION	WORK CATEGORY		TASK	REQUIRED SKILL LEVEL	REGULATORY CONSTRAINTS (Y/N)	TRAINING REQUIRED (Y/N)	DEFERRABLE (Y/N)	EVENT DEPENDENT/ ON DEMAND (Y/N)	TIME DEPENDENT (Y/N)
LPN	2.1		Contribute to care plan	NA					
LPN	2.1	2.2	Contribute to discharge plan	NA					
LPN	2.1	2.2	Contribute to problem list	NA					
LPN	2.1	2.2	Contribute to care conferences	NA					
NA/NT	2.1		Patient safety/Fall prevention	NA					
NA/NT	2.1		Patient safety	NA					
RN	2.1		Interpret	OTHER					
RN	2.1	2.2	Care planning	RN					
RN	2.1		Discharge planning	RN					
RN	2.1		Nursing orders (i.e. comfort, pain)	RN					
RN	2.1		Problem-list for nursing	RN					
RN	2.1	2.2	Attend physician rounds	RN					
RN	2.1	2.2	Case Management	RN					
RN	2.1		Interact with home health	RN					
CLERK	2.1	2.2	Make rounds with attendings	RN					
RN	2.2		Rearrange patients for care/isolation	OTHER					
RN	2.2		Supervise LPN, NA, Tech	RN					
RN	2.2	2.2	Coordinate care with MDs	RN					
RN	2.2		Make patient assignments	RN					
RN	2.2		Check staffing for 24 hours	RN					
RN	2.2		Determine extra staffing needs	RN					
RN	2.2		Discuss staffing with coordinator	RN					
RN	3.1		Pass meds	LPN					
RN	3.1		Verify meds	LPN					
RN	3.1		IV therapy (tubing change, dressing change)	LPN					
LPN	3.1		IV additives	LPN					
LPN	3.1		Meds	LPN					
RN	3.1		Hang blood	RN					
RN	3.2		Ambulate transfer patients	NA					
RN	3.2		Elimination needs	NA					
RN	3.2		Turn, position patient	NA					
RN	3.2		Skin care	NA					
RN	3.2		AM care	NA					
RN	3.2		Oral hygiene	NA					
LPN	3.2		Assist patient with feedings	NA					
LPN	3.2		NG & OG feedings	NA					

CURRENT POSITION	WORK CATEGORY		TASK	REQUIRED SKILL LEVEL	REGULATORY CONSTRAINTS (Y/N)	TRAINING REQUIRED (Y/N)	DEFERRABLE (Y/N)	EVENT DEPENDENT/ ON DEMAND (Y/N)	TIME DEPENDENT (Y/N)
LPN	3.2		PM/HS care	NA					
LPN	3.2		Beds, baths	NA					
NA/NT	3.2		PM/HS care - back rubs	NA					
NA/NT	3.2		ADL's	NA					
NA/NT	3.2		Beds & Baths	NA					
NA/NT	3.2		NG feed	NA					
NA/NT	3.2		OG feed	NA					
NA/NT	3.2		Patient comfort	NA					
NA/NT	3.2		Patient positioning	NA					
NA/NT	3.2		Ambulate patients	NA					
LPN	3.2		Pass patient nurishment	OTHER					
RN	3.2		Change linen	OTHER					
RN	3.2		Set up patient for meals	OTHER					
RN	3.2		Feed patients	OTHER					
NA/NT	3.2		Set up dietary tray	OTHER					
NA/NT	3.2		Assist in patient feeding (peds)	OTHER					
NA/NT	3.2		Pass snacks, nourishments	OTHER					
NA/NT	3.2		Change linen as needed	OTHER					
NA/NT	3.2		Assist patient with meals	OTHER					
LPN	3.3		Sick Day (TBJ)	ALL					
RN	3.3		Oxygen therapy	LPN					
RN	3.3		Recover surgical patients on off shifts	LPN					
RN	3.3		Start IV's and heparin locks	LPN					
RN	3.3		Chest Physical Therapy	LPN					
LPN	3.3		IV site care	LPN					
LPN	3.3		IV tubing changes	LPN					
LPN	3.3		Change IV dressings	LPN					
LPN	3.3		Peritoneal dressings	LPN					
LPN	3.3		Shave and prep for OR	MA					
RN	3.3		Apply Bio-gard mattress	NA					
RN	3.3		Accucheck	NA					
RN	3.3		Shave and prep OR patients	NA					
RN	3.3		Colon prep, enema	NA					
RN	3.3		OR - Scrub	NA					
RN	3.3		Newborn Resuscitation	NA					
RN	3.3		Assist with EENT procedures	NA					

CURRENT POSITION	WORK CATEGORY		TASK	REQUIRED SKILL LEVEL	REGULATORY CONSTRAINTS (Y/N)	TRAINING REQUIRED (Y/N)	DEFERRABLE (Y/N)	EVENT DEPENDENT/ ON DEMAND (Y/N)	TIME DEPENDENT (Y/N)
RN	3.3	4.0	Assist post-op patients who return for post-op visits	NA					
RN	3.3		Suction	NA					
RN	3.3		Cough and deep breathe	NA					
RN	3.3		Collect specimens	NA					
RN	3.3		Change dressings	NA					
RN	3.3		Trach care	NA					
RN	3.3		Draw blood	NA					
RN	3.3		Empty foley bag	NA					
RN	3.3		Ready patient for transfer	NA					
RN	3.3		Ready patient for tests	NA					
RN	3.3		Assist with dialysis	NA					
RN	3.3		Assist with procedure	NA					
RN	3.3		Assist with cardiac arrest	NA					
LPN	3.3		I + O	NA					
LPN	3.3		Position patients	NA					
LPN	3.3		Trach care	NA					
LPN	3.3		Assist with procedures	NA					
LPN	3.3		Perform Accucheck	NA					
LPN	3.3		Perform lab checks (on unit)	NA					
LPN	3.3		Perform specific gravity	NA					
LPN	3.3		Perform dip sticks	NA					
LPN	3.3		Perform hemoccults	NA					
LPN	3.3		Perform GI cultures (and other)	NA					
LPN	3.3		Assist in CPR	NA					
LPN	3.3		Therapy/Comfort measures (TLC)	NA					
LPN	3.3		Implement non-invasive procedures	NA					
LPN	3.3		EKG lead placement	NA					
LPN	3.3		Chest physical therapy	NA					
LPN	3.3		Preps for radiology	NA					
LPN	3.3		Dressing changes	NA					
LPN	3.3		OR (Scrub)	NA					
LPN	3.3		Prep surgical patients	NA					
NA/NT	3.3		Scrub (ORT)	NA					
NA/NT	3.3		Assist with admission/discharge/transfer of patient	NA					
NA/NT	3.3		Assist x-ray tech to position patient	NA					
NA/NT	3.3		Patient mobility	NA					

CURRENT POSITION	WORK CATEGORY		TASK	REQUIRED SKILL LEVEL	REGULATORY CONSTRAINTS (Y/N)	TRAINING REQUIRED (Y/N)	DEFERRABLE (Y/N)	EVENT DEPENDENT/ ON DEMAND (Y/N)	TIME DEPENDENT (Y/N)
NA/NT	3.3		Colon preps	NA					
NA/NT	3.3		Simple dressings	NA					
NA/NT	3.3		Heel stick(NT)	NA					
NA/NT	3.3		Urine tests(NT)	NA					
NA/NT	3.3		Specific gravity (NT)	NA					
NA/NT	3.3		Glucose check (NT)	NA					
NA/NT	3.3		Accucheck (NT)	NA					
NA/NT	3.3		Maintain I & O	NA					
NA/NT	3.3		Assist with procedures	NA					
RN	3.3		Perform EKG	OTHER					
RN	3.3		Accompany patient on discharge	OTHER					
RN	3.3		Physically lift patient to cardiac chairs	OTHER					
LPN	3.3		Transfer patients	OTHER					
LPN	3.3		Set up monitor/equipment functions	OTHER					
LPN	3.3		Perform EKG	OTHER					
LPN	3.3		Draw Blood	OTHER					
NA/NT	3.3		(TBJ) Sick Day Care	OTHER					
NA/NT	3.3		OR preps (shave)	OTHER					
RN	3.3		Restraints	RN					
RN	3.3		Tube insertion	RN					
RN	3.3		OR - Circulate	RN					
RN	3.3		Respond to floor codes	RN					
LPN	4.0		Patient Advocate for patient and family	ALL					
LPN	4.0		Interact/problem-solve with patients, family, physicia	ALL					
LPN	4.0		Preop patient teaching	LPN					
RN	4.0		Patient teaching	NA					
RN	4.0		Family teaching	NA					
RN	4.0		Counselling	NA					
LPN	4.0		Teaching (patient and family)	NA					
LPN	4.0		Routine teaching	NA					
NA/NT	4.0		Mother/baby teaching	NA					
NA/NT	4.0		Read to patients	OTHER					
NA/NT	4.0		Hold infants	OTHER					
RN	5.0		Documenting shift	ALL					
RN	5.0		I & O recording	ALL					
LPN	5.0		Technicon	CLERK					

CURRENT POSITION	WORK CATEGORY		TASK	REQUIRED SKILL LEVEL	REGULATORY CONSTRAINTS (Y/N)	TRAINING REQUIRED (Y/N)	DEFERRABLE (Y/N)	EVENT DEPENDENT/ ON DEMAND (Y/N)	TIME DEPENDENT (Y/N)
CLERK	5.0		Manual back-up if Technicon down	CLERK					
RN	5.0		Documentation (nursing process) - SOAPIE	LPN					
RN	5.0		Write transfer note	LPN					
LPN	5.0		Document Nursing Process	LPN					
NA/NT	5.0		Documentation	NA					
NA/NT	6.0		Inform nurse of patient changes	ALL					
RN	6.0		Evaluate new products	NA					
RN	7.0		Call for linen/trash pick-up	CLERK					
NA/NT	7.0		Forms completion	CLERK					
CLERK	7.0		Make sure room is ready for admissions	CLERK					
RN	7.0		Re-evaluate supply cart	OTHER					
RN	7.0		Check out dated supplies	OTHER					
RN	7.0		Stock nurse servers	OTHER					
RN	7.0		Equipment maintenance	OTHER					
RN	7.0		Clean IV poles	OTHER					
RN	7.0		Stock meds carts	OTHER					
RN	7.0		Check to see if rooms are clean	OTHER					
RN	7.0		Empty trash	OTHER					
RN	7.0		Check room readiness for post-op	OTHER					
RN	7.0		Care/feeding pneumatic tube system	OTHER					
RN	7.0		Discard blood in refrigerator every 24o	OTHER					
RN	7.0		Change needle containers	OTHER					
RN	7.0		Change soap, soap dispensers	OTHER					
RN	7.0		Empty linen	OTHER					
RN	7.0		Clean/disinfect instruments used on wekends, holida	OTHER					
RN	7.0		Clean conference room/break room	OTHER					
RN	7.0		Clean refrigerator	OTHER					
LPN	7.0		Unit/room housekeeping	OTHER					
LPN	7.0		Empty trash	OTHER					
LPN	7.0		Replace full needle containers	OTHER					
LPN	7.0		Clean equipment (IV pole, feeding pumps)	OTHER					
NA/NT	7.0		Empty trash	OTHER					
CLERK	7.0		Clean counter	OTHER					
CLERK	7.0		Clean phones	OTHER					
CLERK	7.0		Clean med room	OTHER					
CLERK	7.0		Care and feeding of pneumatic tube system	OTHER					

CURRENT POSITION	WORK CATEGORY		TASK	REQUIRED SKILL LEVEL	REGULATORY CONSTRAINTS (Y/N)	TRAINING REQUIRED (Y/N)	DEFERRABLE (Y/N)	EVENT DEPENDENT/ ON DEMAND (Y/N)	TIME DEPENDENT (Y/N)
RN	8.0		Attend inservice on new products	ALL					
RN	8.0		Attend mandatory Inservice	ALL					
RN	8.0		Answer calls from patient's family	ALL					
RN	8.0		Cover for lunch	ALL					
LPN	8.0		Attend inservices on new products and/or mandatory	ALL					
LPN	8.0		Answer call lights	ALL					
NA/NT	8.0		Answer call light	ALL					
NA/NT	8.0		Answer phones	ALL					
NA/NT	8.0		Answer call lights	ALL					
CLERK	8.0		Aggression management training	ALL					
RN	8.0		Post inservices, notes	CLERK					
RN	8.0		Call transporter for blood	CLERK					
RN	8.0		Answer calls from "study" departments	CLERK					
RN	8.0		Bed control	CLERK					
RN	8.0		Page physicians	CLERK					
RN	8.0		Get labs, notify physicians	CLERK					
RN	8.0		Notify on-call staff for emergency surgical case	CLERK					
RN	8.0		Get specimen transmittal	CLERK					
RN	8.0		Call staff at home for coverage	CLERK					
RN	8.0		Arrange for sitter	CLERK					
RN	8.0		Call for Interpreter	CLERK					
RN	8.0		Traffic control	CLERK					
RN	8.0		Chart management	CLERK					
RN	8.0		Take orders off	CLERK					
RN	8.0		File chart forms	CLERK					
LPN	8.0		TMS - Enter orders	CLERK					
LPN	8.0		Communicate with respiratory	CLERK					
LPN	8.0		Communicate with PT/OT	CLERK					
LPN	8.0		Communicate with radiology	CLERK					
LPN	8.0		Communicate with diagnostics	CLERK					
LPN	8.0		Communicate with physicians	CLERK					
LPN	8.0		Transcribe orders	CLERK					
LPN	8.0		Clerical functions	CLERK					
LPN	8.0		Take lab results over the phone, notify physician	CLERK					
LPN	8.0		Call dietary for missing trays or late admissions	CLERK					
CLERK	8.0		Answer call light for nurses	CLERK					

CURRENT POSITION	WORK OUTCOME ONLY		TASK	REQUIRED SKILL LEVEL	REGULATORY CONSTRAINTS (Y/N)	TRAINING REQUIRED (Y/N)	DEFERRABLE (Y/N)	EVENT DEPENDENT/ ON DEMAND (Y/N)	TIME DEPENDENT (Y/N)
CLERK	8.0		Take messages	CLERK					
CLERK	8.0		Call for charts	CLERK					
CLERK	8.0		Thin charts	CLERK					
CLERK	8.0		Stuff charts	CLERK					
CLERK	8.0		Stamp all pages of the chart	CLERK					
CLERK	8.0		Charge for treatments	CLERK					
CLERK	8.0		Report to oncoming clerk	CLERK					
CLERK	8.0		Maintain Admission/Discharge/Transfer logs	CLERK					
CLERK	8.0		Maintain daily logs	CLERK					
CLERK	8.0		Maintain destination log	CLERK					
CLERK	8.0		Call for STAT x-rays	CLERK					
CLERK	8.0		File, file	CLERK					
CLERK	8.0		Locate charts	CLERK					
CLERK	8.0		Call facilities	CLERK					
CLERK	8.0		Arrange for ambulance transportation	CLERK					
CLERK	8.0		Xerox charts	CLERK					
CLERK	8.0		Xerox forms	CLERK					
CLERK	8.0		Call nursing office for transfer approval if not IDPA	CLERK					
CLERK	8.0		Call nursing office with staffing	CLERK					
CLERK	8.0		Inform Charge Nurse of call-ins	CLERK					
CLERK	8.0		Inform Charge Nurses of all changes	CLERK					
CLERK	8.0		Coordinate patient transfers	CLERK					
CLERK	8.0		Numerous calls/coordination for admission	CLERK					
CLERK	8.0		Post med sheets	CLERK					
CLERK	8.0		Separate PCP	CLERK					
CLERK	8.0		Answer phones	CLERK					
CLERK	8.0		1:1 contact with MD	CLERK					
CLERK	8.0		1:1 contact with Charge nurse	CLERK					
CLERK	8.0		Schedule tests	CLERK					
CLERK	8.0		Schedule procedures	CLERK					
CLERK	8.0		1:1 contact dietary	CLERK					
CLERK	8.0		1:1 contact housekeeping	CLERK					
CLERK	8.0		1:1 contact bed control	CLERK					
CLERK	8.0		1:1 contact admissions	CLERK					
CLERK	8.0		Contact materiel management	CLERK					
CLERK	8.0		Phone calls for repairs	CLERK					

CURRENT POSITION	WORK CATEGORY		TASK	REQUIRED SKILL LEVEL	REGULATORY CONSTRAINTS (Y/N)	TRAINING REQUIRED (Y/N)	DEFERRABLE (Y/N)	EVENT DEPENDENT/ ON DEMAND (Y/N)	TIME DEPENDENT (Y/N)
CLERK	8.0		Order clerical supplies	CLERK					
CLERK	8.0		Stock clerical supplies	CLERK					
CLERK	8.0		Maintain admission charts	CLERK					
CLERK	8.0		Make admission packs	CLERK					
CLERK	8.0		Transcribe MD orders	CLERK					
CLERK	8.0		Page physicians	CLERK					
CLERK	8.0		Page nurses (intercom)	CLERK					
CLERK	8.0		Get clothes for patients	CLERK					
CLERK	8.0		1:1 contact with patient representatives	CLERK					
CLERK	8.0		Get patient checks cashed	CLERK					
CLERK	8.0		Schedule appoints with physicians	CLERK					
CLERK	8.0		Phone from unit to waiting room	CLERK					
CLERK	8.0		Answer patients phones	CLERK					
CLERK	8.0		Obtain transmittals from blood specimens	CLERK					
CLERK	8.0		Break down discharge chart	CLERK					
CLERK	8.0		Give room assignment to admissions	CLERK					
CLERK	8.0		Inform nurse of new orders	CLERK					
CLERK	8.0		Write down STAT labs	CLERK					
CLERK	8.0		Inform MD, RN of labs	CLERK					
CLERK	8.0		Stamp labels (alot)	CLERK					
CLERK	8.0		Name tags (doors, rooms, lockers, charts)	CLERK					
CLERK	8.0		Call daily census	CLERK					
CLERK	8.0		Call clinic for appointments	CLERK					
CLERK	8.0		Order specialty beds from company	CLERK					
CLERK	8.0		Inform family members of discharge	CLERK					
CLERK	8.0		Change computer paper	CLERK					
CLERK	8.0		Call Zerox (lasers)	CLERK					
CLERK	8.0		Call Technicon	CLERK					
CLERK	8.0		Train clerks	CLERK					
CLERK	8.0		Orient nurses to desk	CLERK					
CLERK	8.0		Orient residents to unit/desk	CLERK					
CLERK	8.0		Order supplies (forms, inventory)	CLERK					
•• RN	8.0		Call floor and give report	LPN					
•• RN	8.0		Shift report	LPN					
RN	8.0		Transfer belongings, valuables	OTHER					
RN	8.0		Move beds	OTHER					

CURRENT POSITION	WORK CATEGORY		TASK	REQUIRED SKILL LEVEL	REGULATORY CONSTRAINTS (Y/N)	TRAINING REQUIRED (Y/N)	DEFERRABLE (Y/N)	EVENT DEPENDENT/ ON DEMAND (Y/N)	TIME DEPENDENT (Y/N)
RN	8.0		Narcotic counts	OTHER					
RN	8.0		Beds ready for OR (oxygen tank, ambubag)	OTHER					
RN	8.0		Equipment checklist	OTHER					
RN	8.0		Accucheck cleaning (daily)	OTHER					
RN	8.0		Accucheck QA (monthly)	OTHER					
RN	8.0		Order patient supplies	OTHER					
RN	8.0		Call for bed repairs	OTHER					
RN	8.0		Call for phone repair	OTHER					
RN	8.0		Call dietary to pick up trays	OTHER					
RN	8.0		Pass water	OTHER					
RN	8.0		Pass linens	OTHER					
RN	8.0		Load paper in Technicon printer	OTHER					
RN	8.0		Trouble shooting/problem-solving	OTHER					
RN	8.0		Move patients for care/isolation	OTHER					
RN	8.0		Change paper in EKG machine	OTHER					
LPN	8.0		Fill printer	OTHER					
LPN	8.0		Interpreter - Find one/or do	OTHER					
LPN	8.0		Sitter functions prn	OTHER					
LPN	8.0		Equipment checks (emergency equipment, other)	OTHER					
LPN	8.0		Ancillary functions: linen	OTHER					
LPN	8.0		Transport (patients and specimens)	OTHER					
LPN	8.0		Occasional pick-up of meds, blood	OTHER					
LPN	8.0		Check equipment	OTHER					
LPN	8.0		Stock isolation care	OTHER					
LPN	8.0		Stock med cart	OTHER					
LPN	8.0		Load paper and fix technican printer	OTHER					
LPN	8.0		Equipment setup - drains	OTHER					
LPN	8.0		Equipment setup - suction	OTHER					
LPN	8.0		Equipment setup - 02	OTHER					
LPN	8.0		OR (Instrument processing)	OTHER					
NA/NT	8.0		Charge tickets	OTHER					
NA/NT	8.0		OR instrument processing	OTHER					
NA/NT	8.0		Stock servers	OTHER					
NA/NT	8.0		Check equipment	OTHER					
NA/NT	8.0		Inventory patient supply needs	OTHER					
NA/NT	8.0		Equipment checking & instrument cleaning	OTHER					

CURRENT POSITION	WORK CATEGORY		TASK	REQUIRED SKILL LEVEL	REGULATORY CONSTRAINTS (Y/N)	TRAINING REQUIRED (Y/N)	DEFERRABLE (Y/N)	EVENT DEPENDENT/ ON DEMAND (Y/N)	TIME DEPENDENT (Y/N)
NA/NT	8.0		Empty linen	OTHER					
NA/NT	8.0		Transport specimen	OTHER					
NA/NT	8.0		Transport patients	OTHER					
NA/NT	8.0		Supervise play room & clean	OTHER					
NA/NT	8.0		"Sitters"	OTHER					
NA/NT	8.0		Check Bill - lights in Nursing	OTHER					
NA/NT	8.0		Pass dietary trays	OTHER					
CLERK	8.0		Check patient for nurses	OTHER					
CLERK	8.0		Safety monitor (line, isolation, other)	OTHER					
CLERK	8.0		Proper handling of charge sticker	OTHER					
CLERK	8.0		Pick green stickers and place	OTHER					
CLERK	8.0		Get med juices	OTHER					
CLERK	8.0		Run STATS to lab	OTHER					
CLERK	8.0		Stamp new charge stickers	OTHER					
CLERK	8.0		"PR" (i.e., family, tours, media, sales)	OTHER					
NA/NT	8.0		Clean unit - Order & organize supplies	OTHER					
RN	8.0		Call/run for meds	OTHR					
NA/NT	8.0		Pass Linen & water	OTHR					
RN	8.0		Unit QA (monthly)	RN					
RN	8.0		Assign lunch	RN					
RN	8.0		Supervision of students (nursing, medical, other)	RN					
RN	8.0		Accompany patients to tests (roadtrips)	RN					
RN	8.0		Communicate to students	RN					
RN	8.0		Orient flex, float, agency staff	RN					
RN	8.0		Orient residents	RN					
RN	8.0		Patient update (Charge Nurse)	RN					
RN	8.0		Self-scheduling	RN					
LPN	8.0		Dischage planning	RN					
CLERK	8.0		Follow up on daily assignments	RN					

ASSISTIVE WORKER JOB CONTENT (CLINICAL) 02-Apr-93

	TASK	TASK GROUP	DIV SPEC	% TIME SPENT
1	PROVIDE PATIENT WITH ADMISSIONS PACK, GOWN, ASSIST IF NEEDED	ADMIT		
2	ORIENT PATIENT TO ROOM, TV, PHONE, CALL LIGHT, VISITING HOURS	ADMIT		
3	SET-UP ROOMS/CRIBS FOR ADMITS	ADMIT		
4	BLOOD PRESSURE (CUFF,DYNAMAP)	ASSESSMENT		
5	OBTAIN PULSE (RADIAL,APICAL/IRREGULAR)	ASSESSMENT		
6	OBTAIN ORAL TEMP (TYMPANIC,TEMP-A-DOT,GLASS)	ASSESSMENT		
7	OBSERVE RESPIRATION/COLOR	ASSESSMENT		
8	OBTAIN WEIGHT, HEIGHT; RECORD DATA	ASSESSMENT		
9	MONITOR PATIENTS FOR SAFETY (IE TUBES)	ASSESSMENT		
2	INCENTIVE SPIROMETER, DEEP BREATHING, COUGHING	ASSESSMENT		
4	OBTAIN RECTAL TEMP	ASSESSMENT		
5	MEASURE GIRTH	ASSESSMENT		
6	ASSESS SKIN INTEGRITY (BRADEN SCALE)	ASSESSMENT		
7	ENSURE THAT ALL PATIENT'S BELONGINGS ARE TAKEN UPON DISCHARGE	DISCHARGE		
8	ASSIST WITH DISCHARGE	DISCHARGE		
9	PROVIDE POST MORTEM CARE	DISCHARGE		
24	OBTAIN EKG RHYTHM STRIPS	EKG		
25	EXTERNAL CATHETER APPLICATION/REMOVAL	ELIMINATION		
26	CARE INCONTINENT PATIENT/USE OF INCONTINENT PRODUCTS	ELIMINATION		
27	ADMINISTER ENEMAS, COLON PREP	ELIMINATION		
28	APPLY AND EMPTY FECAL CONTAINMENT DEVICES	ELIMINATION		
29	ASSESS PAD COUNT	ELIMINATION		
10	ASSESSMENT OF STOOL AND URINE, REPORTING AND DOCUMENTATION	ELIMINATION		
11	PERFORM PERI CARE	ELIMINATION		
12	TOILETING	ELIMINATION		
13	ASSIST WITH CATHETER CARE	ELIMINATION		
14	ASSIST WITH CATHETERIZATION	ELIMINATION		
16	EMPTY FOLEY BAG, MEASURE, DOCUMENT	ELIMINATION		

ASSISTIVE WORKER JOB CONTENT (CLINICAL) 02-Apr-93

	TASK	TASK GROUP	DIV SPEC	% TIME SPENT
37	KNOW LOCATION OF EMERGENCY EQUIPMENT	EMERGENCY		
38	KNOW WHAT TO DO IN CASE OF SEIZURES	EMERGENCY		
39	KNOW HOW TO CALL CODE BLUE (LIGHT/PHONE)	EMERGENCY		
40	KNOW WHAT TO DO IN CASE OF ARREST	EMERGENCY		
41	KNOW WHAT TO DO IN CASE OF FALL	EMERGENCY		
42	KNOW WHAT TO DO IN CASE OF EXCESSIVE BLEEDING	EMERGENCY		
43	KNOW HOW TO USE EMERGENCY CALL LIGHTS	EMERGENCY		
45	ASSIST WITH CARDIAC ARREST	EMERGENCY		
71	PERFORM PM CARE /BACK RUBS	HYGIENE		
72	OR-SCRUB	HYGIENE	OR	
73	SHAVE AND PREP FOR OR	HYGIENE		
74	GIVE COMPLETE BATH	HYGIENE		
75	RANGE OF MOTION (ACTIVE/PASSIVE)	HYGIENE		
76	ASSIST WITH ORAL HYGIENE	HYGIENE		
77	SET UP PATIENT FOR SELF CARE & INFANT CARE	HYGIENE		
78	ASSIST WITH TRANSFERS	TRANSFER		
79	ASSIST WITH BED BATH	HYGIENE		
80	AMBULATE WITH/WITHOUT ASSISTIVE DEVICES	HYGIENE		
81	MAKE OCCUPIED AND UNOCCUPIED BEDS/CRIBS	ENVIRONMENT		
82	DISEASE-SPECIFIC ISOLATION	INFECT CTRL		
83	RESPIRATORY ISOLATION	INFECT CTRL		
84	ASSIST PATIENT WITH MEALS /DYSPHAGIA	NUTRITION		
85	REINFORCE BREAST FEEDING/BOTTLE FEEDING TECHNIQUE	NUTRITION	PC	
86	KNOWLEDGE OF SPECIAL DIETS	NUTRITION		
87	PUSH FLUIDS	NUTRITION		
88	CHECK FOR DIET TRAYS, SNACKS	NUTRITION		
89	ASSIST MOTHER AND INFANTS WITH FEEDING	NUTRITION	PC	
90	PASS WATER AND NOURISHMENT	NUTRITION		

ASSISTIVE WORKER JOB CONTENT (CLINICAL) 02-Apr-93

	TASK	TASK GROUP	DIV/SPEC	% TIME SPENT
92	INTAKE/OUTPUT DOCUMENTATION	NUTRITION		
93	PROVIDE/DOCUMENT SUPPLEMENTS	NUTRITION		
94	POSITION PATIENT FOR ORAL INTAKE/FEEDING TUBE	NUTRITION		
95	MONITOR FLUIDS RESTRICTION	NUTRITION		
96	PERFORM CALORIE COUNT, DOCUMENT	NUTRITION		
97	DEMONSTRATE USE OF TED HOSE/SCD MACHINES	PHYS TX & CAR		
98	DEMONSTRATE USE OF ACE WRAPS	PHYS TX & CAR		
99	DEMONSTRATE USE OF KNEE IMMOBILIZER	PHYS TX & CAR		
100	INITIATE PHOTO THERAPY	PHYS TX & CAR	PC	
101	APPLY SIMPLE DRESSINGS, ASSIST W/ COMPLICATED	PHYS TX & CAR		
103	APPLY BUCKS, PELVIC SUPPORT	PHYS TX & CAR		
105	ASSIST WITH ENT PROCEDURES	PHYS TX & CAR	EEI	
106	OPERATE CPM MACHINE	PHYS TX & CAR		
107	USE OF UNIVERSAL PRECAUTIONS FOR ALL PATIENTS AND PROCEDURES	INFECT CTRL		
108	ASSIST POST-OP PATIENTS WHO RETURN FOR POST OP VISITS	PHYS TX & CAR		
109	DEMONSTRATE USE OF SPLINTS/BRACES,CORSETS,SLINGS,COLLARS	PHYS TX & CAR		
110	UNDERSTAND USE OF OVERHEAD TRAPEZE	PHYS TX & CAR		
112	READY PATIENT FOR TESTS	PHYS TX & CAR		
113	MAINTAIN DRAINS; EMPTY AND DOCUMENT AMOUNT AND COLOR	PHYS TX & CAR		
114	CHANGE DRESSINGS	PHYS TX & CAR		
116	ASSIST WITH IV THERAPY (DRESSING, MONITOR RATE,D/C PERIPHERAL,SE	PHYS TX & CAR		
117	ELEVATE EXTREMITY	PHYS TX & CAR		
118	ASSIST WITH DIALYSIS	PHYS TX & CAR		
120	PERFORM CAST CARE	PHYS TX & CAR		
121	PREP FOR RADIOLOGY	PHYS TX & CAR		
122	ASSIST W/ MONITORING PATIENT RESPONSE POST MED (IE U/O AFTER LA	PHYS TX & CAR		
124	SET UP FOR PELVIC EXAM	PHYS TX & CAR		
125	MAINTAIN CURRENT O2 THERAPY , IE REAPPLY NASAL CANNULAS, MASKS	PHYS TX & CAR		

ASSISTIVE WORKER JOB CONTENT (CLINICAL) 02-Apr-93

	TASK	TASK GROUP	DIV SPEC	%TIME SPENT
126	CONTRIBUTE TO CARE PLAN	PLANNING		
127	CONTRIBUTE TO PROBLEM LIST	PLANNING		
128	APPLY RESTRAINT VEST	RESTRAINTS		
129	UNDERSTAND NURSING POLICY FOR USE OF RESTRAINTS	RESTRAINTS		
130	FILL OUT RESTRAINT FLOWSHEET	RESTRAINTS		
131	LUBRICATE DRY UNBROKEN SKIN	SKIN CARE		
132	PLACE IMMOBILE PATIENTS IN GOOD ALIGNMENT	SKIN CARE		
133	APPLY MATTRESS OVERLAY, UNDERSTAND USE OF SPECIALTY BEDS	SKIN CARE		
134	CHANGE PATIENT'S BODY POSITON Q/2HRS	SKIN CARE		
135	COLLECT SPUTUM SPECIMEN	SPECIMEN		
136	COLLECT URINE SPECIMEN (FOLEY,MIDSTREAM)	SPECIMEN		
137	PERFORM HEEL STICKS	SPECIMEN		
138	COLLECT STOOL SPECIMEN	SPECIMEN		
139	24HR URINE COLLECTION	SPECIMEN		
140	MEASURE CHEST TUBE DRAINAGE	SPECIMEN		
141	REINFORCE PATIENT TEACHING	TEACHING/PSY		
142	PROVIDE THERAPY/COMFORT MEASURES (TLC)	TEACHING/PSY		
143	REINFORCE FAMILY TEACHING	TEACHING/PSY		
144	HOLD INFANTS	TEACHING/PSY	PC	
145	READ TO CHILDREN	TEACHING/PSY	PC	
146	PATIENT/FAMILY ADVOCATE, PROVIDE INFO, SUPPLIES, COMFORT	TEACHING/PSY		
147	TBJ-SICK DAY CARE	TEACHING/PSY	PC	
148	TRANSPORT/ESCORT PATIENTS AS DIRECTED	TRANSPORT		
149	CORRECTLY POSITIONS PATIENT ON TABLE ACCORDING TO PROTOCOL	TRANSPORT		
152	EVALUATE NEW PRODUCTS/ATTEND INSERVICES	UNIT ACTIVITY		
153	ANSWER CALLS FROM PATIENT FAMILY	UNIT ACTIVITY		
154	ATTEND MANDATORY INSERVICES	UNIT ACTIVITY		
156	ACCOMPANY STABLE INFANT OFF UNIT FOR TESTS	UNIT ACTIVITY	PC	

ASSISTIVE WORKER JOB CONTENT (CLINICAL) 02-Apr-93

	TASK	TASK GROUP	DIV SPEC	% TIME SPENT
158	REPORT OFF TO NURSE BEFORE BREAKS/SHIFT END	UNIT ACTIVITY		
159	ANSWER CALL LIGHT	UNIT ACTIVITY		
160	OBTAIN REPORT ON PATIENTS FROM RN	UNIT ACTIVITY		
161	ATTEND MULTI-DISCIPLINARY CONFERENCES	UNIT ACTIVITY		
162	PULSE OXIMETRY	UNIT TEST		
164	PERFORM BLOOD GLUCOSE	UNIT TEST		
165	PERFORM SPECIFIC GRAVITY	UNIT TEST		
166	IMPLEMENT NON-INVASIVE PROCEDURES/TESTS, AS DIRECTED	UNIT TEST		
168	CHECK PH OF GASTRIC CONTENTS	UNIT TEST		
169	CHECK PH, URINE ?? (DIPSTICKS?)	UNIT TEST		
170	PERFORM HEMOCCULTS	UNIT TEST		

ASSISTIVE WORKER JOB CONTENT (NON-CLINICAL) 02-Apr-93

	TASK	TASK GROUP	DIV SPEC	% TIME SPENT
7	KNOW LOCATION OF EMERGENCY EQUIPMENT	EMERGENCY		
8	KNOW WHAT TO DO IN CASE OF SEIZURES	EMERGENCY		
9	KNOW HOW TO CALL CODE BLUE (LIGHT/PHONE)	EMERGENCY		
0	KNOW WHAT TO DO IN CASE OF ARREST	EMERGENCY		
1	KNOW WHAT TO DO IN CASE OF FALL	EMERGENCY		
3	KNOW HOW TO USE EMERGENCY CALL LIGHTS	EMERGENCY		
6	STRAIGHTEN AND RESUPPLY TREATMENT ROOMS	ENVIRONMENTA		
7	STRAIGHTEN KITCHEN AREA	ENVIRONMENTA		
8	MAINTAIN COMMON AREAS (CONF.ROOM, PLAY ROOM, BREAK ROOM, ETC)	ENVIRONMENTA		
9	CLEAN COUNTERS	ENVIRONMENTA		
0	CHECKS/CALIBRATES AND MAINTAINS EQUIP	ENVIRONMENTA		
1	CHECK TO SEE IF ROOMS ARE CLEAN	ENVIRONMENTA		
2	STOCK NURSE SERVERS	ENVIRONMENTA		
3	CLEAN PHONES	ENVIRONMENTA		
4	CHANGE NEEDLE CONTAINERS	ENVIRONMENTA		
5	ASSIST WITH FLOOR WASHING AND FURNITURE CLEANUP (ROOM TURNAROUN	ENVIRONMENTA	OR	
6	CARE/FEEDING PNEUMATIC TUBE SYSTEM	ENVIRONMENTA		
7	DECONTAMINATES,CLEANS & PACKS & STERILIZES INSTRUMENTS	ENVIRONMENTA	OR	
8	ASSIST TEAM IN TOTAL ROOM/AREA PREP AND CLEANUP	ENVIRONMENTA	OR	
9	ARRANGE ROOM EQUIP/FURNITURE TO ACCOMMODATE SCHEDULED PROCED	ENVIRONMENTA	OR	
0	COLLECT AND BAG SOILED LINEN	ENVIRONMENTA		
1	STOCK LINEN	ENVIRONMENTA		
2	STRAIGHTEN CHARTING AREA	ENVIRONMENTA		
3	STRAIGHTEN REPORT ROOM	ENVIRONMENTA		
4	WASH EQUIPMENT	ENVIRONMENTA		
5	CHECK FOR EXPIRED TRAYS	ENVIRONMENTA		
6	STRAIGHTEN CARTS IN REPORT ROOMS/REPLACE SUPPLIES	ENVIRONMENTA		
7	ASK UNIT CLERK TO CALL DEPTS TO PICK UP SUPPLIES,LINEN,TRASH,EQUIP	ENVIRONMENTA		
8	PREPARE EQUIPMENT FOR RETURN TO CENTRAL STERILE	ENVIRONMENTA		
9	STRAIGHTEN DIRTY UTILITY ROOM	ENVIRONMENTA		
148	TRANSPORT/ESCORT PATIENTS AS DIRECTED	TRANSPORT		
150	DELIVER SURGICAL SPECIMENS	TRANSPORT	OR	
151	DELIVERS AND RETRIEVES SPECIMENS/LAB RESULTS AS DIRECTED	TRANSPORT		
159	REPORT OFF TO NURSE BEFORE BREAKS/SHIFT END	UNIT ACTIVITY		
167	REPLACEMETN OF RESUSCITATION KIT	ENVIRONMENTA		
169	MAINTAINS RECORDS OF PKU, HEPATITIS VAC. IMMUNIZATIONS	UNIT ACTIVITY		

INA Nurses Local Unit of the U of I Hospital & Clinics

THE NEEDLE

March 30, 1993

Operations Improvement: How Will It Impact Patient Care?

We are registered nurses at the U. of I. who are concerned about the "quality of patient care" and the negative impact that will result from the proposed "Operations Improvement." The area we'd like to focus specifically on is Women's and Children's Health, and O.I.'s adverse impact on infant mortality. Preventive primary care and patient education play a major role in reducing the infant mortality rate. The infant mortality rate of our clients is one of the highest in the country. The U. of I. serves a primarily impoverished population, educationally, socially and economically. The majority of these clients have no insurance or are I.D.P.A., clients. Many cannot read or write. Only registerred nurses are educationally prepared to proveide primary care and patient education.

In the Obstetric Clinic and Labor and Delivery, over 50% speak Spanish only. Currently the Obstetric Clinic sees between 400-500 clients/week; Labor and Delivery has over 100 unregistered (no pre-natal care) clients/month. They come to us because there is no one else who will or can take care of them. Many of them come late in pregnancy.

Patient education and preventive primary care through early pre-natal care, well child care and immunizations are key to decreasing infant mortality. Even if we are successful in delivering a healthy baby at term, many children continue to have an uphill battle due to impoverished conditions, and die prior to their first birthday primarily from preventable reasons, i.e., infections, accidents. Teen pregnancies also continue to rise. We see approximately 200-250/month in our Teen Clinic. We recently lost that grant, and now even those who are to come in to register are not seen because they only want to be seen in Teen Clinic. All these clients need the education, follow-up and quality care that we provide, without which there will be greater infant mortality.

Registered nurses are professionals, educated to provide holistic care that identifies educational, psychosocial, and medical problems. These interventions play an important role in helping decrease infant mortality. Assistive workers have no training, or formal education in patient care. How can assistive workers replace registered nurses in areas where an RN's skills are *not* replacable?

Those registered nurses left will have to take valuable time away from patient education/care to supervise these assistive workers. A minimum of 90% of our clients are high-risk, having serious medical conditions, i.e., diabetes, hypertension, seizures, heart problems, history of previous intrauterine fetal demise or stillborns. These clients need "quality care" and "intense education," something that is difficult even now to do. Clients currently wait as long as 3-5 hours to see a doctor. Many clients are falling thru the cracks for follow-up for abnormal labs, failing appointments, and most importantly, patient education.

These are just a few obstacles we face in our struggle to decrease in infant mortality. Think of what "quality of care" will be if in fact there is a decrease in the number of registered nurses, and an increase in assistive workers. While cost containment in health care today is important, "quality care" shouldn't be sacrificed just for the sake of "cost containment." The nursing profession should lead the way to improving quality health care, not follow a road to sure catastrophe in a health care industry that is in crisis already.

Written by the OB Clinic Nurses

Artist: Judy Hopkins

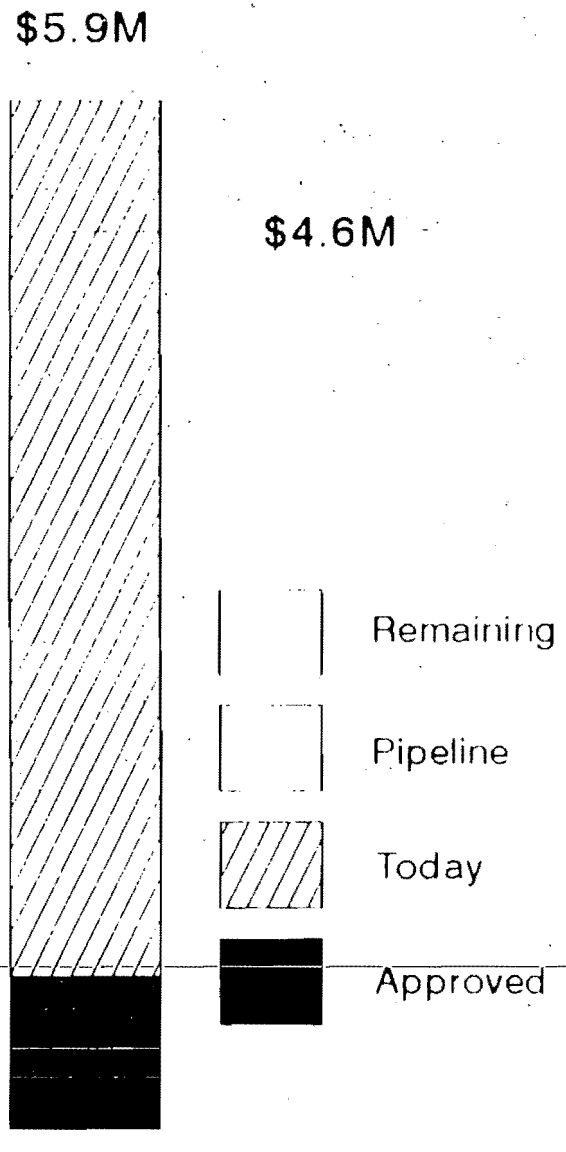
What Does O.I. Plan for your Unit?

The following infromation is extracted from a 17 page documnet requested by and given to the INA by the Department of Nursing on March 18, 1993. Highlighted is the proposed reductions in RN positions and what classifications will replace RNs.

UNIT	01.7/94	Now	Variance
7WTR			
Staff Nurse	12.20	13.70	(1.50)
LPN I & II	4.92	1.90	3.02
MICU			
Staff Nurse	14.44	21.20	(6.76)
Nurse Tech	3.40	0.00	3.40
SICU			
Staff Nurse	23.10	29.60	(6.50)
Nurse Tech	9.25	1.00	8.25
CTU/CCU			
Staff Nurse	22.39	27.90	(5.51)
Nurse Tech	6.36	1.00	5.36
6WSD			
Staff Nurse	20.84	29.30	(8.46)
Nurse Tech	7.78	0.00	7.78
6ESD			
Staff Nurse	15.35	26.80	(11.45)
LPN I & II	4.92	0.00	4.92
ER			
Staff Nurse	25.37	28.00	(2.63)
Med Asst.	10.83	6.00	4.83
8EAP			
Staff Nurse	12.27	15.10	(2.83)
MH Counselor	8.83	5.00	3.83
8ENP			
Staff Nurse	8.80	8.80	0.00
8WES			
Staff Nurse	19.63	28.90	(9.27)
Nurse Tech	7.31	3.00	4.31
7EAS			
Staff Nurse	18.75	30.00	(11.25)
LPNI & II 7.57	3.90	3.67	
Nurse Tech	6.63	1.00	5.63
7EON			
Staff Nurse	12.31	13.20	(0.89)
Nurse Tech	3.44	2.00	1.44
5EAS			
Staff Nurse	10.90	18.30	(7.40)
Nurse Tech	4.98	0.00	4.98
5EAR			
Staff Nurse	9.26	10.10	(0.84)
7WES			
Staff Nurse	14.69	22.70	(8.01)
Nurse Tech	6.46	1.00	5.46
EEI1/EESC			
Staff Nurse	12.60	8.60	(6.00)
Nurse Tech	6.76	0.00	6.76
Unit Clerk	0.00	2.00	(2.00)
EEOR			
Staff Nurse	7.50	12.00	(4.50)
ENTC			
Staff Nurse	3.50	3.50	0.00
EYEC			
Staff Nurse	3.00	7.00	(4.00)
Opthal Tech	4.00	0.00	4.00
NICU			
Staff Nruse	56.91	73.80	(16.89)
LPN I & II	8.82	0.00	8.82
Nurse Tech	11.32	1.00	10.32
PICU			
Staff Nurse	12.88	17.40	(4.52)
LPN I & II	2.73	0.00	2.73
Nurse Tech	2.17	0.00	2.17
PEDS			
Staff Nurse	15.56	25.30	(9.74)
Nurse Tech	5.80	0.00	5.80
MB			
Staff Nurse	19.40	31.80	(12.40)
Nurse Tech	16.96	5.00	11.96
APSD			
Staff Nurse	12.94	19.00	(6.06)
LPN I & II	3.31	0.00	3.31
Nurse Tech	3.00	0.00	3.00
4 ELD			
Staff Nurse	34.00	35.10	(1.10)
LP I & II	8.40	2.00	6.40
RHSC			
Staff Nurse	3.50	3.50	0.00
RHRR			
Staff Nurse	8.00	8.00	0.00
RHOR			
Staff Nurse	25.70	32.00	(6.30)
Nurse Tech	6.00	1.00	5.00
OR Tech	6.50	3.50	3.00
IV THER			
Staff Nurse	4.00	0.00	4.00
Nurse Tech	2.00	0.00	2.00
MEDC			
Staff Nurse	10.40	10.00	0.40
Hist Tech	2.00	2.00	0.00
MEDD			
Staff Nurse	10.60	11.00	(0.40)
Med. Asst.	2.00	1.00	1.00
SURC			
Staff Nurse	11.90	11.90	0.00
OBGN			
Staff Nurse	9.00	16.30	(7.30)
Med. Asst.	8.00	1.00	7.00
Comm Svc.	4.00	0.00	4.00
PDCL			
Staff Nurse	9.20	7.40	1.80
Med Asst.	2.00	.60	1.40
NURSING GRAND TOTALS			
Staff Nurse	**511.89**	**668.20**	**(156.31)**
LPN I & II	**74.87**	**30.40**	**44.47**
Med. Asst	**34.83**	**17.60**	**17.23**
Nurse/OR Tech	**133.51**	**37.30**	**96.21**

The next INA O.I. strategy meeting is April 8 at 5pm. We meet every other Thursday. Make sure a rep from you unit attends!

The Patient Care task force is presenting the new patient care delivery model today.



Previously Presented	
All Ideas	$2,034,087
Enabling Ideas	($1,161,672)
Approved "Hard" $$$	$872,415
Presenting Today	
Redesigned Patient Care Delivery Model	$4,833,752
Discontinue Pilot Weekend Bonus	$174,000
Total Presenting Today	$5,007,752
Total To Date	$5,880,167

Patient Care Model: Results

Upon complete implementation, the new patient care model will achieve an ongoing annual savings of $4.8M.

Change skill mix & hours per patient day[1]	$5,433,000
Unit Support (education, QI, Case Management, etc.)	($324,000)
Dedicate transporters to high volume units	($111,000)
Decentralize equipment/supply attendants	($140,000)
Deduct ongoing training costs for assistive caregivers[2]	($25,000)
	$4,833,752
One time training costs (incurred in year 1)[2]	**($350,000)**

[1]$50,000 from EEI savings in Surgery Task Force

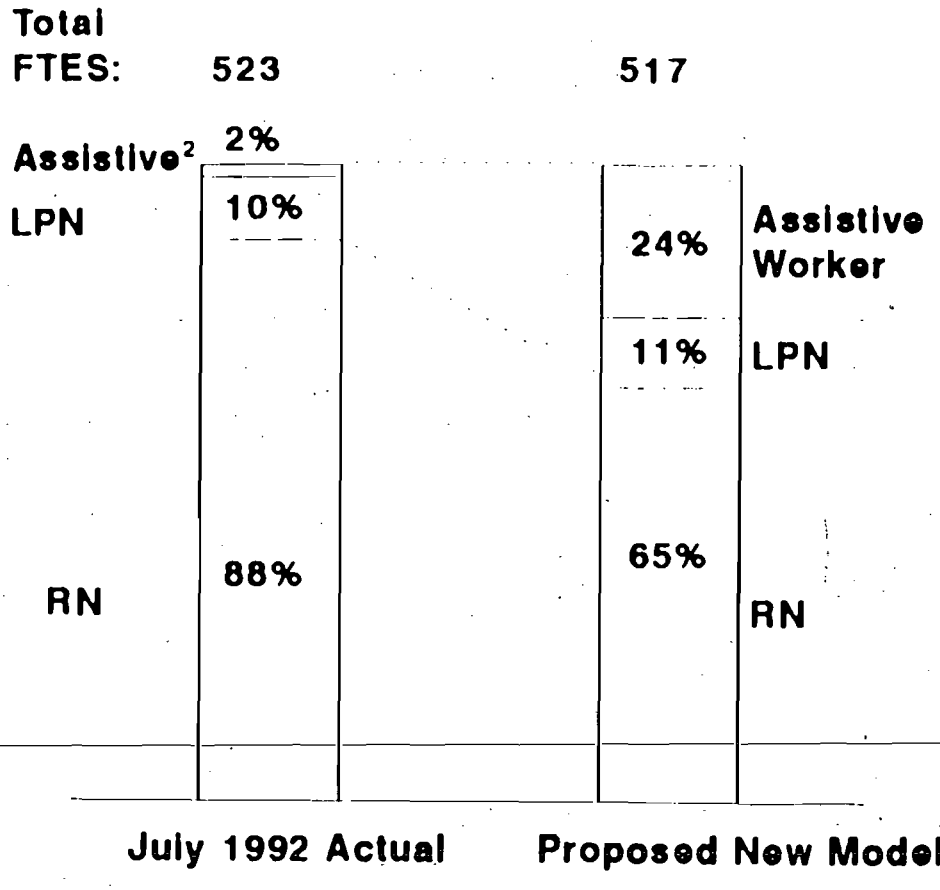
[2]These reflect costs for all patient care areas which fall under the Nursing Department

2

Patient Care Model: Results

Redistribution of work will require an increase in the number of LPNs and assistive workers, as well as a reduction in RNs.

Housewide Caregiver Skill Mix[1]



Division Skill Mix (Percent RN)

	Before	After
Med/Surg	82%	60%
Parent Child (excl. L&D)	89%	66%
Critical Care (excl. ER)	93%	70%
EEI (Unit 1 & SC)	100%	59%

[1] Includes all in hospital floors and units except ER, OR, L&D; also includes EEI Unit 1

[2] Assistive workers include NT, ORT, MHC, NA, SA

- Match work to workers
- Cross-train
- Evaluate aggregation of patients
- Coordinate care
- Streamline documentation
- Evaluate decentralization
- Simplify processes

PRINCIPLES

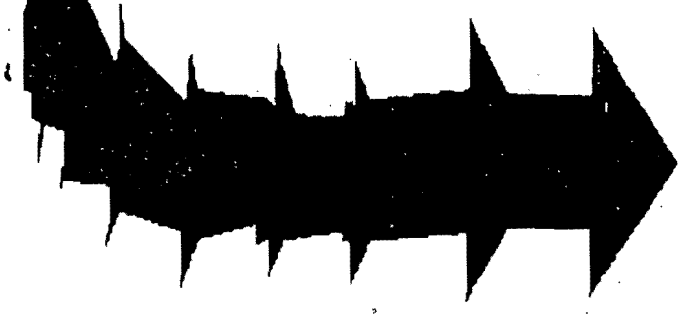
VALUES

OBJECTIVES

ROLES

- Quality of care
- Respect for patient
- Care planning
- Competent adequate staff
- Professionalism
- Increased accountability

ORGANIZATION OF CARE



STAFFING/SKILL MIX

Patient Care Model Objectives

Increase or maintain quality of care

Increase or maintain patient service level

Maintain total care giver/patient ratios

Increase staff satisfaction

Increase RN professional time in direct patient care

Patient Care Model: Roles and Functions

New patient care roles provide the foundation for the patient care model.

RNs	Focus on direct patient care, including assessment, planning, patient and student education, coordination and physician communication; New training for delegation skills, teambuilding
LPNs	Dedicated med passers on days and evenings; provide additional support to RNs at night
Assistive Workers	Expanded skills training for a set of RN-delegated direct patient care tasks; ancillary and clerical support
Transporters	Decentralized; direct report to nursing for high volume units
Equipment/Supply	Decentralized; shared across floors

Nurses created staffing patterns unique to their units based on acuity and census level:

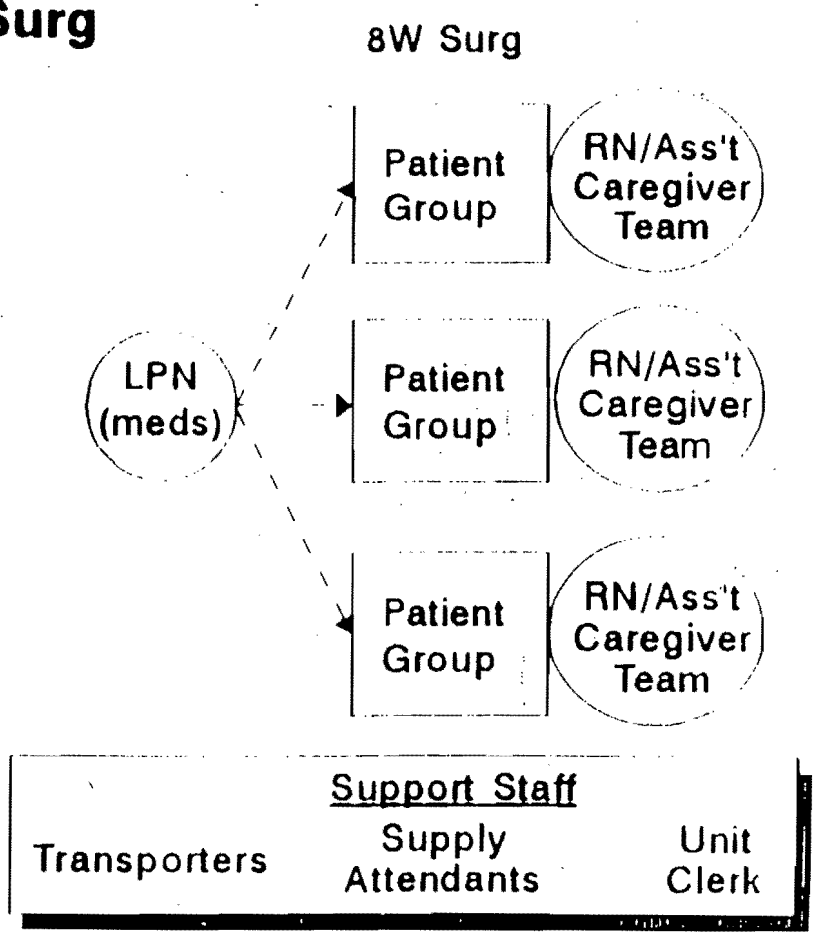
7 West Med

Census	DAY/EVENING			NIGHT	
	RN	LPN	NT	RN	LPN
27	4	1	2	3	2
26	4	1	2	3	2
25	3	1	2	3	1
24	3	1	2	3	1
23	3	1	2	3	1
22	3	1	2	3	1

Each unit designed a care model to meet the unique needs of its patient population

Med/Surg

Unit	HPPD After	Skill Mix Before	After
7E Med	5.4	85%	56%
7E Onc	7.0	73%	71%
7W Med	5.5	83%	58%
8W Surg	5.5	82%	56%
8E Psych	6.0	73%	62%
5E Rehab	6.8	94%	74%
5E Orth/Gyne	5.8	87%	63%
Average	6.2	82%	61%



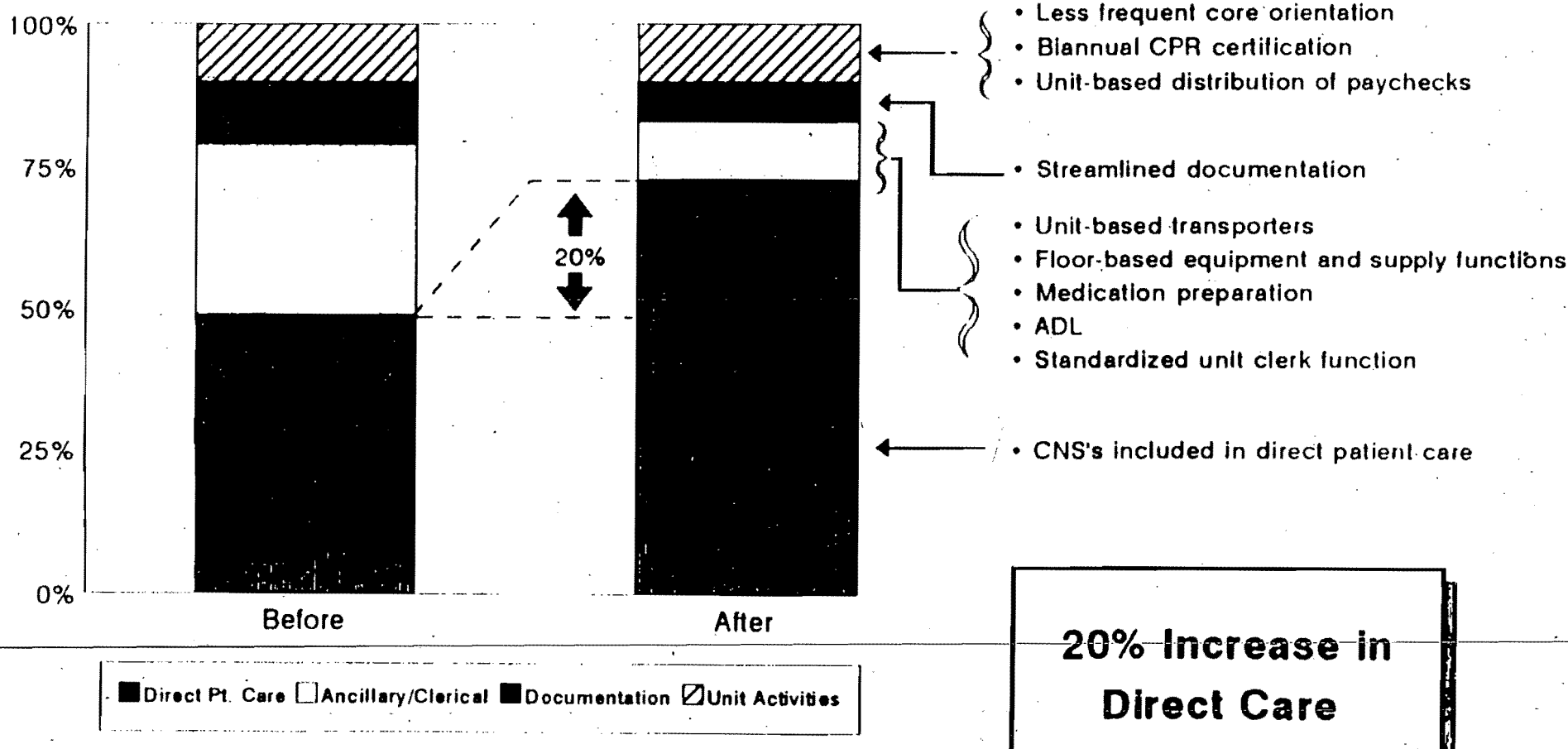
Caregiver to Patient Ratio

1 : 4

The new patient care model will enable the RN to spend more time on direct patient care.

MED/SURG STAFF NURSE

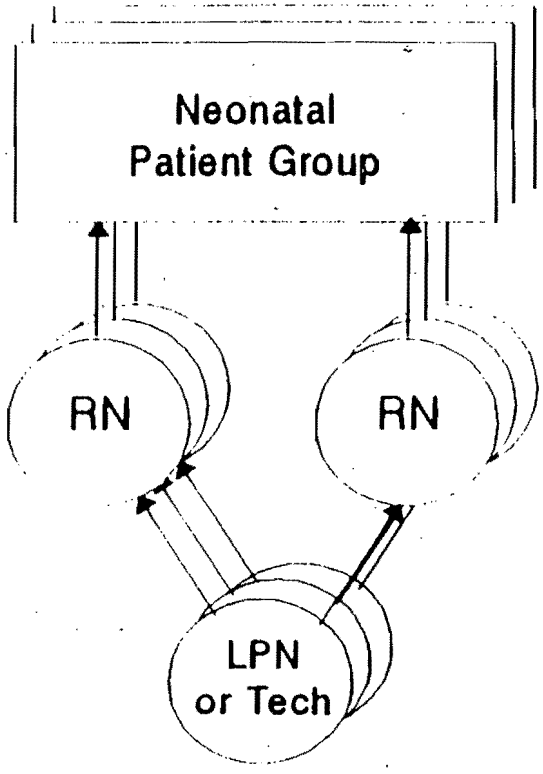
Time Allocation



20% Increase in Direct Care

Parent/Child

Unit	HPPD After	Skill Mix Before	After
NICU/ICN	10.0		74%
PICU	16.6	95%	72%
5W (PEDS)	6.6	87%	59%
APSD	8.7		67%
Mother/Baby	4.0		52%
FCC+FCCN+NICU		89%	67%
Average	8.5		66%



Support Staff

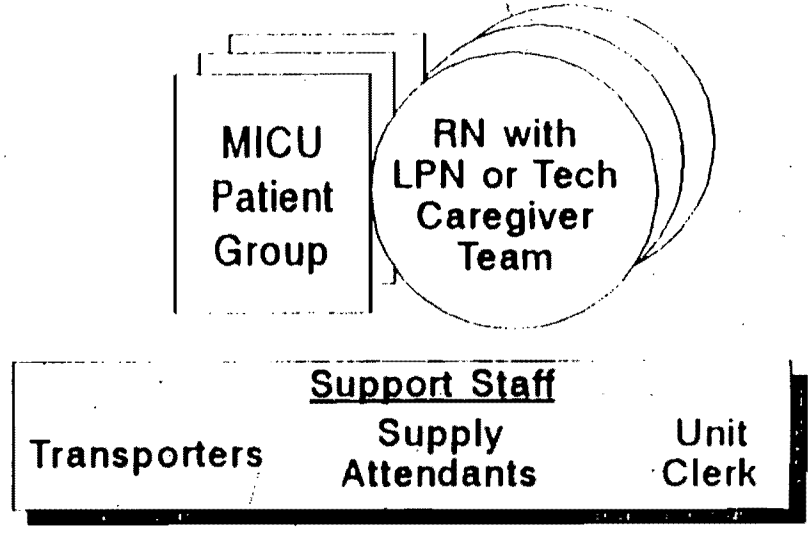
Transporters | Supply Attendants | Unit Clerk

Caregiver to Patient Ratio

1 : 2.5

Critical Care

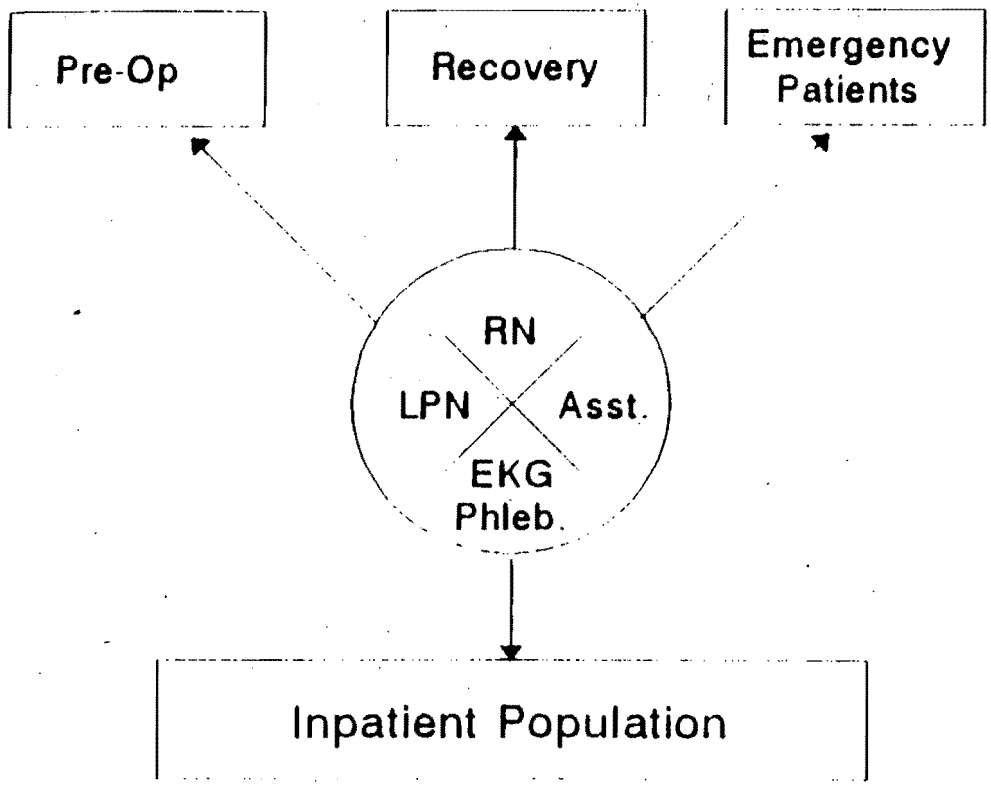
Unit	HPPD After	Skill Mix Before	After
CTU & CCU	16.6	100%	78%
MICU	17.8	100%	80%
SICU	18.9	96%	70%
6W Stepdown	7.7	93%	62%
6E Stepdown	8.8	90%	59%
7W Transplant	10.1	83%	66%
Average	16.6	94%	70%



Caregiver to Patient Ratio

1 : 2

EEI (Surgicenter and Unit 1)

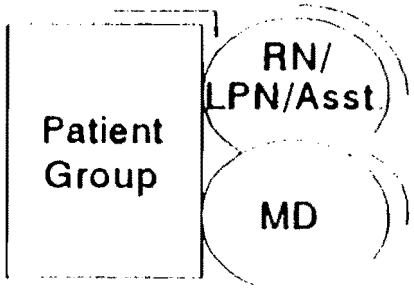


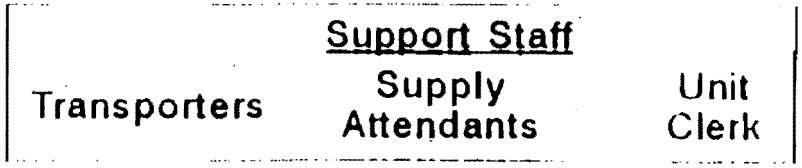
Caregiver to Patient Ratio
1 : 3

Skill Mix:
Before 100% RN
After 59% RN

Savings: $242,000
80% to Patient Care

ER





Caregiver to Patient Ratio
1 : 3

Skill Mix:
Bef e 100% RN
After 68% RN

Savings: $150,000

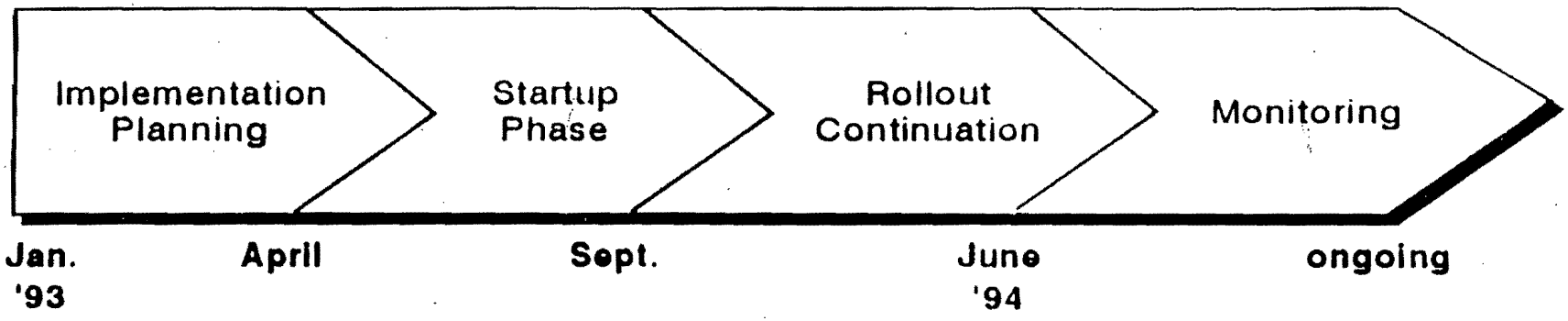
Patient Care Model: Next Steps

Several issues are still in the developmental stage:

- Reaggregation of patient units
- Labor and Delivery staffing
- IV team
- Administrative revisions
- Integrated role of respiratory therapy
- "Road-trip" team
- Supply issues
- Phlebotomy model

Patient Care Model: Implementation Timeframe

Planning for implementation will begin in January. Full implementation will take 12-18 months.



Outputs:

- Detailed Timelines
- Communications plan
- Human res. plan
- Training curriculum
- Job descriptions, and evaluation criteria
- Startup programs determined
- Quality evaluation criteria
- Management

- 1-2 units initiated
- Evaluate effectiveness

- 1-2 units "rollout" every few months
- Adjustments as necessary
- Evaluate for quality, service and satisfaction

- Evaluate for quality, service and satisfaction

In evaluating the new patient care model, remember.....

- A multidisciplinary task force developed the guiding principles for the model
- Staff RN's assisted with the design of roles and organization of care
- Middle managers determined staffing levels and skill mix to match the unique needs of their units
- The implementation phase begins with 3 months of planning, and extends for 18 months
- Successful model implementation is dependent upon strong leadership, <u>extensive</u> training, open communication and active staff involvement

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Executive Director

STATE HEALTH PLANS

As several of the states enact and propose their own health care plans, nursing has become concerned over the lack of clearly defined criteria for those plans. ANA believes that such criteria must be established to ensure universal access, quality and cost containment. States should be required to demonstrate that their managed care plans will not lessen access to health care services in their effort to cut costs.

ANA urges the Administration to establish bottom line criteria to determine the adequacy of state health plans. We recommend that the following principles be included in such criteria:

1. The state must demonstrate that the plan will increase access for the underserved including preservation of institutions and provider groups that have a historic mission or commitment to the disenfranchised.

2. States should be prohibited from opting out of support/social services which enable access and compliance, e.g. transportation, day care, outreach, etc.

3. The state benefits package must be at least as comprehensive as the federal standard benefits package.

4. The state plan must contain a quality assessment mechanism.

5. The state must adopt the broadest practice language for nursing that exists in the U.S. e.g. Alaska.

6. The state must adopt anti-discrimination language to prohibit payor restrictions on benefits, services and reimbursement based on provider types.

   The use of **anti-discrimination** maintains the autonomy of state authority over licensure but will permit licensed advanced practice nurses and other professionals to practice within their lawful scope of practice while prohibiting discriminatory and restrictive payor practices in coverage and reimbursement.

   Specific Language

   "Nothing in this act shall be construed to permit a participating health benefit plan or purchasing cooperative to deny any licensed health care provider (or

type, or class, or category of health care provider) practicing within their lawful scope of practice from inclusion as a qualified provider and receiving the identified reimbursement for all health related services covered by the plan or to prohibit their provision of benefits for the items and services described in the plan."

7. A federal multidisciplinary advisory committee should be established to advise the Health Care Financing Administration (HCFA) regarding state health plan experimentations and demonstrations.

Lastly, we urge the Administration to promote an aggressive public health model and primary health care delivery in community-based settings to the states considering their own health care plans.

k:\grel\transition\stheaplans
4/29/93

AMERICAN NURSES ASSOCIATION

TRANSITION PHASE HEALTH CARE REFORM

HOSPITAL REFORM

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

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

Hospital Reform

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

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

The decisions of hospitals and other institutions to significantly alter staffing levels, mix, or re-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 via educational programs and other means for re-deployment, evaluation and reporting to consumers, certifying bodies and professional providers the impact of re-deployment on patient outcomes and other quality of care indicators, and assurance that re-deployment plans use professional personnel in accord with licensure laws, educational preparation and assessed competence.

A national transition plan should contain at a minimum:

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

- Use of conversion boards to assess the opportunity for the hospital to be converted to some other use thereby keep jobs in the community.

- Training programs on "How to Start a Business" and access to small business loans.

- Pre-notification of hospital closure or merger.

- Continuation of health and pension benefits.

- Continuation of HIV disability coverage.

- Limits on discounting health care services to prevent cost shafting.

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

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

- Wage pass through for providers of direct care.

- De-certification or fines of hospitals.

- Protection of hospitals that are sold providers or provide a high percentage of uncompensated care by establishing uncompensated care pools until all citizens have universal access.

TION ALERT. ACTION ALERT. ACTION ALERT. ACTION A

September 15, 1993

RESPOND ASAP

SENATE COORDINATORS

ACTION NEEDED
SUPPORT FOR S. 466 - MEDICAID REIMBURSEMENT

On February 25, 1993, Senator Tom Daschle (D-SD) introduced S. 466, a bill to provide direct Medicaid reimbursement to nurse practitioners and clinical nurse specialists for services which they are legally authorized to perform under State law.

This measure expands the provision enacted as part of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) which provided direct Medicaid reimbursement to certified pediatric and family nurse practitioners. **The goal of S. 466 is to promote provider choice and permit all nurse practitioners and clinical nurse specialists to be directly reimbursed under Medicaid, thereby enhancing the availability and quality of health care for our country's unserved and underserved population.**

S. 466 has been referred to the Finance Committee. It is Senator Daschle's intent to obtain as much support as possible for the bill and to have it considered by the Finance Committee at the earliest possible date.

In order for this legislation to receive favorable action, it is essential that it have strong bipartisan support. **We urgently need your assistance to win approval for this proposal and ask that you contact your Senators to request that they cosponsor S. 466.** To assist with this effort, we are attaching a sample letter in support of S. 466.

Your timely assistance in accomplishing this goal is greatly appreciated. **Please contact Marjorie Vanderbilt at 202/554-4444, ext. 453 if you have any questions.** Thank you very much for your assistance.

AMERICAN NURSES ASSOCIATION ■ 600 Maryland Ave, SW ■ Suite 100W ■ Washington, DC 20024-2571
(202) 554-4444 FAX: (202) 554-2262

SAMPLE LETTER TO SENATORS

(DATE)

The Honorable (name of Senator)
US Senate
Washington, D.C. 20510

Dear Senator _____:

I am writing to express my strong support for S. 466, a bill to provide direct Medicaid reimbursement to nurse practitioners and clinical nurse specialists delivering care to patients in both rural and urban areas, and to request that you cosponsor this important measure.

S. 466, which was introduced by Senator Tom Daschle, would permit nurse practitioners and clinical nurse specialists to receive direct Medicaid payments for the services which they are legally authorized to perform in the state in which they work. This measure expands the provision enacted as part of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) which provided direct Medicaid reimbursement to certified pediatric and family nurse practitioners.

At the present time, many Medicaid recipients are foregoing essential health care services because physicians and other health care providers are not available to them. S. 466 recognizes that better utilization of nurse practitioners and clinical nurse specialists will help to fill those gaps in our health care system by increasing access to quality care for our country's unserved and underserved population. It will also decrease acute care admissions and the misuse of emergency rooms and hopefully the adverse effects of uncompensated care.

I hope that you will agree that it is time for Medicaid to fully recognize the quality of care and cost-effectiveness of nurse practitioners and clinical nurse specialists and that you will cosponsor S. 466.

I appreciate your consideration of this important legislation and look forward to hearing your views about it.

Sincerely,

(Your Name), R.N.

TION ALERT. ACTION ALERT. ACTION ALERT. ACTION A

September 15, 1993

RESPOND ASAP

SENATE COORDINATORS

ACTION NEEDED
SUPPORT FOR S. 833 -- MEDICARE REIMBURSEMENT

On April 28, 1993, Senators Charles Grassley (R-Iowa) and Kent Conrad (D-North Dakota) introduced S. 833, a bill entitled the "Primary Care Health Practitioner Incentive Act", to provide direct Medicare reimbursement to nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified nurse midwives (CNMs).

Under this bill, NPs, CNSs and CNMs would be paid 97 percent of the physician fee schedule for services which they are legally authorized to perform under State law, regardless of location or practice setting and regardless of whether or not they are under the supervision of, or associated with, a physician. In addition, modeled after the bonus payment to physicians who work in health professional shortage areas (HPSAs), these practitioners would also be paid a bonus payment when they work in HPSAs. This provision is designed to encourage non-physician providers to relocate to areas in need of health care services.

Senators Grassley and Conrad also introduced S. 834, a bill entitled the "Physician Assistant Incentive Act", which provides Medicare reimbursement to physician assistants (PAs). We are supporting the PAs in their efforts, as they are supporting us.

S. 833 and S. 834 have been referred to the Finance Committee. In order for this legislation to receive favorable action, it is essential that it have strong bipartisan support. **We urgently need your assistance to win approval for this proposal and ask that you contact your Senators to request that they cosponsor S. 833 and S. 834.** To assist with this effort, we are attaching a sample letter to the Senate in support of these two bills. If your Senator is either Senator Grassley or Senator Conrad, please write to thank him for his support of this important legislation.

Your timely assistance in accomplishing this goal is greatly appreciated. **Please contact Marjorie Vanderbilt at 202/554-4444, ext. 453, if you have any questions.** Thank you very much for your assistance.

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SAMPLE LETTER TO SENATORS

(DATE)

The Honorable (name of Senator)
U.S. Senate
Washington, D.C. 20510

Dear Senator _____:

I am writing to express my strong support for S. 833, the "Primary Care Health Practitioners Incentive Act", and S. 834, the "Physician Assistant Incentive Act", and to request that you cosponsor these two important measures.

S. 833, which was introduced by Senators Grassley and Conrad, would provide direct Medicare reimbursement to nurse practitioners, clinical nurse specialists and certified nurse midwives at 97 percent of the physician fee schedule for the services which they are legally authorized to perform in the state in which they work. In addition, modeled after the bonus payment of physicians who work in health professional shortage areas (HPSAs), these practitioners would also be paid a bonus payment when they work in HPSAs.

Under direct Medicare reimbursement, these advanced practice nurses could provide essential services to meet the health care needs of those older Americans who currently have no access to affordable health care. The bonus payment would encourage them to relocate to areas in need of health care services.

Senators Grassley and Conrad also introduced S. 834 which would provide Medicare reimbursement, as well as the HPSA bonus payment, to physician assistants.

I hope that you will agree that it is time for Medicare to fully recognize the quality of care and cost-effectiveness of these non-physician providers and to remove barriers to access to care for underserved populations that you will cosponsor S. 833 and S. 834.

I appreciate your consideration of this important legislation and look forward to hearing your views about it.

Sincerely,

(Your Name), RN

TION ALERT. ACTION ALERT. ACTION ALERT. ACTION A

September 15, 1993

RESPOND ASAP

CONGRESSIONAL DISTRICT COORDINATORS

ACTION NEEDED
SUPPORT FOR H.R. 2386 -- MEDICARE REIMBURSEMENT

On June 10, 1993, Representatives Edolphus Towns (D-New York) and William Coyne (D-Pennsylvania) introduced H.R. 2386, a bill entitled the "Primary Care Health Practitioner Incentive Act", to provide direct Medicare reimbursement to nurse practitioners (NPs), clinical nurse specialists (CNSs) and certified nurse midwives (CNMs).

Under this bill, NPs, CNSs and CNMs would be paid 97 percent of the physician fee schedule for services which they are legally authorized to perform under State law, regardless of location or practice setting and regardless of whether or not they are under the supervision of, or associated with, a physician. In addition, modeled after the bonus payment to physicians who work in health professional shortage areas (HPSAs), these practitioners would also be paid a bonus payment when they work in HPSAs. This provision is designed to encourage non-physician providers to relocate to areas in need of health care services.

Representatives Towns and Coyne also introduced H.R. 2387, a bill entitled the "Physician Assistant Incentive Act", which provides Medicare reimbursement to physician assistants (PAs). We are supporting the PAs in their efforts as they are supporting us.

H.R. 2386 and H.R. 2387 have been referred jointly to the Ways and Means and Energy and Commerce Committees. In order for this legislation to receive favorable action, it is essential that it have strong bipartisan support. **We urgently need your assistance to win approval for this proposal and ask that you contact your Representative to urge that they cosponsor H.R. 2386 and H.R. 2387.** To assist with this effort, we are attaching a sample letter in support of these two bills. If your Representative is either Rep. Towns or or Rep. Coyne, please write to thank him for his support of this important legislation.

Your timely assistance in accomplishing this goal is greatly appreciated. **Please contact Marjorie Vanderbilt at 202/554-4444, ext. 453, if you have any questions.** Thank you very much for your assistance.

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SAMPLE LETTER TO REPRESENTATIVE

(DATE)

The Honorable (Name of Representative)
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative _____:

I am writing to express my strong support for H.R. 2386, the "Primary Care Health Practitioner Incentive Act", and H.R. 2387, the "Physician Assistant Incentive Act", and to request that you cosponsor these two important measures.

H.R. 2386, which was introduced by Representatives Towns and Coyne, would provide direct Medicare reimbursement to nurse practitioners, clinical nurse specialists and certified nurse midwives at 97 percent of the physician fee schedule for the services which they are legally authorized to perform in the state in which they work. In addition, modeled after the bonus payment to physicians who work in health professional shortage areas (HPSAs), these practitioners would also be paid a bonus payment when they work in HPSAs.

Under direct Medicare reimbursement, these advanced practice nurses could provide essential services to meet the health care needs of those older Americans who currently have no access to affordable health care. The bonus payment would encourage them to relocate to areas in need of health care services.

Representatives Towns and Coyne also introduced H.R. 2387 which would provide Medicare reimbursement, as well as the HPSA bonus payment, to physician assistants.

I hope that you will agree that it is time for Medicare to fully recognize the quality of care and cost-effectiveness of these non-physician providers and to remove barriers to access to care for underserved populations that you will cosponsor H.R. 2386 and H.R. 2387.

I appreciate your consideration of this important legislation and look forward to hearing your views about it.

Sincerely,

(Your Name), RN

TION ALERT. ACTION ALERT. ACTION ALERT. ACTION A

September 15, 1993

RESPOND ASAP

CONGRESSIONAL DISTRICT COORDINATORS

ACTION NEEDED
SUPPORT FOR H.R. 1683 - MEDICAID REIMBURSEMENT

On April 2, 1993, Representative Bill Richardson (D-New Mexico) introduced H.R. 1683, a bill to provide direct Medicaid reimbursement to nurse practitioners and clinical nurse specialists for services which they are legally authorized to perform under State law whether or not they are under the supervision of, or associated with, a physician.

This measure expands the provision enacted as part of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) which provided direct Medicaid reimbursement to certified pediatric and family nurse practitioners. **The goal of H.R. 1683 is to promote provider choice and permit all nurse practitioners and clinical nurse specialists to be directly reimbursed under Medicaid, thereby enhancing the availability and quality of health care for our country's unserved and underserved population.**

H.R. 1683 has been referred to the Energy and Commerce Committee. It is Representative Richardson's intent to obtain as much support as possible for H.R. 1683 and to have it considered by the Energy and Commerce Committee at the earliest possible date.

In order for this legislation to receive favorable action, it is essential that it have strong bipartisan support. **We urgently need your assistance to win approval of this proposal and ask that you contact your Representative to request that she/he cosponsor H.R. 1683.** To assist with this effort, we are attaching a sample letter in support of H.R. 1683.

Your timely assistance in accomplishing this goal is greatly appreciate. **Please contact Marjorie Vanderbilt at 202/554-4444, ext 453 if you have any questions.** Thank you very much for your assistance.

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SAMPLE LETTER TO REPRESENTATIVES

(Date)

The Honorable (name of Representative)
US House of Representatives
Washington, D.C. 20515

Dear Representative _____:

I am writing to express my strong support for H.R. 1683 a bill to provide direct Medicaid reimbursement to nurse practitioners and clinical nurse specialists delivering care to patients in both rural and urban areas, and to request that you cosponsor this important measure.

H.R. 1683, which was introduced by Representative Bill Richardson, would permit nurse practitioners and clinical nurse specialists to receive direct Medicaid payments for the services which they are legally authorized to perform in the state in which they work. This measure expands the provision enacted as part of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) which provided direct Medicaid reimbursement to certified pediatric and family nurse practitioners.

At the present time, many Medicaid recipients are foregoing essential health care services because physicians and other health care providers are not available to them. H.R. 1683 recognizes that better utilization of nurse practitioners and clinical nurse specialists will help to fill those gaps in our health care system by increasing access to quality care for our country's unserved and underserved population. It will also decrease acute care admissions and the misuse of hospital emergency rooms and hopefully the adverse effects of uncompensated care.

I hope that you will agree that it is time for Medicaid to fully recognize the quality of care and cost-effectiveness of nurse practitioners and clinical nurse specialists and that you will cosponsor H.R. 1683.

I appreciate your consideration of this important legislation and look forward to hearing your views about it.

Sincerely,

(Your Name), R.N.