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ANA [American Nurses Association] : Nurses for a Healthier America

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NURSES FOR A HEALTHIER AMERICA

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Marjorie W. Vanderbilt
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Virginia Trotter Betts, JD, MSN, RN
President

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AMERICAN ACADEMY OF NURSING
AMERICAN NURSES CREDENTIALING CENTER
AMERICAN NURSES POLITICAL ACTION COMMITTEE

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MESSAGE

As promised! another copy

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AMERICAN NURSES ASSOCIATION

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VIRGINIA TROTTER BETTS, JD, MSN, RN
PRESIDENT

GERI MARUTLO, MSN, RN
EXECUTIVE DIRECTOR

July 11, 1995

Mr. Harold Ickes
Assistant to the President
Deputy Chief of Staff for Policy
and Political Affairs
The White House
1600 Pennsylvania Avenue N.W.
Washington, DC 20500

Dear Mr. Ickes:

Thank you again for meeting with representatives of the American Nurses Association (ANA) on June 21, 1995. As you will recall, during that meeting you requested a list of the ten issues which ANA regards as top priorities for immediate Administration action. I have attached a list of these issues, along with some explanatory text, for your consideration.

We look forward to discussing these issues with you, and would appreciate an expeditious review of these modest requests and an opportunity to discuss the Administration's reaction to each as soon as possible. Please contact Marjorie Vanderbilt, Director of Federal Governmental Affairs, at (202) 651-7085 and me regarding any questions and to let us know how we can assist further in proceeding with these requests.

Best regards,

Virginia Trotter Betts, JD, MSN, RN
President

cc: Marilyn Yager
Office of Public Liaison

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VIRGINIA TROTTER BETTS, JD, MSN, RN
PRESIDENT

GERI MARUILO, MSN, RN
EXECUTIVE DIRECTOR

TEN IMPERATIVES FOR ACTION

1. **Take action on threats to patient safety and quality.**

As health care institutions and systems continue to cut down on use of professional nursing staff, even in the face of increasing patient acuity levels, a real threat to patient safety and quality care continues to increase. Unfortunately, information regarding nurse staffing and patient outcomes remains, for the most part, "proprietary" information that is inaccessible to regulators or to the public.

As important first steps toward accountability, **hospitals and other institutions that receive Medicare funds should be required, as part of the Medicare Conditions of Participation, to disclose data regarding nurse staffing and outcome data,** including numbers and mix of nursing staff and the ratios of nursing staff to patients. In addition, ANA is preparing to have introduced legislation on patient safety that would (1) require providers to make available to the public certain information regarding nurse staffing and patient outcomes; (2) protect "whistleblowers" employed by a health plan, who point out dangerous or potentially dangerous conditions; and (3) provide a process for the Secretary of Health and Human Services to review any application for merger by a provider of services, to determine its impact on patient care. **ANA requests the Administration's support for this legislation.**

We have noted with some interest recent reports of initiatives involving HCFA, the National Committee for Quality Assurance, public employee groups and large employers, to address the issue of quality within managed care programs. **ANA strongly believes that nursing must play a part in this process.**

ANA also believes that the Administration **must hold firm on current health and safety regulations,** including those issued under OBRA '87's nursing home reform provisions.

2. **Support legislation to provide reimbursement for services of all advanced practice nurses, regardless of geographic location or practice setting, under Medicare and Medicaid. Reject state Medicaid waiver applications that fail to ensure utilization of nurses as primary care providers.**

The Administration has previously shown its recognition of the fact that advanced practice nurses are a proven and valuable resource for providing needed primary and specialty care services, particularly to underserved populations. ANA appreciates the Administration's previous support for direct Medicare and Medicaid payment for all

advanced practice nurses, regardless of geographic location or practice setting. Legislation has been introduced in the 104th Congress to provide for coverage of advanced practice nursing services in all geographic locations and practice settings. These are: MEDICARE REIMBURSEMENT: H.R. 1750 (Ed Towns [D-NY] and Nancy Johnson [R-CT]); S.864 (Charles Grassley [R-IA] and Kent Conrad [D-ND]). MEDICAID REIMBURSEMENT: H.R. 1339 (Bill Richardson [D-NM]; S.972 (Tom Daschle [D-SD]. **ANA requests that the White House provide letters of support to the Congressional leadership for these bills,** which would do much to increase access to high-quality, cost-effective health care providers.

Kiegner 690-7027

In addition, as we have previously discussed, some state Medicaid waiver programs have excluded advanced practice nurses from serving as primary care providers or have otherwise blocked their full participation. Generally, this has been as a result of reserving primary care or "gatekeeper" roles for physicians only. In some cases, this has been a feature of the state's waiver proposal itself. In others, it has been imposed by the insurers with whom the state has contracted to administer the program. **We call upon the Administration to reject any state Medicaid waiver proposals--under both Sections 1115 and 1915(b)--that fail to ensure the utilization of nurses as primary care providers.**

X

3. **Increase the number of nurses appointed to visible federal positions that affect public policy and to federal commissions.**

As you know, this area has already been the subject of discussion with you and other appropriate Administration officials. We have recently provided Bob Nash a preliminary list of names of nurses who are both highly qualified and readily available for appointment to key federal positions, and we are continuing a dialogue with Mr. Nash regarding open positions and available, qualified nurse candidates.

4. **HRSA should conduct a National Sample Survey of Registered Nurses beginning in 1995.**

HRSA

The single most important need for health workforce planning is the availability of comparable data that spans long time periods. Because of rapid and ongoing changes in the health care industry, the demographics of the registered nurse population are changing dramatically. There is currently no reliable data to document and track these changes or to predict future changes. The National Sample Survey of Registered Nurses conducted every four years by the Division of Nursing is the largest and most comprehensive survey of the registered nurse workforce. This survey, which is scheduled to be done in 1996, incorporates all nurses in all practice settings and provides the data necessary for workforce planning. It will also allow for a more comprehensive understanding of some of the changes effected by unprecedented health care restructuring and a continued shift away from acute care services. It is important that this survey remain a priority and be adequately funded.

5. **Secretary Reich should allow the H-1A Visa Program to sunset, as scheduled, in September, 1995 as recommended by the Minority Report of the Immigration Nursing Relief Advisory Committee.**

DOL

The H-1A Visa Program was instituted at a time of an immense nursing shortage in the United States. There is simply no reason to continue the importation of nurses from other countries at a time when many current U.S. resident nurses are facing layoffs as a result of health care industry downsizing. The Department of Labor and its Secretary must support working registered nurses in the U.S.

6. **The U.S. Trade Representative should initiate discussions with Canada and Mexico to remove registered nurses and other health professionals from Appendix 1603.D.1 of the NAFTA.**

USTR

As noted above, many U.S. nurses are currently facing displacement as a result of health care restructuring and downsizing. The impact of the flow of Canadian and Mexican nurses into the United States on the domestic nursing workforce requires serious reconsideration of the inclusion of registered nurses on this list.

Kleppner

7. **Provide vocal support for funding of nursing education, including full reauthorization of the Nurse Education Act (S.555) as well as full funding of the Nurse Education Act. Support for continuation and funding of the Division of Nursing at HRSA, National Institute for Nursing Research and the Agency for Health Care Policy and Research and public health programs under the Health Resources and Services Administration.**

Marla Salmon

The rapidly evolving changes in our health care system call for the fullest utilization possible of the multi-disciplinary providers who care for patients and families in an ever-increasing array of settings; hospitals, subacute care facilities, long term care facilities, schools and universities, workplaces and communities. Federal support for nursing education through the Nurse Education Act is critical to meeting the health care needs of this country, particularly its primary health care needs. Support for nursing and health care research are also critical components of addressing this country's continued health care needs.

8. **Revamp HCFA guidelines for the "incident to" provision under Medicare B, to include removal of the requirement for on-site presence of a physician in order for "incident to" services to be covered.**

HCFA

HCFA guidelines for Medicare Part B services provided "incident to" those of a physician should be re-examined and revamped. They currently include restrictive and archaic requirements, such as requiring a physician's on-site presence when services are provided. **This has greatly limited the use of registered nurses, including advanced practice nurses, in many ambulatory settings and in providing home visits. This has provided a barrier for access to care to many Medicare beneficiaries.**

9. Support reauthorization of the Community Nursing Organization (CNO) project (due to sunset at end of 1996).

As the nation moves further toward managed care, there is serious examination of the potential for safe, high quality, cost-efficient care in a capitated context. The Community Nursing Organization project, a Medicare demonstration project, serves Medicare beneficiaries through capitated healthcare services, in four sites across the country. Preliminary reports are exciting: the services have been well received by beneficiaries, outcomes have been good, and costs have been kept down. The CNO project is a model for Medicare managed care. **It deserves to be continued and expanded, and ANA requests Administration support for efforts to accomplish this goal.**

HCFA

10. Make the Chiefs of the military nursing services two-star flag officers instead of one-star.

Military nursing leaders should be of equivalent rank as to those military leaders with comparable responsibilities. The Nurse Corps Chiefs/Directors command about 13,000 active duty troops, plus about 22,000 in the National Guard and Reserves. This is equivalent in size to other 2-star commands.

Col. Rich

Moreover, the essential nature of the mission of the military nursing services should be appropriately recognized and acknowledged. In addition, the Nurse Corps Chiefs/Directors each have additional duties and command beyond their nursing-related functions--such as Deputy Surgeon General, Director of Personnel (for all medical officers), and Commander for Health Promotion and Preventive Medicine.

TO: Jennifer Klein

FROM: Jennifer Boulanger

Subject: Status of HCFA activities listed on the ANA Action Imperatives

1. Require Public Disclosure of Staffing and Outcome Data [by changing Medicare conditions of participation for hospitals]

HCFA is currently rewriting the hospital conditions of participation and have received this comment from the ANA in response to a draft put out for industry/affected party comment. ANA's comment is in direct opposition to the direction from the Vice President on regulatory reform -- he instructed HCFA to deregulate staffing requirements. In addition, adopting this comment would be perceived as making unduly burdensome regulatory requirements on hospitals.

Changing the conditions of participation requires notice and comment rule making. HCFA plans to publish the proposed rule in early 1996.

2. Reject Medicaid Waivers Which Permit Exclusion of Advanced Practice Nurses

Under Medicaid, nurse practitioners have the right of direct payment. To date, they have been included in waivers (in Tennessee directly) that have been approved and in Ohio, problems with State payment of nurse practitioners was resolved before the waiver was approved. HCFA could make this an explicit requirement, however the White House would need to provide public support. Without the public support, Governors would accuse HCFA of reneging on the President's commitment of more flexibility in Medicaid waivers.

3. Continue Funding Initiatives for Nurse Retraining.

HCFA is funding demonstration projects that examine greater involvement of nurse practitioners in providing direct patient care and in patient case management.

- Community Nursing Organization Demonstration -- This tests monthly capitated payment for nurse-managed case management of home care, durable medical equipment, and certain ambulatory care services. There are four sites: Mahomet, Illinois, Tucson, Arizona, New York City, and St. Paul, Minnesota.

- Evercare -- This tests whether nurse practitioners (rather than physicians) providing the primary intervention in permanent nursing home residents' care

lessens residents trips to hospital emergency rooms. There will be nine sites; one has begun in Atlanta, Georgia, the second site will be in Baltimore, Maryland, the third in Boston, Massachusetts. The remaining six sites are being determined.

- Essential Access Community Hospital/Rural Primary Care Hospitals (EACH/RPCHs) and Medical Assistance Facilities (MAFs) --These two demonstrations expanded what nurse practitioners could do in small rural facilities. They both permitted nurse practitioners to admit and treat patients under remote physician supervision. There are RPCHs in seven states (California, Colorado, Kansas, New York, North Carolina, South Dakota, West Virginia) and the MAF demonstration is in Montana.

FACT SHEET

NATIONAL INSTITUTE OF NURSING RESEARCH
NATIONAL INSTITUTES OF HEALTH

Research supported by the National Institute of Nursing Research (NINR) is a critical component of the nation's biomedical and behavioral research effort. NINR's mission is to:

- reduce the burden of illness and disability by understanding and easing the effects of acute and chronic illness,
- improve health-related quality of life by preventing or delaying the onset of disease or slowing its progression,
- establish better approaches to promoting health and preventing disease,
- improve clinical environments by testing interventions that influence patient health outcomes and reduce costs and demand for care.

RELEVANCE OF NURSING RESEARCH

Answers to many of the nation's most pressing health problems are being pursued by nursing research. For example:

- How can health professionals provide high quality care in a cost-effective way? One concern is that the recent trend to discharge patients from the hospital early might compromise their health. Studies indicate that transitional care from hospital to residence, provided by advanced practice nurses, can reduce the incidence and length of rehospitalizations, increase patients' satisfaction with their care, and lower costs, in some cases by as much as 38%. Another research emphasis is to test methods to provide care to underserved at-risk populations in rural areas. Health promotion and disease prevention strategies are stressed.

- How can premature delivery and low birth weight be prevented to avert developmental problems and infant mortality? The infant mortality rate in the United States remains high. Health-care costs for children weighing less than 5.5 pounds at birth can be at minimum $21,000 a year, compared to $2,800 for normal weight infants. Studies show that such factors as culturally sensitive prenatal care, availability of telephone contact for the mother with advanced practice nurses, adequate social support systems, and education programs that promote maternal and fetal health can result in significant reductions in premature births and low birth weight.

- How can patients, caregivers and families cope with devastating illnesses such as Alzheimer's disease? As more of the U.S. population live to an older age, the number of people with dementia will increase dramatically, escalating health care costs for institutionalization and compromising the health and quality of life for all concerned. Researchers are testing techniques to slow the progression of cognitive impairment through such methods as mental stimulation exercises and strategies that promote self sufficiency. Methods to encourage urinary continence and ease the burden on caregivers are also being developed. The goal is to forestall costly institutionalization while promoting ways to cope with the disease.

- How can the little understood health problems of women in midlife be addressed? Symptoms associated with physiological changes in midlife, coupled with difficult health-related choices concerning hormone replacement therapy, hysterectomy, and breast cancer screening and treatment, are issues faced by many middle-aged women. Studies are revealing ways to ease menopausal symptoms, such as insomnia, gastrointestinal problems, and hot flashes, and help women make important health decisions that can affect the rest of their lives. This research has the potential to reduce demand for health care and the loss of work time for treatment of symptoms.

- How can the management of symptoms of acute and chronic illness be improved? Treatment of disease is vital but can produce highly discomforting, possibly dangerous side effects, sometimes causing patients to avoid life-saving therapies. Researchers are revealing ways to control side effects of such treatments as chemotherapy and HIV medication, promote adherence to treatment for people with tuberculosis and other illnesses, and ease pain, which if undertreated can be life-threatening and compromise recovery.

These are but some of the directions of nursing research today. The NINR at the National Institutes of Health is the Federal Government's focal point for nursing research and research training. Funding support is provided for studies at universities, clinical sites such as hospitals, and research centers across the United States. The findings are applicable to the practice of all health care providers and to the health of all the American people.

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The American Nurses Association is the national professional organization representing the nation's 2.2 million registered nurses. Its 53-member constituent associations include:

Alabama State Nurses Association
Alaska Nurses Association
Arizona Nurses Association
Arkansas Nurses Association
California Nurses Association
Colorado Nurses Association
Connecticut Nurses Association
Delaware Nurses Association
District of Columbia Nurses Association, Inc.
Florida Nurses Association
Georgia Nurses Association, Inc.
Guam Nurses Association
Hawaii Nurses Association
Idaho Nurses Association
Illinois Nurses Association
Indiana State Nurses Association
Iowa Nurses Association
Kansas State Nurses Association
Kentucky Nurses Association
Louisiana State Nurses Association
Maine State Nurses Association
Maryland Nurses Association, Inc.
Massachusetts Nurses Association
Michigan Nurses Association
Minnesota Nurses Association
Mississippi Nurses Association
Missouri Nurses Association
Montana Nurses Association
Nebraska Nurses Association
Nevada Nurses Association
New Hampshire Nurses Association
New Jersey State Nurses Association
New Mexico Nurses Association
New York State Nurses Association
North Carolina Nurses Association
North Dakota Nurses Association
Ohio Nurses Association
Oklahoma Nurses Association
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Texas Nurses Association
Utah Nurses Association
Vermont State Nurses Association, Inc.
Virgin Islands State Nurses Association
Virginia Nurses Association
Washington State Nurses Association
West Virginia Nurses Association, Inc.
Wisconsin Nurses Association, Inc.
Wyoming Nurses Association

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Jennifer Klein - make sure DPC stays in loop on response

Virginia Trotter Betts, JD, MSN, RN
President

Geri Marullo, MSN, RN
Executive Director

July 14, 1995

Ms. Carol Rasco
Assistant to the President for Domestic Policy
The White House
Washington, D.C. 20500

Dear Carol:

Thank you again for the opportunity to meet with you on May 31 to discuss several legislative and regulatory issues of great importance to the American Nurses Association (ANA). As you suggested, ANA staff has been in contact with Jennifer Klein since our meeting to provide additional information on the matters discussed.

I wanted to take this opportunity to advise you that on June 21 I met with Harold Ickes, Marilyn Yager, Bob Nash and Jennifer Klein. During that meeting, Mr. Ickes requested a list of the ten issues which ANA regards as top priorities for immediate Administration action. I am enclosing, for your review, a copy of that list of issues.

We look forward to working with the Administration on all of these issues as well as other topics of mutual concern and interest. If you or your staff have any questions, or if we can provide any additional information, please contact Marjorie Vanderbilt, Director of Federal Governmental Affairs at (202) 651-7085 or me at your convenience.

Again, many thanks for your assistance and friendship. I appreciate the consistent openness and hospitality that you have provided to me, and I extend my continued best wishes to you and the Administration.

Best regards,

Virginia Trotter Betts

Virginia Trotter Betts, JD, MSN, RN
President

Enclosure

cc: Marilyn Yager
Office of Public Liaison

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VIRGINIA TROTTER BETTS, JD, MSN, RN
PRESIDENT

GAIL MARCELLO, MS, RN
EXECUTIVE DIRECTOR

July 10, 1995

Mr. Harold Ickes
Assistant to the President
Deputy Chief of Staff for Policy
and Political Affairs
The White House
1600 Pennsylvania Avenue N.W.
Washington, DC 20500

Dear Mr. Ickes:

Thank you again for meeting with representatives of the American Nurses Association (ANA) on June 21, 1995. As you will recall, during that meeting you requested a list of the ten issues which ANA regards as top priorities for immediate Administration action. I have attached a list of these issues, along with some explanatory text, for your consideration.

We look forward to discussing these issues with you, and would appreciate an expeditious review of these modest requests and an opportunity to discuss the Administration's reaction to each as soon as possible. Please contact Marjorie Vanderbilt, Director of Federal Governmental Affairs, at (202) 651-7085 and me regarding any questions and to let us know how we can assist further in proceeding with these requests.

Best regards,

Virginia Trotter Betts

Virginia Trotter Betts, JD, MSN, RN
President

cc: Marilyn Yager
Office of Public Liaison

June 20, 1995

MEMORANDUM TO HAROLD ICKES AND BOB NASH

FROM: MARILYN YAGER

CC: CAROL RASCO, JENNIFER KLEIN, KAREN HANCOX, AND CRAIG SMITH.

MEETING: Meeting with Virginia (Ginna) Trotter Betts, President of the American Nurses Association.

DATE/TIME: Wednesday, June 21
1:15 pm (Pre-brief at 1:00pm)

LOCATION: Roosevelt Room, West Wing

PURPOSE/BACKGROUND:

The Ginna Trotter Betts asked for this meeting several months ago to discuss several political of concern to the American Nurses Assn. This follows a meeting several weeks ago with Carol Rasco during which they raised the top priority issues for the ANA (Summary of these issues are provided in attached memo by Jennifer Klein).

You should be aware that the ANA has been very good supporters, not only on the Health Security Act (when we were asking Ginna Betts to fly all over the Country on our behalf), but also on budget and other priorities.

Karen Hancox, Craig Smith, and I met with ANA staff last week to review the political issues they plan to discuss tomorrow:

APPOINTMENTS: The ANA believes that the Administration has failed to appoint high profile nurses to political slots. Although they are aware that we have appointed nurses to various positions, they indicated that since the nurses were not well known ANA members, they failed to receive recognition within the ANA.

As with many groups that endorsed the Clinton/Gore ticket, the ANA wants to see appointments that they recommend so that they can make the argument to their members that their endorsement had direct results.

It is clear in our discussions with staff that Ginna Trotter Betts, herself, wants an appointment (she will not be this specific in the meeting). Although she is thrilled to be an appointee to the Beijing Conference, she really wants a permanent position.

GENERAL ACCESS AND RECOGNITION:
The nurses do not believe they have the access nor the recognition that they received the first two years of the Administration. Although part of this is due to the closing down of the health care operation, which resulted in most health care groups having less pro-active contact with the White House, the other part is probably the result of Mike Lux's open slot in OPL. The groups that Mike handled are not getting the normal hands on treatment while we are understaffed.

However, the lack of nurses recognition extends throughout the administration according to the ANA staff. They cited as an example that Secretary Shalala recently indicated that further areas for budget cuts might include the Nurse Education Act (we are checking this out).

Short term solutions that we have discussed with the ANA staff is getting more Administration speakers at their key events. I have asked for a list of their key state conventions (CA, NY, IA, NH, NJ, and ILL) so that we may insure an administration speaker. I have also arranged for Betsy Myers to speak next week to the ANA-PAC luncheon. They obviously hope that the President will speak at their big anniversary meeting in June of 1996. As we get into the re-elect process they are likely to withhold endorsement until they get a commitment on the President speaking at this 1996 meeting.

Either way, their message is clear, that endorsement for 1996 is not a foregone conclusion, and that their membership is feeling neglected.

THE WHITE HOUSE

WASHINGTON

June 19, 1995

MEMORANDUM TO HAROLD ICKES

FROM: Carol Rasco
Jennifer Klein

SUBJECT: The American Nurses Association

When we met with the American Nurses Association (ANA), we agreed to look into four issues that they refer to as "Action Imperatives." We thought it would be useful for you to know where these issues stand before you meet with the ANA on Wednesday, June 21.

1. Require Public Disclosure of Staffing and Outcomes Data

The ANA believes that Medicare Conditions of Participation should be changed to require public disclosure of nursing staffing and patient outcome data. The Health Care Financing Administration (HCFA) is currently rewriting these Conditions of Participation and has already received this comment from the ANA as part of the rulemaking process. While they are moving toward evaluating facilities based on outcomes data (in response to the Vice President's regulatory reform initiative), public release of this data, as well as collection and release of information about nursing staffing, could be burdensome and will be very controversial (particularly among hospitals). However, Jennifer (who is heading the VP's Regulatory Reform Health Industry Group) will continue to push HCFA on this.

2. Reject Medicaid Waivers Which Permit Exclusion of Advanced Practice Nurses

The ANA claims that nurse practitioners and nurse-midwives are effectively being excluded from participating in Medicaid programs in states with waivers. While the ANA has cast this as a waiver problem, it actually reflects a more basic concern about managed care. Services performed by advanced practice nurses are covered by Medicaid, and nothing in the waiver process changes that. The real worry is that managed care plans exclude advanced practice nurses, and that in states with waivers there is more managed care.

This problem will be difficult for us to solve. Any requirement by the Federal government that plans in states with waivers must include advanced practice nurses would be a significant infringement on state flexibility in Medicaid as well as a possible intrusion on state law.

3. Continue Funding Initiatives for Nurse Retraining

The ANA acknowledged that the Department of Labor (DOL) has a number of initiatives underway to retrain displaced health care workers, including registered nurses. They were unaware of any work by the Department of Health and Human Services (HHS) to fund initiatives on new models of nursing care. HHS is funding the following demonstration projects to explore greater involvement of nurse practitioners in providing direct patient care and in patient case management:

- Community Nursing Organization Demonstration -- This demonstration tests the use of monthly capitated payment for nurse-managed case management of home care, durable medical equipment and certain ambulatory care services.

- Evercare -- This looks at whether hospital emergency room visits by nursing home residents decrease if nurse practitioners (rather than physicians) are the primary caregivers for the residents.

- Essential Access Community Hospital/Rural Primary Care Hospitals (EACH/RPCHs) and Medical Assistance Facilities (MAFs) -- These two demonstrations permit nurse practitioners in small rural facilities to admit and treat patients under the supervision of "remote" physicians (i.e., located far from these facilities).

There is no expectation that these demonstration projects will be discontinued.

4. Allow the Immigration and Nursing Relief Act (INRA) to Sunset

The ANA and the unions are urging that the Administration recommend to Congress that the INRA (which was intended to address a severe nursing shortage in 1990) be allowed to sunset. Secretary Reich has received a report from a statutorily created Advisory Committee recommending that the INRA be extended. A dissenting report was filed by the AFL-CIO, the ANA, and the Service Employees International Union. In addition, the Department of Labor is currently drafting an internal report that will most likely conclude that the INRA *should* be allowed to sunset. This paper will be submitted to Reich soon, and DOL plans to provide the Administration's recommendations to Congress by mid-July.

We will brief you on Wednesday before your meeting. Jennifer has contacted the ANA about these issues and may have an update on our progress at that time.

cc: Marilyn Yager

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Virginia Trotter Betts, JD, MSN, RN
President

Geri Marullo, MS, RN
Executive Director

AMERICAN NURSES ASSOCIATION ACTION IMPERATIVES

1. Require Public Disclosure of Staffing and Outcome Data.

ANA believes the Administration must take action to protect the safety of American health care consumers. Medicare Conditions of Participation for hospitals should be changed to require public disclosure of nursing staffing and patient outcome data.

2. Reject Medicaid Waivers Which Permit Exclusion of Advanced Practice Nurses.

Need no more rules to do it. GAO/OIA reports supporting franchise this does this.

Nurse practitioners and certified nurse-midwives are effectively being excluded from participating in Medicaid programs in many states as a result of waivers from federal Medicaid requirements. Any proposed state waiver that permits exclusion of advanced practice nurses should be *rejected.*

3. Continue Funding Initiatives for Nurse Retraining.

ANA appreciates the Department of Labor's undertaking of initiatives on retraining of displaced health care workers, including registered nurses. We look forward to continued work with DOL on this. ANA also believes that the Department of Health and Human Services should fund initiatives on new models of nursing care that could allow for utilization of the skills of experienced registered nurses in emerging health care settings.

4. Allow the Immigration and Nursing Relief Act to Sunset.

The Immigration Nursing Relief Act (INRA), which was intended to address the severe nursing shortage that was in effect in 1990, is due to sunset in September of this year. Secretary Reich is currently considering alternatives for INRA's fate. ANA and other organizations have urged that INRA be allowed to sunset.

ANA believes that Administration support on this issue is imperative.

Dem. project funded through Medicare - community nursing service - costs way below FFS and high satisfaction rate

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VIRGINIA TROTTER BETTS, JD, MSN, RN
PRESIDENT

GERI MARULLO, MS, RN
EXECUTIVE DIRECTOR

May 31, 1994

Bruce Vladeck, PhD, Administrator
Health Care Financing Administration
U.S. Department of Health and Human Services
200 Independence Avenue, Suite 314G
Washington, DC 20201

Dear Dr. Vladeck:

I would like to thank you and your staff once again for meeting with me and members of the American Nurses Association (ANA) staff on May 10. I found it an informative and productive meeting and look forward to a continuing close working relationship with you and the Health Care Financing Administration (HCFA).

I appreciated the opportunity to begin a discussion with you on the worsening state of patient care quality in hospitals and other institutions. As you know, ANA is alarmed by the fact that hospitals are making significant cuts in their use of professional nursing staff and are substituting unlicensed assistive personnel for registered nurses. As promised, we will supply you with the large number of reports we have received. It will be mailed under separate cover this week. A larger, systematic study is being conducted by Lewin and Associates; we anticipate that it will be available in September of this year.

As you probably know, at my meeting with Secretary Shalala which followed my meeting with you, the Secretary expressed interest in commissioning a study to identify current threats to patient safety and patient care quality that have been caused by recent marked changes in hospital staffing. We are hopeful that this study will also generate data that will be useful to HCFA in addressing these safety and quality problems.

On the matter of the three states (Illinois, Ohio and Rhode Island) that remain non-compliant with the OBRA 1989 requirement to provide reimbursement for certified family nurse practitioners and certified pediatric nurse practitioners, we very much appreciate the information and ideas which you and your staff shared with us. Of course, we remain willing to assist HCFA in any way possible to achieve compliance from these three states. You can, of course, also expect the cooperation of the state nurses associations in those states in this matter.

We also found useful our discussion of state Medicaid waivers and their effects on accessibility of Medicaid services, including the services of advanced practice nurses. We appreciated your staff's offer to make Medicaid waiver applications available to us.

As you will recall, our meeting also touched on the issue of Medicaid provider taxes. It was noted at the meeting that no state has, to our knowledge, imposed such a tax in the form of a payroll tax on nurses' incomes, although Kentucky has proposed such a tax but abandoned it in the face of political opposition. While we hope that the assessment expressed by your staff that the issue of taxes on nurses' salaries may be a largely "academic" one at this point proves to be correct, we do remain concerned by HCFA's interpretation that such taxes are in fact permissible. This remains a source of concern for many of our state nurses associations. We plan to remain in contact with the Medicaid Bureau to explain our specific concerns and seek resolution of them.

On the matter of availability of nurse practitioner and clinical nurse specialist services to Medicare beneficiaries in counties that have been redesignated from non-Metropolitan Statistical Area (non-MSA) counties to MSA counties, we appreciate HCFA's concern with this issue. While we do intend to put forward a technical amendment to address this problem through statute, we remain hopeful that HCFA will remain open to discussion on any possible modifications that may be made administratively to address this problem. One issue that particularly concerns us is avoiding assessments to nurses for overpayments based on billing in counties that have been redesignated. We know of only one county in which the Medicare carrier has informed nurse practitioners and clinical nurse specialists that the county in which they provide services has been redesignated as an MSA county and that nurses can thus no longer be paid for Medicare services delivered there. We believe that nurses who have <u>not</u> been informed of a change in their county's status should not be held responsible for payments made to them.

Finally, we were glad to be able to begin a discourse with HCFA on the issue of physician/American Medical Association dominance of the CPT coding and RVU processes. This is an area in which ANA has been actively exploring policy options and alternatives. We look forward to sharing some of these with you in the near future.

Thank you again for your time. I look forward to speaking with you again soon. Please feel free to contact me or David Keepnews, JD, MPH, RN at (202) 651-7063 if we can provide any additional information or assistance.

Yours sincerely,

Virginia Trotter Betts, JD, MSN, RN
President

VTB Copy

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Virginia Trotter Betts, JD, MSN, RN
President

June 21, 1994

The Honorable Donna E. Shalala
Secretary, U.S. Department of Health and Human Services
Room 615F
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Madam Secretary:

At the May 10 meeting with you and several key Department staff, the American Nurses Association (ANA) was invited to submit ideas for a Commission to gather facts about the impact of cost containment on the quality of care in health care institutions (hospitals, nursing homes) and related nursing services. Attached is a proposed description of a Blue Ribbon Commission, and a proposed description of the issues to be examined. The Blue Ribbon Commission would take a conceptual approach to the policy issue of how quality of patient (resident) care is affected by registered nurse staffing. We agreed to identify how the components of quality might be conceptualized and measured and what elements of registered nurse staffing are necessary to study.

I am pleased that quality of care and quality of life are overarching foci of the Department. The work of each Agency in the Department addresses quality of care in some way, notably the Health Care Financing Administration (HCFA) and the Agency for Health Care Policy and Research (AHCPR). ANA is very interested in providing assistance to HCFA, AHCPR and others involved with quality of care. Registered nurse staffing and registered nurse activities must be included in ongoing quality measurement and reporting functions throughout the Department. We are hopeful that a private foundation will be interested in funding the work of the Blue Ribbon Commission.

For questions and clarification, the immediate point of contact at ANA is Karen S. O'Connor, Deputy Executive Director for Policy and Programs. Her direct dial telephone number is (202) 651-7013.

I look forward to the rapid evolution of this project. I can assure you that ANA is committed to its successful and expeditious completion and we will assist you in any way that we can.

With warm regards,

Virginia Trotter Betts

Virginia Trotter Betts
President

Attachments

cc: Judith Feder
Deputy Assistant Secretary
Center for Human Resource Strategic Planning & Policy, HHS

Philip Lee
Office of the Secretary
Department of Health & Human Services

Marla E. Salmon, ScD, RN, FAAN
Director, Division of Nursing

Barbara K. Redman, PhD, RN, FAAN
Judith A. Huntington, MN, RN
Karen S. O'Connor, MA, RN
Janet H. Heinrich, DrPH, RN, FAAN
Anna M. Gilmore, RN, BS
Donna R. Richardson, JD, RN
Daniel J. O'Neal, MA, RN, CNAA

VTB:MPC:g:\mpc\shalala.jun

May 27, 1994

Tom Hoyer, Director
Division of Provider Services Coverage Policy
Office of Coverage and Eligibility Policy
Bureau of Policy Development
Health Care Financing Administration
405 East High Rise
6325 Security Boulevard
Baltimore MD 21207

Re: Hospital Conditions of Participation

Dear Mr. Hoyer:

This is to follow up on a most productive meeting held on April 14 between representatives of the American Nurses Association (ANA) and you, Wayne Smith, Mary Vienna and Susan Levy. We wanted to let you know some of our initial thinking on changes in the Medicare Conditions of Participation (COPs) for hospitals. We are, of course, continuing to examine these issues in the light of last month's discussion. I have every expectation that we will continue to be in touch on this important project.

Although I realize that many of the COPs may be reworked, renumbered and otherwise rearranged, we have identified changes in the existing COPs for ease of reference and discussion.

1. Section 482.1(a)(3)

Eliminate the second sentence. Medical "supervision" of services of advanced practice nurses is not required by law or regulation. This sentence is unnecessary and misleading.

Alternatively, we would suggest changing that sentence to read:

> Regulations interpreting those provisions specify that hospitals receiving payment under Medicaid must meet the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife and nurse practitioner (NP) services).

Section 6405 of OBRA 1989 added the services of certified family nurse practitioners and certified pediatric nurse practitioners to the list of federally mandated Medicaid services. The language that did so is virtually identical to the language that added certified nurse-midwife (CNM) services; these groups of practitioners should be treated similarly for purposes of these rules. Both the provisions on Medicaid reimbursement for NPs and for CNMs specify that these practitioners need not be supervised by or associated with a physician or other health care provider. (Title XIX, Section 1905(a)(17) and (21).)

2. Section 482.12(c)(1)

Add a (c)(1)(vi), to read:

> (vi) another practitioner who is authorized to furnish services which would be a physician's services if provided by a physician, as this term is used in Section 1861(K) of the Act, except that this shall apply without regard to the geographic location in which services are furnished.

or, alternatively:

> (vi) another practitioner permitted under State law or regulation to manage the health care of a patient in a hospital setting.

This would allow for other practitioners who are legally permitted by State law or regulation to be responsible for the care of a hospital patient to do so.

3. Section 482.12(c)(2)

Change the second sentence to read:

> If a Medicare patient is admitted by a practitioner not specified in paragraph (c)(1) of this section, ~~that patient is under the care of a doctor of medicine or osteopathy~~ a doctor of medicine or osteopathy is always available for consultation.

"Under the care of" is not clear. If an advanced practice nurse admits a patient to the hospital, for instance, how much involvement must a doctor of medicine or osteopathy have with the patient's treatment for that patient to be considered "under the care of" that physician? We believe that this suggested change makes it clear that a consultative, collaborative relationship with the admitting practitioner should exist, but avoids the ambiguity of requiring that the patient be "under the care of" another practitioner.

Alternatively, this sentence could be eliminated altogether, since the need for a doctor of medicine or osteopathy to be involved in aspects of care that are not within the scope of an admitting practitioner is addressed in 482.12(c)(4).

4. 482.12(c)(4)

Change Section 482.12(c)(4) to:

> (4) A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that--
>
> (i) is present on admission or develops during hospitalization; and
>
> (ii) is not specifically within the scope of practice of ~~a doctor of dental surgery, dental medicine, podiatric medicine or optometry, or a chiropractor~~ the admitting practitioner, as that scope is--
>
> (A) Defined by the medical staff;
>
> (B) Permitted by State law; and
>
> (C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors.

This requirement should apply to the Medicare patient of any admitting practitioner, including those who are not considered "physicians" under the law.

5. Section 482.21

a. Change Section 482.21(b)(1) to:

Discharge planning must be initiated ~~in a timely manner~~ upon admission.

b. Change Section 482.21(b)(2) to:

Patients, along with necessary ~~medical~~ health information, must be . . . .

c. Section 482.21(c) should be reworked to reflect the use of reliable outcome data in quality improvement programs. This is an area in which both ANA and HCFA recognize that considerable work must be done, and we will be in touch with you about possible approaches and language.

d. We suggest inserting new **482.21(d) and (e)**, to read as follow:

(d) Standard: Staffing information. Documentation regarding nursing staffing shall be made available to the public. Such information shall include, at a minimum:

(1) the number of registered nurses providing direct care. This information shall be expressed both in raw numbers and as percentage of nursing staff and shall be broken down in terms of the total hospital nursing staff; each hospital unit; and each shift.

(2) number of unlicensed personnel utilized to provide direct patient care. This information shall be expressed both in raw numbers and as percentage of nursing staff and shall be broken down in terms of the total hospital nursing staff; each hospital unit; and each shift.

(3) The average number of patients per registered nurse providing direct patient care. This information shall be broken down in terms of the total hospital nursing staff; each hospital unit; and each shift.

(e) Standard: Data on complaints and investigations. Data regarding complaints filed with the state agency, HCFA or an accrediting agency with deeming authority and regarding investigations and findings as a result of those complaints shall be made available to the public, as shall the findings of scheduled inspection visits.

We believe that hospitals should be required to disclose such information and data to consumers to enable them to make informed choices in seeking care. We believe that this is in keeping with the Administration's proposal to utilize consumer "Report Cards" under health care reform. Currently, such information is largely unavailable to the public.

6. Section 482.23

a. In Section 482.23(a), change second sentence to read:

The director of nursing must be a licensed registered nurse with a graduate degree in nursing or a closely related field.

The demands of running a nursing department of a hospital require a minimum of masters-

level preparation.

b. Change Section 482.23(b) to read:

(b) Standard: Staffing and delivery of care. The nursing service must have adequate numbers of licensed registered nurses~~, licensed practical (vocational) nurses, and other personnel~~ to provide nursing care to all patients as needed. Licensed practical (vocational) nurses (LPNs/LVNs) and unlicensed personnel may be utilized to assist registered nurses and must work only under the direct supervision of a registered nurse. Policies must restrict the duties which may be performed by unlicensed personnel to simple, non-invasive tasks that pose no threat of harm to the patient. There must be supervisory and staff personnel for each department or nursing unit to ensure~~, when needed,~~ the immediate availability of a registered nurse for bedside care of any patient.

LPNs/LVNs and unlicensed personnel provide assistance to the registered nurse. Adequate numbers of registered nurses are key to provision of good nursing care. The use of unlicensed personnel should be circumscribed and clearly limited to ensure patient safety. A registered nurse should always be immediately availability to provide care for any patient.

c. Change 482.23(b)(1) to read:

(1) The hospital must provide 24-hour nursing services furnished ~~or supervised~~ by a registered nurse, and have a ~~licensed practical nurse or~~ registered nurse present, on duty and immediately available at all times~~, except for rural hospitals that have in effect a 24 hour nursing waiver granted under Section 405.1910 (c) of this chapter~~.

A hospital that is licensed and holds itself out as a hospital must be capable of providing safe care to acutely ill patients. This must include the presence and immediate availability of a registered nurse twenty-four hours a day. Granting a waiver from this requirement for rural facilities is no longer appropriate or needed in light of the availability of EACH/RPCH status for rural facilities that do not function as acute care hospitals.

d. Change 482.23(b)(2) to read:

(2) The nursing service must have a procedure to ensure that hospital nursing personnel for whom licensure is required have valid and current licensure. Staff who hold themselves out, or who are held out by the hospital, as being "certified" must hold valid and current certification in the occupation

or category in which certification is claimed. Such certification must be by a state agency or nationally recognized body.

As we discussed, we believe that this is a simple "truth in advertising" requirement. Consumers should not be mislead by hospitals' use of "certified" unlicensed personnel whose training and "certification" is not standardized and is often provided by the employing hospital itself.

e. Change 482.23(b)(3) to read:

(3) A registered nurse must supervise and evaluate the nursing care for each patient. Each patient must be assessed by a registered nurse at least once every eight hours.

We believe that this should be the absolute minimum to ensure that the patient's condition is adequately assessed and monitored.

f. Change 482.23(b)(4), (5) and (6) to read:

(4) The hospital must ensure that ~~the nursing staff~~ a registered nurse develops, and keeps current, a nursing care plan for each patient.

(5) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. There must be an appropriate supply of registered nurses to meet patient care needs as determined by a registered nurse's assessment of individual patient needs.

(6) Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the continuing competency, adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing service.****

g. Add 482.23(b)(7):

(7) The competency of all nursing personnel working in the facility shall be ensured. This shall include provisions for ensuring that nursing staff who are assigned to a clinical unit outside their usual area of assignment have demonstrated current competency in the area.

h. Change 482.23(c)(1) to read:

All drugs and biological must be administered by ~~, or under supervision of,~~ nursing or other personnel in accordance with Federal and State laws and regulations . . . .

This phrase is unnecessary; no personnel should administer drugs unless it is in accordance with applicable regulations.

i. Change 482.23(c)(3) by deleting the second sentence.

7. Section 482.51

After 482.51(a)(1), add a new subsection (a)(2):

(2) a registered nurse must be present at all times that patients are present in the operating suite.

and renumber subsequent subsections.

This is necessary to ensure patient safety.

8. Section 482.52

In 482.52(a)(4), eliminate the words "who is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed." In most states, certified registered nurse anesthetists are independently licensed and do not require physician "supervision." The operating practitioner who is there during the procedure should be available to consult and collaborate with the certified registered nurse anesthetists (CRNA).

9. Section 482.54

a. 482.54(b)(2)

Change to read:

Have adequate numbers of registered nurses and other professional staff, as appropriate, to provide safe care. At least one registered nurse must be present and available at all times when patients are present.

This is necessary to ensure patient safety. In addition, we believe that this section should be fleshed out in other ways. We anticipate offering suggestions in this area very shortly.

10. Section 482.55

This section needs to be fleshed out, particularly as regards requirements for personnel. We will forward language to you shortly.

11. Section 482.62

a. Section 482.62(d)(2)

Change as follows:

> The staffing patterns must ~~ensure~~ the physical presence and immediate availability of a registered professional nurse on each unit 24 hours each day. There must be adequate registered nurses, assisted as necessary by licensed practical nurses~~,~~ and mental health workers~~,~~ to provide the nursing care necessary under each patient's active treatment programs. Policies must ensure that each patient is assessed by a registered nurse at least once every eight hours.

This is necessary to ensure patient safety.

Of course, this letter includes some of our initial observations and suggestions only. We expect that this will be the first step in a series of written and oral communications with you concerning changes to be made in the hospital conditions of participation. We look forward to working closely with you on this important project.

Yours sincerely,

Donna R. Richardson, JD, RN
Director, Governmental Affairs

g:\dk\cophoyer
i:\hcfa\cophoyer

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VIRGINIA TROTTER BETTS, JD, MSN, RN
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GERI MARULLO, MS, RN
EXECUTIVE DIRECTOR

PRINCIPLES FOR PROVIDER ACCOUNTABILITY FOR PATIENT SAFETY

* Health care facilities which receive Medicare funds should make available to the public specific information regarding nurse staffing and patient outcomes. Such information should include the following:

    * Numbers, mix and percentages of registered nurses providing direct patient care in the facility and on each unit

    * Numbers, mix and percentages of unlicensed nursing personnel providing direct patient care in the facility and on each unit

    * The average number of patients per registered nurse providing direct patient care. This information shall be broken down in terms of the total hospital nursing staff; each hospital unit; and each shift.

    * Patient mortality rate (in raw numbers and by diagnosis or diagnostic-related group)

    * Incidence of adverse patient care incidents, including but not limited to medication errors, patient injury, decubitus ulcers, nosocomial infections, nosocomial urinary tract infections.

    * Methods used for determining and adjusting staffing levels and patient care needs and the provider's compliance with these methods.

    * Data regarding complaints filed with the state agency, HCFA or relevant accrediting agencies should be made publicly available, along with data regarding investigations and findings as a result of those complaints and the findings of scheduled inspection visits.

* Health care facilities which receive Medicare funds should be prohibited from terminating or taking other retaliatory action against any employee or groups of employees for notifying the facility, a federal or state agency, an accrediting agency or the public about conditions which they believe to be potentially dangerous to patients or employees of the facility.

c:\princ

David Koepnews
Policy Director
Am. Nurses Assn.
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Executive Director

AMERICAN NURSES ASSOCIATION
FIVE HEALTH CARE FINANCING ADMINISTRATION (HCFA) CHANGES

1. Medicare Conditions of Participation (for hospitals, but for all other Part A providers as well) should be changed to emphasize public disclosure and access to information. Staffing data and outcomes should be made available to the public.

2. As a matter of policy, any Medicaid waiver proposal that would allow for circumventing federal requirements on advanced practice nursing reimbursement should be rejected.

3. HCFA and the state agencies with whom it contracts for Medicare inspections should be a new emphasis on public input and comment. Complaints and comments should be solicited through an 800 number.

4. Streamline existing regulations to eliminate unnecessary, duplicative and costly physician supervision requirements under Medicare. The "incident to" rule should be changed so that on-site supervision is no longer required. Many patients are denied access to care because of this particular requirement. ANA will identify additional regulations and policies which could be changed.

5. Similarly, allow nurses to certify medical necessity for durable medical equipment, etc. Physician involvement in paperwork is costly and unnecessary.

g:\grel\mwv\changes.hcfa
6/21/95

E X E C U T I V E O F F I C E O F T H E P R E S I D E

09-Jun-1995 01:49pm

TO: Carol H. Rasco

FROM: Stephen C. Warnath
Domestic Policy Council

CC: Jeremy D. Benami

SUBJECT: Immigration Nursing Relief Act

The following is the status of DOL's consideration of the Immigration and Nursing Relief Act. Secretary Reich received a report from the statutorily-created Advisory Committee looking at this issue several weeks ago. They recommended extension of the program with changes made to the requirements for use of foreign nurses. There was a minority report prepared by unions (and perhaps others) that recommended letting the the Act sunset.

DOL staff is in the process of preparing a paper with 4-5 options for Reich. I am told that this internal paper will probably recommend that the Act not be extended, but will offer Reich several options. This paper should be completed soon.

DOL hopes to provide the Administration's recommendations to Congress by mid-July after it receives interagency clearance through the OMB process.

From what I can tell, this is a somewhat unusual issue since there seems to be general agreement that a nurse shortage exists, which is the reason a country would consider bringing in foreign workers, but at the same time nurses are being laid off, which argues against foreign workers.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

14-Jun-1995 03:08pm

TO: Carol H. Rasco
TO: Jennifer L. Klein

FROM: John O. Sutton
Office of the Chief of Staff

SUBJECT: Gina Betts - ANA

Carol, you mentioned to me a couple of weeks ago that you and Jennifer would do a very brief memo for Harold summarizing the four imperatives that the ANA gave to you in your guys' meeting with them.

He is scheduled to meet with Gina Betts on Wednesday the 21st at 1:30pm. Pat Romani has scheduled you to pre-brief Harold for 10-15 minutes before the meeting. Jennifer can you make it also? Both of you should feel free to sit in on the meeting if either a) you want to b) you feel it would be beneficial. But, if you guys have no desire than it is not a problem.

Will you still be able to get a brief memo for him to look at next Monday or Tuesday? He is out of town until then anyway? Let me know if you have any desire in sitting in the meeting.

¶ ¶¾

EXECUTIVE OFFICE OF THE PRESIDENT

14-Jun-1995 07:09pm

TO: Jennifer L. Klein

FROM: Carol H. Rasco
Economic and Domestic Policy

SUBJECT: immigration and nurses

I found it! Wonder of wonders!

Do you think you should call one of the ANA people tomorrow and give them updates or on Monday since I told them we would try hard to give them an update this week? That way they wouldn't be able to add to their gripe list that we weren't responsive..???

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

31-May-1995 02:35pm

TO: Jennifer L. Klein

FROM: Carol H. Rasco
Economic and Domestic Policy

SUBJECT: ANA

Harold's office reports they have set the meeting for 1:30 p.m. on June 21. Marilyn Yager set it up for Harold, Bob Nash and Alexis. I told them we would get info to Harold on the four imperatives brought to us. I suggest that you and I try to have some info gathered by June 12, compare notes and then probably visit with Harold before getting back to the ANA...thanks.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

31-May-1995 02:39pm

TO: Jeremy D. Benami

FROM: Carol H. Rasco
Economic and Domestic Policy

CC: Jennifer L. Klein

SUBJECT: Nurses and immigration

Jennifer and I met with reps of American Nurses Assoc. One of their concerns is the INRA (Immigration and Nursing Relief Act) which they hope will be allowed to sunset in Sept. of this year. Would you please have appropriate staff member get a status on this issue from Labor Dept.; I need the update by close of business June 9 (realize I will be out of town but want it here to be able to use info early on June 12)? ANA thinks Reich is currently considering the issue and any possible alternatives.

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    * The average number of patients per registered nurse providing direct patient care. This information shall be broken down in terms of the total hospital nursing staff; each hospital unit; and each shift.

    * Patient mortality rate (in raw numbers and by diagnosis or diagnostic-related group).

    * Incidence of adverse patient care incidents, including but not limited to medication errors, patient injury, decubitus ulcers, nosocomial infections, nosocomial urinary tract infections.

    * Methods used for determining and adjusting staffing levels and patient care needs and the provider's compliance with these methods.

    * Data regarding complaints filed with the state agency, HCFA or relevant accrediting agencies should be made publicly available, along with data regarding investigations and findings as a result of those complaints and the findings of scheduled inspection visits.

* Health care facilities which receive Medicare funds should be prohibited from terminating or taking other retaliatory action against any employee or groups of employees for notifying the facility, a federal or state agency, an accrediting agency or the public about conditions which they believe to be potentially dangerous to patients or employees of the facility.

c:\princ

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VIRGINIA TROTTER BETTS, JD, MSN, RN
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GERI MARULLO, MS, RN
EXECUTIVE DIRECTOR

BY HAND-DELIVERY

March 6, 1995

Ms. Carol Rasco
Assistant to the President
for Domestic Policy
The White House
Washington, DC 20500

Dear Ms. Rasco:

I would like to thank you again for the opportunity to meet with you last November. As President of the American Nurses Association (ANA), I appreciate the consistent openness and hospitality that you and other representatives of the Administration have provided to us.

The changed political climate in Washington clearly poses a new set of challenges to the Administration and to those who, like ANA, share the goal of creating a health care system that provides high-quality health care to all, while controlling costs. We continue to believe that this goal is as critical today as it was last year, despite Congress' failure to enact comprehensive health care reform legislation. We expect to work with the Administration in making progress toward this goal despite the new challenges posed to all of us by the new political climate.

There are two ongoing issues of great concern to ANA that move me to write you at this time. These are (1) the problem of unsafe staffing in health care institutions and (2) the use of state Medicaid waivers to exclude advanced practice nurses from participation in state Medicaid programs. Over the last several months, we have raised these issues while meeting with other Administration officials, including HHS Secretary Donna Shalala, HCFA Administrator Bruce Vladeck and Nancy-Ann Min of OMB. I am writing to you to request that we arrange a meeting in the very near future to discuss how ANA and the Administration can work together to fashion solutions to these problems, both of which are critical issues for ANA and for nursing.

1. Unsafe Staffing in Health Care Institutions

It is clear that marked, rapid changes continue to transform the health care industry, without the benefit of the structured and coordinated approach that comprehensive health care reform

would have afforded. In an increasingly competitive environment, the industry has set its sights on cost-containment at the expense of quality. This has resulted in alarming changes in America's health care institutions, which have sought to cut costs at any cost--even where it means sacrificing the safety of America's health care consumers and the quality of care they enjoy.

It is important to keep in mind that cost-containment efforts are not, for the most part, driven by attempts to avoid insolvency. Hospitals are in fact seeking to increase profit (or revenue) margins. While we do not believe that patient safety should be compromised even in financially failing hospitals, for financially healthy, profit-generating institutions to endanger patients in order to increase profit margins is reprehensible and should not be allowed to continue.

As part of their frantic effort to bring down operational costs, health care institutions have made drastic and radical cuts in their operating budgets. Nursing--which represents only approximately 23% of hospital labor costs--have, in a great many instances, formed the first and hardest-hit of budget cut targets. Because patients are admitted to hospitals later and discharged much earlier (due to a number of factors, including cost and the availability of technology that allows for out-of-hospital treatment options), the patient population that is hospitalized at any one time is much more acutely ill than in years past. Despite this increase in acuity, budget cuts have resulted in smaller numbers of registered nurses to care for these patients. In many instances, RN positions have been eliminated and replaced by hospital-trained unlicensed assistive personnel who are given increasing patient care responsibilities. The result is that fewer RNs are left to care for larger numbers of increasingly ill patients, while also having to oversee the care given by unlicensed personnel.

Patient safety is directly endangered as a result of these budget-cutting schemes, as RNs find themselves stretched to the breaking point and beyond. Today's hospitals simply cannot provide safe care without adequate numbers of registered nurses.

This situation is occurring in every type of institution and in every part of the country. Nurses continue to report incidents of unsafe care due to inadequate staffing, and they do so with increasing frequency and alarm. ANA is continuing to collect information from nurses and patients around the country. In addition, we have launched a large-scale effort to generate the data and research needed to link staffing and patient outcomes. As you may know, much of the data needed to accomplish this end is unavailable--simple information such as numbers of RNs providing direct care, adverse incidents such as patient falls or medication errors--are not made public. Moreover, important as the development of outcomes indicators is, it is a new science that cannot be expected to yield results which lend themselves to commonly agreed on interpretation for some time.

The safety of the American health care consumer cannot be deferred until that time. It is critical the Administration address this issue now. We have raised this issue previously with Bruce Vladeck, Administrator of the Health Care Financing Administration and with Donna Shalala, Secretary of Health and Human Services. Both expressed clear concern; however, when we last met with them on this subject, all believed that these issues could be addressed in the context of passage and implementation of health care reform legislation. Secretary Shalala had expressed interest in appointing a special "blue-ribbon" commission to investigate the issue of patient safety in the restructured health care industry. Regrettably, no progress toward effectuating this plan been, and it is our current understanding that the Secretary does not plan to proceed with it.

We recognize that the Administration's actions in the regulatory sphere fall under particular scrutiny in the first days of a new Congressional majority that is pledged to an "anti-regulatory" agenda. However, we strongly believe that the federal government, including the administrative agencies, remains charged with the responsibility to protect the American consumer. Health care institutions continue to receive Medicare moneys based in large part on the diagnoses and complexities of the patients for whom they provide care. We believe that hospitals, in accepting this money, accept a responsibility to provide the level and type of care that each patient's diagnosis and condition requires. Yet hospitals, in slashing their nursing budgets are cutting back sharply on patient care while continuing to accept full DRG payments. This lack of accountability concerns us greatly, and we believe it should concern the Administration as well.

ANA has proposed a series of measures to require hospitals and other institutions to disclose publicly data on staffing levels, staffing mix and patient outcomes, as a first step toward public awareness and accountability of their performance. These measures are a step toward fashioning a "Report Card" on patient care services.

Many of these measures could be undertaken through Administration initiatives. We believe that public understanding of the need for such regulatory measures could be generated through a variety of means that could be undertaken by ANA, consumer groups and the Administration. Some of these measures could include conducting public hearings on this issue, conducting other public fact-finding efforts, and undertaking investigations and reports through various administrative bodies.

We regard this as an opportunity for the Administration to initiate public awareness of an escalating threat to public safety and to create the demand for solutions to this threat. A central tenet of the Administration's health care reform efforts in 1994 was that both access and cost-containment could be achieved without sacrificing quality. The phenomenon that cynically passes for "market-based reform" is stressing cost-savings and profits at the expense of all other considerations, including quality and safety. In order to hold to its

health reform principles and to protect the safety of the American people, we call upon the Administration to make safety and quality of health care services a top priority. It is an area in which the ANA is, as before, willing to work in close partnership with the Administration and to devote its energies and its resources.

2. Use of State Medicaid Waivers to Exclude Advanced Practice Nurses

Another area with which we are deeply concerned is in that of Medicaid waivers. We do not take issue with the idea of state flexibility or with piloting new approaches to delivering Medicaid services. We note, however, that many states have entered into Medicaid waiver programs in such a way as to undercut the goals of access, quality and cost-containment.

Specifically, we are very concerned that in most states which utilize a primary care case management system or a similar "gate-keeper" model, the role of primary care provider has been limited to physicians only. This is in spite of the fact that advanced practice registered nurses (such as nurse practitioners and certified nurse-midwives) are fully qualified to take on this role. As you may know, current federal Medicaid law mandates that states include the services of CNMs, and of certified pediatric NPs and certified family NPs, in their state Medicaid plans. (In practice, most states have opted to go beyond the federal mandate by including all NP services, as opposed to limiting NP services to those of pediatric and family NPs.) In many instances, the Medicaid waiver programs have allowed the states to circumvent this federal requirement not by waiving it outright, but by treating CNM and NP services as "specialty" services requiring a referral by a primary care physician.

Requiring a referral by one primary care provider in order to see another is costly, duplicative and largely impractical. In practice, it cuts off access to NPs and CNMs--who are most capable and cost-effective primary care providers.

This problem has manifested in both 1115 waivers and in 1915(b) waivers. In many states, it has created heightened access problems--such as in the case of Pennsylvania's 1915(b) waiver, which effectively struck NPs from the ranks of Medicaid providers serving children in many rural counties--counties in which they had been the only providers seeing new patients.

In both Tennessee and Hawaii, the original waiver proposals would have excluded advanced practice nurses by requiring that primary care providers be physicians. In both states, nurses were able to convince state policy-makers to expand the eligibility for participation in the waiver program. Notably, in Hawaii, despite the fact that the waiver program allows for advanced practice nurses to participate as primary care providers, the private insurance company which administers the program refuses to allow these nurses to participate.

In its emphasis on access to primary care, the Administration's health care reform proposals stressed availability of the services of all primary care providers, regardless of their professional discipline or licensure. The Administration wisely noted the need to break down barriers to practice and payment for non-physician practitioners. This was not merely for reasons of fairness and equity, but also because the Administration recognized that in order to provide increased access to care, all available primary care providers would be needed. This understanding should be used in the approval or disapproval of Medicaid waiver applications. In judging the effect on access and cost of such applications, we believe that one of the criteria to be applied should be: *Does this plan exclude any class of primary care providers solely on the basis of professional discipline or licensure? Does it permit such exclusion by any plans which contract with the single state agency for the administration of the Medicaid program?*

Conclusion

We appreciate your consideration of our concerns and we look forward to working in partnership with the Administration on these and other health care issues. There are issues of paramount importance to us. Just as we have worked closely with the Administration in campaign to effectuate its health reform agenda, we expect to work closely with you on these issues as well. In order to discuss ways in which we can work together, we request a meeting with you in the very near future. We will be contacting you shortly to coordinate scheduling this meeting.

Please contact Geri Marullo, ANA's Executive Director, at (202) 651-7012, if, in the meantime, we may provide additional information or assistance on any of the issues discussed in this letter.

My good wishes to you and the Administration as always.

Yours sincerely,

Virginia Trotter Betts

Virginia Trotter Betts, JD, MSN, RN
President

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VIRGINIA TROTTER BETTS, JD, MSN, RN
PRESIDENT

GERI MARULLO, MS, RN
EXECUTIVE DIRECTOR

March 15, 1995

Via Fax Delivery

Ms. Nancy-Ann Min
Associate Director for Health and Personnel
Office of Management and Budget
Old Executive Office Building
Seventeenth Street and Pennsylvania Avenue, NW
Room 262
Washington, DC 20503

Dear Nancy-Ann:

I wanted to thank you again for meeting with me, Geri Marullo and David Keepnews on February 1. I appreciated your perspective on two of the issues of central concern to ANA--decreasing quality and safety of patient care in acute settings, and federal policy on utilization of registered nurses under federal Medicaid waivers.

We look forward to continuing to work with the Administration in addressing the declining quality and level of safety that is resulting from elimination of registered nurse positions in many of our nation's healthcare facilities. We realize that the Administration feels some reluctance to launch new regulatory initiatives at this time. However, we also believe that this growing health care crisis must be addressed, and we are more than willing to continue working with you to formulate means of resolving this growing problem. However, the Administration has a responsibility to address the provision of unsafe care in institutions that participate in the Medicare program and I believe the Administration would be lauded for its advocacy on behalf of this population.

We also look forward to working with you to address the issue of states utilizing Medicaid waiver programs as a means to circumvent federal requirements that mandate coverage of nurse practitioner and nurse midwife practice. Again, as part of the Administration's commitment to developing cost-effective models of providing Medicaid services and increasing access, we believe that the continued support for including services of cost-

effective providers such as advanced practice nurses is essential. We expect to work with you and others in the Administration to develop approaches to this problem as well.

Again, thank you for a most interesting meeting on February 1. I look forward to seeing you again in the near future.

Yours sincerely,

Virginia Trotter Betts

Virginia Trotter Betts, JD, MSN, RN
President

cc: Geri Marullo, MSN, RN
Executive Director

Proposal for a Blue Ribbon Commission
to Examine the Impact of Cost Containment on the
Quality of Care in Health Care Institutions (Hospitals, Nursing Homes) and
Related Nursing Services

Assumption

Dramatic restructuring is occurring in today's health care system. Many hospitals and community-based facilities are expanding, realigning or eliminating services. Such restructuring is occurring with minimal assessment of community health care needs or related infrastructure impact. Restructuring is also resulting in unprecedented health care workforce redesign. This redesign is intended to increase health care worker productivity by increasing the cash reserves of institutions. These cash reserves are enabling institutions to position for the future in order to acquire market segments of the health care industry. Such positioning sustains non-profit and profit margins. Increasing anecdotal evidence from consumers and nurses indicate these trends are resulting in a "crisis of confidence" in the delivery of safe, quality care to patients. This "crisis of confidence" must be examined.

Purpose of Blue Ribbon Commission

To examine current institutional workforce redesign in health care, its cost-effectiveness, and the impact on patient safety, quality of care, and related nursing services.

Composition of Blue Ribbon Commission

There will be 15 members of the Blue Ribbon Commission representing expertise in the following areas:

- Known consumer advocates concerned with quality, i.e., AARP, Consumers Union
- Workforce redesign
- Risk management
- Quality assurance
- Clinical outcomes
- Nursing practice
- Hospital administration
- Health care financing

Proposed Areas to be Examined

The Blue Ribbon Commission will obtain information from a selected number of hospitals that have undertaken redesign in the past 3 years. Types of information to be collected are:

- General demographic data including:
    - Changes in aggregate patient demographics in the community
    - Changes in numbers of beds per 1,000 patient population in the state

- Gain or loss in managed care contracts in the facility

- Total expenditures and savings of redesigning the workforce

- How the savings were achieved

- Methods the institution used to reduce costs of patient care delivery, including:
  - Use of workforce redesign consultants
  - Use of technology
  - Cross-training
  - Substitution
  - Layoffs and elimination of FTEs through attrition
  - Replacement of full-time workers with part-time workers
  - Changes in categories and numbers of FTEs of direct care providers

- Impact on quality and safety of patient care as measured by:
  - Client complaints
  - Changes in occurrence of adverse incidents, including medication errors, patient falls, nosocomial infection rates, use of restraints, and other acts of omission because routine care was not delivered or there was poor response time to patient needs
  - Changes in lengths of stay, readmission rates and mortality rates
  - Hospital malpractice claims
  - Hospital measures of patient satisfaction
  - Changes in rates of discharges to nursing home and home
  - Physician perception of quality of care delivery
  - Registered Nurse perception of quality of care delivery

- Impact on workforce as measured by:
  - Layoffs by job class and length of service
  - Voluntary separation rates by job class
  - Changes in part-time vs full-time workers
  - Changes in categories and numbers of FTEs of direct care providers/occupied bed
  - Cross-training
  - Substitution
  - The facility's pattern in using results from the acuity system to determine staffing levels.
  - Nurse satisfaction survey
  - Change in amount of sick leave use
  - Worker compensation claims
  - RN health claims based on workplace injuries

Process for Data Collection

The Blue Ribbon Commission will conduct its fact-finding in the next six months by an entity identified by HHS, in consultation with ANA. It would consist of a collection of case studies and models about institutions, located in no more than six or seven specific markets, that have instituted institutional workforce redesign in the last one to three years.

Possible Markets

ANA would suggest the following cities because of information and anecdotes received from the field: (1) Minneapolis/St. Paul; (2) Boston; (3) San Diego; (4) Seattle; (5) Chicago; (6) Los Angeles; (7) New Haven.

These cities are suggestions only; ANA would welcome suggestions about other markets from the Blue Ribbon Commission. The criteria used to select these cities, in addition to reports from the field, were: (1) length of time since workforce redesigns was initiated; and (2) health reform initiatives in these states.

Sources of Information

- Anecdotes/information
- Public hearings conducted by HHS
- Surveys, either existing surveys or a survey designed and conducted as part of this study
- Division of Nursing information, including surveys
- Literature search
- HCFA data/information
- JCAHO data/information

Suggested Fact-finding Steps

1. Collect anecdotes and other information.

2. Select cities.

3. Identify relevant institutions (hospitals and long-term care facilities) within each city or market area.

4. For each institution, a case study would be written that would include:

    - Description of the relevant geographic market
    - Description of the institution
    - Relevant events leading up to the institution's workforce redesign

- Impact on patient safety and the quality of patient care, the workforce, and related nursing services as measured by the criteria

5. The Blue Ribbon Commission report would conclude with recommendations about possible models for undertaking institutional workforce redesign. It would assess the impact on patient safety, quality of care, related nursing services and the institutional workforce of the approach used in each institution and draw conclusions about which approaches had the least adverse impact.

Timeframe

The study would be conducted within the next six months; the report would be written within the next eight months; ANA and HHS would have the opportunity to comment on a draft report.

Glossary

Restructuring

Restructuring refers to macro-system changes occurring in the health care industry stimulated by increased competition, shifts in sites of care delivery brought about by technology, and changes in the payment system. Restructuring include changes where provider entities and others seek to vertically and horizontally integrate their services to provide a seamless system of care for consumers. The goal of restructuring is to decrease costs, achieve economies of scale and increase market share. Restructuring is frequently accomplished through formation of managed care networks; new mergers and acquisitions and/or closures of health care institutions; or formation of totally new alliances through networking groups of local health care providers, social service agencies, community organizations and insurers. Other terms used for this activity include: downsizing, right-sizing, community care networks, health care alliances.

Workforce Redesign

Workforce redesign refers to current efforts, usually by health care institutions, to improve worker productivity, reduce costs and increase the organization's cash reserves. Other terms frequently used for workforce redesign include: reengineering, workforce transformation, patient-focused care, workforce transformation, high performance workplace. Redesign often results in changes in staffing patterns and skill-mix; cross-training; substitution of lesser skilled workers for more highly trained professionals; elimination of jobs and job redesign (where functions of one job are subsumed into another).

Cross-training

Cross-training of workers involves training of a worker to more than one job. For example: a registered nurse whose primary area of practice is a medical ICU may be cross-trained to a different specialty area that may or may not be within his/her area of practice. This practice is often called "floating." Cross-training should be competency-based and in concert with established standards of practice for the specialty. Measures of training, and frequency of experience needed to maintain competency should be addressed and measured.

Substitution

Substitution is where a worker of one job class is used provide care instead of a worker in another job class. The most frequent type of substitution, called down-substitution, is the use of a lower-paid, lesser trained and skilled worker to replace a higher-paid, more highly skilled and educated worker. The primary purpose of substitution is to achieve cost-savings and the focus is on task activity not on professional judgment.

Adverse Incidents

Adverse incidents are unexplained and/or unexpected events which occur or should not have occurred in the course of a patient's stay and which could cause the patient's recovery to be adversely effected. Adverse incidents also include those planned interventions that did not occur that should have occurred and which could cause the patient's recovery to be adversely affected.

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December 9, 1994

Thomas Hoyer
Acting Director
Office of Coverage and Eligibility Policy
Bureau of Policy Development
Health Care Financing Administration
405 East High Rise

Wayne Smith
Director, Division of Hospitals and
Ambulatory Services
Office of Survey and Certification
Health Standards and Quality Bureau
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Re: Medicare Conditions of Participation

Gentlemen:

The American Nurses Association appreciates the opportunity to assist you in the timely revision of the hospital conditions of participation. We strongly support your efforts and your commitment to make the Conditions of Participation patient-centered and outcome oriented. We fully endorse HCFA's stated concern for quality improvement and have offered some specific suggestions as to how this can be operationalized.

We have culled the collective expertise of the structural units of our Association, elected officials, senior staff and members of our organizational affiliates to recommend the following changes to the draft document you sent us. We would direct you to our request on page five for the language of the Discharge Planning section which was not included in this document, and which we desire to review.

Our comments have been organized by section number, and page references reflect those indicated on your draft document. Language in boldface type is new language as suggested by ANA. Language in strikeout represents ANA's recommendation to delete said language.

We thank you again for the opportunity to participate in this effort and will be happy to respond to any questions you may have concerning our comments. Please contact Kay Fulwider, MPH, RN, Assistant Director, Governmental Affairs at (202) 651-7097 for further on clarification.

Very truly yours,

Donna R. Richardson, JD, RN
Director
Governmental Affairs

grel/dkf/hosp.con
12-09-94

RECOMMENDATIONS:

We suggest that throughout the document the word "physician" be replaced with **practitioner** to reflect instances where certified nurse practitioners, certified nurse midwives and others are providing care.

In addition, we recommend replacing the terminology "medical record" with **patient record** as is now common usage.

Subpart A: Patient Care Activities

Page 1, Patient Assessment Activities

(a)(1) In this section, "examining practitioner" would be an appropriate substitution.

With the suggested revision, this section would now read: The patient will have a ~~medical~~ history and physical completed within 24 hours of inpatient admission, or up to 30 days prior to a scheduled admission. A durable copy of the history and physical done prior to admission must be in the ~~medical~~ **patient** record, and the ~~physician~~ **practitioner** must indicate in writing...hospital.

(b) We support the strong focus on multidisciplinary, comprehensive and collaborative care planning as an indicator of patient-centered, quality care.

Page 2, Patient Care

(a)(1)(i) Insert **who** between "osteopathy" and "may".
With this revision, the new section would read:
A doctor of medicine or osteopathy **who** may delegate tasks to other qualified....mechanism;

(a)(1)**(vi)** Add a new section:

(vi) An advanced practice registered nurse who is licensed by the state and acting within the scope of his or her license.

(a)(4) Insert **advanced practice registered nurse**
between "optometry," and "or".
With this revision, the new section would read.
A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization and is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine or optometry, **advanced practice nurse** or . . . law.

Page 3, Patient Care (continued)

(a)(5) Omit "physician" in first line.
#5 will then read "**All orders must be in writing and signed.....**"

(b)(1) "Licensed practical nurse" should be removed from this section, since the level of responsibility implied here requires the education and skills of a registered nurse.

This section would then read: The hospital must provide 24-hour nursing services **furnished or supervised by a registered nurse,** and have a ~~licensed practical nurse, or~~ registered
nurse....

(b)(3) A registered nurse is responsible for the provision and evaluation of the nursing care for each patient....

The word "supervise" carries numerous connotations, and has become the center of much debate and confusion following a recent Supreme Court decision regarding when nurses may be considered "supervisors" within the meaning of the National Labor Relations Act. We believe that to avoid involving HCFA and the Medicare CoPs into this debate, the word "supervise" should be used as carefully and precisely as possible. Thus, we have suggested alternative language to (b)(3) that stresses the responsibility of the registered nurse for the delivery of nursing care without using the term "supervise."

Page 4

(c)(4) Recommend addition of "**and nursing**" after "medical staff" since administering blood transfusions is purely a nursing function and should be driven by appropriate nursing policies and procedures. Language would then read:

Blood transfusions must be administered in accordance with State law, approved medical staff and nursing policies and procedures,.....

(c)(5) Add this sentence to language already existing: A registered nurse is present and available whenever a patient is in an outpatient area. Additional registered nurses are present in the outpatient area in sufficient numbers to ensure safe and quality care, and to be available for emergency situations.

(c)(6) Add to present sentence: Staffing must be at a level that is adequate to ensure safe and quality care.

(c)(7) Again, remove the reference to "physician" to reflect orders of the practitioner responsible for the patient's care.

The revised section would read:

Restraints (chemical and physical) and seclusion may only be used in accordance with ~~physician~~ the orders of a health care practitioner responsible for the patient's care and institutional policy and may only be employed to meet the ~~medical~~ needs....designated staff.

Page 5, Medication Use

(a)(1) A formulary or drug list is available to the ~~medical~~ appropriate professional **staff for prescribing.....**

Page 6,

(c)(1)(iv) Medications administered, refused by the patient, or not given are ~~properly, time~~ administered in a timely manner as indicated by hospital policy, and the **dosage, route of administration....**

Page 7,

(d) Parenteral Nutrition: Add a new #(5) to identify individuals who may appropriately administer parenteral nutrition.

(d)(5) Policies shall specify that the personnel who may administer parenteral nutrition are limited to physicians and registered nurses.

Page 8, Nutritional Services

(a)(1) Add after first sentence: **Staffing is adequate to ensure that patients needing assistance with meals (partial or total) will be fed in a timely, humane and dignified manner.**

Page 10, Safety for Patients and Personnel

New language for #1,2,3 is offered to bring the Conditions more in line with other federal agencies, such as OSHA and FDA, regarding safety requirements.

1. All services offered and equipment used must ensure a safe and healthful treatment environment and workplace. This includes protection for patients, employees, visitors and temporary and contract staff. Services extend to the storage and disposal of materials as well as their use.

2. All hazards identified must be promptly corrected. There should exist clear policies and procedures for (i) reporting and abatement of the hazards and (ii) regular inspection of equipment.

3. Exposure monitoring of the health care environment, biological monitoring of employees and occupational health surveillance activities should follow federal regulatory standards and guidelines.

Number 4 remains as proposed with i, ii, and iii added. This revised section will read as follows:

4. There must be a hospital procedure for **i) averting, ii) responding promptly to, and iii)** reporting blood transfusion reactions.

Page 11, Discharge Planning

The American Nurses Association requests a copy and the opportunity to respond to the "new Discharge Planning Regulation, BPD-421-F."

Page 12, Patient Rights

A new section (a)(4) is proposed:
The hospital shall post prominently, at the entrance to the hospital and in all patient care areas, the names and telephone numbers of the state agency, accrediting agency and others who may receive complaints about patient care quality and/or safety, and an explanation of how to record such a complaint.

A new section (b)(9) is proposed, to read as follows:

(9) The patient has the right to safe, quality care delivered by sufficient numbers of appropriately prepared and licensed professional personnel.

A new section (b)(10) is proposed:

(b)(10) The patient and the patient's family has the right to know how to record complaints and concerns regarding patient care quality and/or safety, or other hospital practices. This information includes hospital offices which are prepared to receive and evaluate complaints, as well as relevant state, federal and private accrediting agencies and organizations.

Page 13, Quality Assessment and Improvement

Include the following phrases in the proposed (a)(1) to revise as follows:

(a)(1) The hospital must develop, implement and maintain a quality assessment and improvement program which guides all hospital activities **and which is clearly communicated to staff.** The approach must give the hospital a systematic view of its performance and **include data collection on staffing mix and patterns. This approach should** enable it to create a strategy...performance.

A new section **(a)(8)** is proposed:
The hospital will collect and make available to the public at least the following data regarding patient care services and outcomes:

(A) **the number of registered nurses providing direct care, expressed both in raw numbers and as percentage of nursing staff, and broken down in terms of total hospital nursing staff; each hospital unit; and each staff.**

(B) **numbers of unlicensed personnel utilized to provide direct patient care. This information shall be expressed both in raw numbers and as percentage of nursing staff and shall be broken down in terms of the total hospital nursing staff; each hospital unit; and each shift;**

(C) **The average number of patients per registered nurse providing direct patient care. This information shall be broken down in terms of the total hospital nursing staff; each hospital unit; and each shift.**

(D) **Patient mortality rate (in raw numbers and by diagnostic-related group) for the previous year;**

(E) **Average length of stay per diagnostic-related group;**

(F) **Incidence of adverse patient care incidents, including but not limited to medication errors and patient injuries;**

(G) **Incidence of patient care complications, including but not limited to decubitus ulcers, nosocomial infections, nosocomial urinary tract infections;**

(H) **Incidence of occupational injuries of employees providing direct patient care.**

(I) **Data regarding complaints filed with the state agency, the Secretary and/or with an accrediting agency, compliance with the standards of which have been deemed to demonstrate compliance with Medicare conditions of participation;**

(J) **Data regarding investigations and findings as a result of the complaints identified in (I) above and findings of scheduled inspection visits.**

(a)(2) All hospital programs, departments and functions are involved in **developing, implementing and evaluating** the hospital's...improvement.

Revise Section (b)(2) to read as follows:

Customer satisfaction (patients, families, hospital employees, physicians **and other practitioners who admit patients to the hospital)**

Page 14, (c) Program Responsibilities

Add to end of current statement, "**through information exchange and discussion with staff from each of the various departments." With this revision, the new section will read:**

(c) The chief executive officer, ...of improvement actions**, through information exchange and discussion with staff from each of the various departments.**

Page 15, Information Management

(b)(1) Change "medical record" terminology to "**patient record.**" With this revision, this section will read:

The **patient** record must contain information...services.

(b)(3) Change "medical record" terminology to "**patient record.**" With this revision, this section will read:

All patients must have a ~~medical~~ **patient** record.....

(b)(4) Change "medical records" to "**patient records.**"
With this revision, this section will read:

Patient records must be retained....years.

Page 19, Emergency Services

Suggest adding a new #2, as follows: **When emergency services are provided by the hospital, sufficient numbers of adequately prepared licensed personnel, including physicians and registered nurses, shall be utilized to provide safe and quality care.**

(2) How will evidence of "integration with other departments" be demonstrated? For instance, will an Emergency Department that is owned and operated independently from a hospital meet the requirement that such services are "provided by the hospital"?

Keep current #2, but re-number it as #3; renumber #3 as #4, etc.

Page 20, Infection Control

(a) Revise this section to include references to hazardous agents and avoiding transmission of infection and disease.

With these revisions, this section would read:

(a) The hospital meets CDC and OSHA standards for providing an environment **which** avoids ~~sources of~~ **transmission of** infections and communicable diseases, **and exposure to hazardous agents.**

(b)(i)...(add to current language), **and relies heavily on worker training.**

Page 21, Human Resources

(b) Standard: Staffing
New language proposed as follows:

All hospital areas are staffed to reflect the volume, complexity and intensity of the service provided, based on a systematic appraisal of these factors. Hospital policies must detail what tool or tools are used to determine staffing, and the hospital must demonstrate that this tool is utilized.

Page 22, Education and Training

Add a new #3 to provide safety guidelines for staff temporarily assigned to work outside their area of expertise.

New language proposed:

(3) **The hospital must ensure that personnel who provide patient care in any hospital area are competent to provide the type of care required by patients in that area. When staff is sent to a hospital area that is not their usual area of assignment, the hospital will provide training and orientation necessary to ensure competent care in that area.**

Page 23, Physical Environment

(a) Change standard title to **Comprehensive** Safety Management

Replace proposed (a) down to beginning of (3) with the following which reflects the requirements of other government agencies such as OSHA and CDC)

There is a comprehensive health and safety program designed to provide an environment free of hazards; to quickly and effectively address hazards identified and to implement prevention measures to reduce the risk of injury and illness. This includes:

(1) A system for routine assessment of the environment for hazards;
(2) Policies and procedures for reporting and abating recognized hazards;
(3) Policies and procedures for follow-up of suspected health effects due to exposure to hazards;
(4) Surveillance systems to monitor trends in infection, injury, illness and incidents among personnel and patients;
(5) Same as current #3
(6) Same as current #4.

Page 25, Surgical and Anesthesia Services

(a)(3)(v) Omit this section. We have serious concerns about the safety of the practice of allowing anesthesia to be administered by "anesthesiologist's assistants." We believe the public interest is better served by requiring administration by either an anesthesiologist or a certified registered nurse anesthetist. This concern was also voiced by the Association of Operating Room Nurses, Inc. and the American Society of Post Anesthesia Nurses. Separate comments will be submitted by the American Association of Nurse Anesthetists.

We propose new language for a #4 to reflect appropriate education and skill required for perioperative nursing services.

With the proposed revision, this new #4 would read:

Perioperative nursing services shall be under the direction of a registered nurse who is skilled and experienced in perioperative nursing, as evidenced by eligibility for certification as a perioperative nurse by a nationally recognized certifying body.

(5) Current language of #4 would be renumbered #5.

(6) Current language of #5 would be renumbered #6.

Page 26, Documentation of Care

(6) Add "and nursing" to reflect policies and procedures to govern the nursing services delivered.

Revised language as proposed would read as follows:

(6) A postanesthesia evaluation and report....approved by the medical **and nursing** staff.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	SSN; DOB (Partial) (1 page)	05/30/1995	P6/b(6)

COLLECTION:
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Domestic Policy Council
Jennifer Klein
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FOLDER TITLE:
ANA [American Nurses Association] : Nurses for a Healthier America

2014-0209-S
ms746

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 advice 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]

[001]

AMERICAN NURSES ASSOCIATION

AMERICAN NURSES FOUNDATION
AMERICAN ACADEMY OF NURSING
AMERICAN NURSES CREDENTIALING CENTER
AMERCIAN NURSES POLITICAL ACTION COMMITTEE

600 Maryland Avenue, SW, Suite 100 West
Washington, DC 20024-2571
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~~CONFIDENTIAL~~

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To: Julie Demeo Fax No.: (202) 456-2878

Organization/Business: Office of Domestic Policy

From: Lori Davis, Office Manager, Executive Offices Extension: 7017

Date: May 30, 1995 Total Pages (Including Cover): 2

MESSAGE

Julie,

Attached please find the agenda for the Carol Rasco meeting. The people that will be in attendance are:

Virginia T. Betts
Geraldine (Geri) Marullo
Marjorie White Vanderbilt
(b)(6)

If you have any other questions, please give me a call.

Thank you.

Lori

DETERMINED TO BE AN ADMINISTRATIVE MARKING
INITIALS: MA DATE: 2-27-14

AMERICAN NURSES ASSOCIATION

600 MARYLAND AVENUE SW
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WASHINGTON, DC 20024-2571
202 651-7000 • FAX: 202 651-7001

VIRGINIA TROTTER BETTS, JD, MSN, RN
PRESIDENT

GERI MARULLO, MS, RN
EXECUTIVE DIRECTOR

AGENDA

Meeting between American Nurses Association and Carol Rasco
Wednesday, May 31, 12:30 P.M.

Attending from ANA:

Virginia Trotter Betts, President
Geri Marullo, Executive Director
Marjorie Vanderbilt, Director, Governmental Affairs

1. Patient Safety in Health Care Institutions

2. Exclusion of Advanced Practice Nurses under State Medicaid Waivers

3. Retraining of Displaced Registered Nurses

Monday

Marilyn scheduling

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: KLEIN

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: x 3/23

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : ☐ Accept ☐ Pending ☐ Regret

Designee to attend: _____

Remarks: _____

Roz: Ticketed 3/23

AMERICAN NURSES ASSOCIATION

600 MARYLAND AVENUE SW
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WASHINGTON, DC 20024-2571
202 651-7000 • FAX: 202 651-7001

VIRGINIA TROTTER BETTS, JD, MSN, RN
PRESIDENT

BY HAND-DELIVERY

March 6, 1995

Ms. Carol Rasco
Assistant to the President
for Domestic Policy
The White House
Washington, DC 20500

Dear Ms. Rasco:

I would like to thank you again for the opportunity to meet with you last November. As President of the American Nurses Association (ANA), I appreciate the consistent openness and hospitality that you and other representatives of the Administration have provided to us.

The changed political climate in Washington clearly poses a new set of challenges to the Administration and to those who, like ANA, share the goal of creating a health care system that provides high-quality health care to all, while controlling costs. We continue to believe that this goal is as critical today as it was last year, despite Congress' failure to enact comprehensive health care reform legislation. We expect to work with the Administration in making progress toward this goal despite the new challenges posed to all of us by the new political climate.

There are two ongoing issues of great concern to ANA that move me to write you at this time. These are (1) the problem of unsafe staffing in health care institutions and (2) the use of state Medicaid waivers to exclude advanced practice nurses from participation in state Medicaid programs. Over the last several months, we have raised these issues while meeting with other Administration officials, including HHS Secretary Donna Shalala, HCFA Administrator Bruce Vladeck and Nancy-Ann Min of OMB. I am writing to you to request that we arrange a meeting in the very near future to discuss how ANA and the Administration can work together to fashion solutions to these problems, both of which are critical issues for ANA and for nursing.

1. Unsafe Staffing in Health Care Institutions

It is clear that marked, rapid changes continue to transform the health care industry, without the benefit of the structured and coordinated approach that comprehensive health care reform

would have afforded. In an increasingly competitive environment, the industry has set its sights on cost-containment at the expense of quality. This has resulted in alarming changes in America's health care institutions, which have sought to cut costs at any cost--even where it means sacrificing the safety of America's health care consumers and the quality of care they enjoy.

It is important to keep in mind that cost-containment efforts are not, for the most part, driven by attempts to avoid insolvency. Hospitals are in fact seeking to increase profit (or revenue) margins. While we do not believe that patient safety should be compromised even in financially failing hospitals, for financially healthy, profit-generating institutions to endanger patients in order to increase profit margins is reprehensible and should not be allowed to continue.

As part of their frantic effort to bring down operational costs, health care institutions have made drastic and radical cuts in their operating budgets. Nursing--which represents only approximately 23% of hospital labor costs--have, in a great many instances, formed the first and hardest-hit of budget cut targets. Because patients are admitted to hospitals later and discharged much earlier (due to a number of factors, including cost and the availability of technology that allows for out-of-hospital treatment options), the patient population that is hospitalized at any one time is much more acutely ill than in years past. Despite this increase in acuity, budget cuts have resulted in smaller numbers of registered nurses to care for these patients. In many instances, RN positions have been eliminated and replaced by hospital-trained unlicensed assistive personnel who are given increasing patient care responsibilities. The result is that fewer RNs are left to care for larger numbers of increasingly ill patients, while also having to oversee the care given by unlicensed personnel.

Patient safety is directly endangered as a result of these budget-cutting schemes, as RNs find themselves stretched to the breaking point and beyond. Today's hospitals simply cannot provide safe care without adequate numbers of registered nurses.

This situation is occurring in every type of institution and in every part of the country. Nurses continue to report incidents of unsafe care due to inadequate staffing, and they do so with increasing frequency and alarm. ANA is continuing to collect information from nurses and patients around the country. In addition, we have launched a large-scale effort to generate the data and research needed to link staffing and patient outcomes. As you may know, much of the data needed to accomplish this end is unavailable--simple information such as numbers of RNs providing direct care, adverse incidents such as patient falls or medication errors--are not made public. Moreover, important as the development of outcomes indicators is, it is a new science that cannot be expected to yield results which lend themselves to commonly agreed on interpretation for some time.

The safety of the American health care consumer cannot be deferred until that time. It is critical the Administration address this issue now. We have raised this issue previously with Bruce Vladeck, Administrator of the Health Care Financing Administration and with Donna Shalala, Secretary of Health and Human Services. Both expressed clear concern; however, when we last met with them on this subject, all believed that these issues could be addressed in the context of passage and implementation of health care reform legislation. Secretary Shalala had expressed interest in appointing a special "blue-ribbon" commission to investigate the issue of patient safety in the restructured health care industry. Regrettably, no progress toward effectuating this plan been, and it is our current understanding that the Secretary does not plan to proceed with it.

We recognize that the Administration's actions in the regulatory sphere fall under particular scrutiny in the first days of a new Congressional majority that is pledged to an "anti-regulatory" agenda. However, we strongly believe that the federal government, including the administrative agencies, remains charged with the responsibility to protect the American consumer. Health care institutions continue to receive Medicare moneys based in large part on the diagnoses and complexities of the patients for whom they provide care. We believe that hospitals, in accepting this money, accept a responsibility to provide the level and type of care that each patient's diagnosis and condition requires. Yet hospitals, in slashing their nursing budgets are cutting back sharply on patient care while continuing to accept full DRG payments. This lack of accountability concerns us greatly, and we believe it should concern the Administration as well.

ANA has proposed a series of measures to require hospitals and other institutions to disclose publicly data on staffing levels, staffing mix and patient outcomes, as a first step toward public awareness and accountability of their performance. These measures are a step toward fashioning a "Report Card" on patient care services.

Many of these measures could be undertaken through Administration initiatives. We believe that public understanding of the need for such regulatory measures could be generated through a variety of means that could be undertaken by ANA, consumer groups and the Administration. Some of these measures could include conducting public hearings on this issue, conducting other public fact-finding efforts, and undertaking investigations and reports through various administrative bodies.

We regard this as an opportunity for the Administration to initiate public awareness of an escalating threat to public safety and to create the demand for solutions to this threat. A central tenet of the Administration's health care reform efforts in 1994 was that both access and cost-containment could be achieved without sacrificing quality. The phenomenon that cynically passes for "market-based reform" is stressing cost-savings and profits at the expense of all other considerations, including quality and safety. In order to hold to its

health reform principles and to protect the safety of the American people, we call upon the Administration to make safety and quality of health care services a top priority. It is an area in which the ANA is, as before, willing to work in close partnership with the Administration and to devote its energies and its resources.

2. Use of State Medicaid Waivers to Exclude Advanced Practice Nurses

Another area with which we are deeply concerned is in that of Medicaid waivers. We do not take issue with the idea of state flexibility or with piloting new approaches to delivering Medicaid services. We note, however, that many states have entered into Medicaid waiver programs in such a way as to undercut the goals of access, quality and cost-containment.

Specifically, we are very concerned that in most states which utilize a primary care case management system or a similar "gate-keeper" model, the role of primary care provider has been limited to physicians only. This is in spite of the fact that advanced practice registered nurses (such as nurse practitioners and certified nurse-midwives) are fully qualified to take on this role. As you may know, current federal Medicaid law mandates that states include the services of CNMs, and of certified pediatric NPs and certified family NPs, in their state Medicaid plans. (In practice, most states have opted to go beyond the federal mandate by including all NP services, as opposed to limiting NP services to those of pediatric and family NPs.) In many instances, the Medicaid waiver programs have allowed the states to circumvent this federal requirement not by waiving it outright, but by treating CNM and NP services as "specialty" services requiring a referral by a primary care physician.

Requiring a referral by one primary care provider in order to see another is costly, duplicative and largely impractical. In practice, it cuts off access to NPs and CNMs--who are most capable and cost-effective primary care providers.

This problem has manifested in both 1115 waivers and in 1915(b) waivers. In many states, it has created heightened access problems--such as in the case of Pennsylvania's 1915(b) waiver, which effectively struck NPs from the ranks of Medicaid providers serving children in many rural counties--counties in which they had been the only providers seeing new patients.

In both Tennessee and Hawaii, the original waiver proposals would have excluded advanced practice nurses by requiring that primary care providers be physicians. In both states, nurses were able to convince state policy-makers to expand the eligibility for participation in the waiver program. Notably, in Hawaii, despite the fact that the waiver program allows for advanced practice nurses to participate as primary care providers, the private insurance company which administers the program refuses to allow these nurses to participate.

In its emphasis on access to primary care, the Administration's health care reform proposals stressed availability of the services of all primary care providers, regardless of their professional discipline or licensure. The Administration wisely noted the need to break down barriers to practice and payment for non-physician practitioners. This was not merely for reasons of fairness and equity, but also because the Administration recognized that in order to provide increased access to care, all available primary care providers would be needed. This understanding should be used in the approval or disapproval of Medicaid waiver applications. In judging the effect on access and cost of such applications, we believe that one of the criteria to be applied should be: *Does this plan exclude any class of primary care providers solely on the basis of professional discipline or licensure? Does it permit such exclusion by any plans which contract with the single state agency for the administration of the Medicaid program?*

Conclusion

We appreciate your consideration of our concerns and we look forward to working in partnership with the Administration on these and other health care issues. There are issues of paramount importance to us. Just as we have worked closely with the Administration in campaign to effectuate its health reform agenda, we expect to work closely with you on these issues as well. In order to discuss ways in which we can work together, we request a meeting with you in the very near future. We will be contacting you shortly to coordinate scheduling this meeting.

Please contact Geri Marullo, ANA's Executive Director, at (202) 651-7012, if, in the meantime, we may provide additional information or assistance on any of the issues discussed in this letter.

My good wishes to you and the Administration as always.

Yours sincerely,

Virginia Trotter Betts

Virginia Trotter Betts, JD, MSN, RN
President

THE PATIENT SAFETY ACT OF 1995

SECTION 1.

1. Any provider under this program shall, as a condition of continued participation in this program, make available to the public certain information regarding nurse staffing and patient outcomes. Such information shall include, at a minimum:

   (1) the number of registered nurses providing direct care. This information shall be expressed both in raw numbers, in terms of total hours of nursing care per patient (including adjustment for case mix and acuity) and as percentage of nursing staff and shall be broken down in terms of the total hospital nursing staff; each hospital unit; and each shift.

   (2) numbers of unlicensed personnel utilized to provide direct patient care. This information shall be expressed both in raw numbers and as percentage of nursing staff and shall be broken down in terms of the total hospital nursing staff; each hospital unit; and each shift.

   (3) The average number of patients per registered nurse providing direct patient care. This information shall be broken down in terms of the total hospital nursing staff; each hospital unit; and each shift.

   (4) Patient mortality rate (in raw numbers and by diagnosis or diagnostic-related group)

   (5) Incidence of adverse patient care incidents, including but not limited to medication errors, patient injury, decubitus ulcers, nosocomial infections, nosocomial urinary tract infections.

   (6) Methods used for determining and adjusting staffing levels and patient care needs and the provider's compliance with these methods.

2. Data regarding complaints filed with the state agency, HCFA or an accrediting agency, compliance with the standards of which have been deemed to demonstrate compliance with Medicare conditions of participation shall be made publicly available, as shall data regarding investigations and findings as a result of those complaints and the findings of scheduled inspection visits.

3. "Made publicly available" means:

   (1) Provided to the Secretary and to any state agency responsible for licensing or accrediting the provider;

(2) Provided to any state agency which approves or oversees health care services delivered by the provider directly or through an insuring entity or corporation.

(3) Provided to any member of the public which requests such information directly from the provider.

4. For purposes of this section, "provider" shall mean:

(a) a hospital, skilled nursing facility, home health agency, hospice or any other entity as defined at Section 1861 of the Social Security Act;

(b) any group of three or more practitioners

(1) who participate in the Title XVIII program;

(2) who employ other licensed or unlicensed staff to provide care to patients; and

(3) who hold themselves out to the public as a operating a "clinic," "urgent care center," or other entity that is

(a) not required to be licensed under State law; or

(b) not required to enroll as a provider in the Title XVIII program.

5. All data made publicly available under this Section shall indicate the source and currency of the data provided.

SECTION 2.

1. No provider under the Title XVIII program shall terminate or take other adverse action against any employee or groups of employees for actions taken for the purpose of:

(A) Notifying the provider of conditions which the employee or group of employees identify, in their communications with the provider, as dangerous or potentially dangerous or injurious to:

(i) patients who currently receive services from the provider;
(ii) individuals who are likely to receive services from the provider; or
(iii)employees of the provider.

(B) Notifying a federal or state agency or an accreditation agency, compliance with the standards of which have been deemed to demonstrate compliance with

Medicare conditions of participation, of such conditions as are identified in subdivision (A) above;

(C) Notifying other individuals of conditions which the employee or group of employees reasonably believe to be such as are described in subdivision (A) above; or

(D) Discussing such conditions as are identified in subdivision (A) above with other employees for the purposes of initiating action described in subdivisions (A), (B) or (C) above.

2. A determination by the Secretary that a provider has taken such action as described in subsection (1.) above shall result in termination from participation in the Title XVIII program for a period of time to be specified by the Secretary, such period not be less than one month.

SECTION 3.

1. Any provider of services under Title XVIII that files with the Department of Justice and the Federal Trade Commission notification of a transaction which is required to be reported pursuant to Title 15 U.S.C. Section 18a shall, on the same date as such notification is submitted, provide the Secretary a written report that includes:

(a) the overall impact of such merger on the health services available and readily accessible to the community, including but not limited to:

(1) availability and accessibility of primary, acute care and emergency services;

(2) availability and accessibility of services for mothers and children;

(3) availability and accessibility of services to the elderly;

(4) availability and accessibility of services to other specific populations, including but not limited to: the poor, the uninsured; ethnic minority populations; women; the disabled; and the lesbian and gay communities;

(5) availability and accessibility of specialized services, including services for the prevention, detection and treatment the human immunodeficiency virus and related illnesses; mental health services and substance abuse services;

(6) The safety and quality of health care services to be provided, including anticipated changes in numbers and mix of nursing and other patient care staff and on other factors related to patient outcomes;

(b) the availability and accessibility of social services and other services within the community;

(c) impact on overall employment within the community;

(d) impact on the hospital workforce, including:

(1) the status of existing collective bargaining contracts, if any;

(2) plans for retraining and redeployment of employees who are displaced as a result of the contemplated transaction.

(e) The financial stability of the merged entity, taking into account projected acquisition costs, related expenses, planned marketing or advertising campaigns for the new entity, etc;

3. This plan shall be in addition to any documentation required by any other federal or state agency.

4. The plan submitted to the Secretary shall be made readily available to the public by the hospital or other entity and by the Department upon request. In addition, the hospital or other entity shall make available to the public any documentation submitted to the Department of Justice or Federal Trade Commission or other federal or state agency regarding the contemplated transaction.

5. The Department shall conduct, or arrange for, public hearings on the above elements and any other factors related to the health, safety and welfare of patients served by the provider nd on the community, including the hospital's workforce, such hearings to be held at a time or times and location or locations readily accessible to the public. Hearings may be conducted jointly with relevant State agencies.

6. The Secretary shall review the proposed transaction. Such review shall be based on the written plan submitted to the Secretary; a transcript of testimony at the public hearing described above; and any other factors which the Secretary finds are relevant to the health, safety and welfare of the patients served by the hospital and of the community, including the hospital's workforce.

7. The Secretary shall, within 45 days of the hearing, issue written findings on the likely impact of the contemplated transaction of the health and safety of the patients and communities served by the hospital, including the hospital's workforce. If the Secretary determines that the overall impact of the transaction on the health and safety

of patients and the community is a negative one, the Secretary shall issue, as part of her findings, a "Finding of Negative Impact on Health and Safety."

8. In issuing her findings, the Secretary may confer with such other agencies as may have an interest in the impact on the public of the proposed business arrangement including, but not limited to, the Department of Justice, the Federal Trade Commission and the Department of Labor.

9. A provider that executes a transaction which is the subject of a "Finding of Negative Impact on Health and Safety" pursuant to Article 8 of this Section (or a provider which fails to file a report with the Secretary pursuant to Article I of this Section) shall be deemed not to be in compliance with the conditions of participation in the Title XVIII program. Such a determination shall be subject to such procedures and appeal as provided for in regulations promulgated by the Secretary, except that a determination that conditions effected by the arrangement in question pose immediate jeopardy or irreparable harm to patient health, safety and welfare; in such case, such entity's participation in the program shall take place immediately and shall continue in force during any administrative or judicial review as the entity may seek.

psa
5/30/95

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: Julia Paradise **To:** Jennifer Klein

Phone: (202) 690- 6476
(202) 690-6870
FAX: (202) 401-7321

Phone: 456-2599
Fax: 456-2878

Number of Pages (Including Cover): 5

Comments:
Hi. Here are the promised pgs. On pg 49, 2nd ¶ from bottom, is the reference to adjusted Edp. paymts to non-MD practitnrs. The language I read over the phone starts at the bottom of pg 53 & continues on pg. 54.
Let me know if you need more stuff.
Julia

STATE OF OKLAHOMA

Application to the Department of Health and Human Services for the Development of *SoonerCare*

A Statewide Demonstration Project Incorporating Rural Managed Care Initiatives

December, 1994

Primary Care I & II

The Primary Care I & II options will be open to providers in areas of the State where pre-paid health plans or outpatient networks are not feasible. Individuals will select a primary care provider or be assigned to one at the time of application for enrollment in ***SoonerCare*** or upon re-determination of eligibility (see section III.5 for a description of enrollment procedures).

Only designated categories of physicians in most circumstances will be permitted to serve as primary care providers, specifically physicians practicing: family practice, general practice, general pediatrics, or general internal medicine. However, in areas with insufficient numbers of physicians, the State may contract directly with non-physician practitioners to serve as primary care providers (see section III.3 for further details). In addition, pregnant women will be permitted to select their own obstetrical provider for prenatal, delivery, and post-partum care, subject to the procedures described below.

OB should be used as primary care provider for all?

Finally, the State may expand the list of qualifying specialties at such time as the Aged, Blind, and Disabled populations are added to ***SoonerCare,*** to include sub-specialist internists and pediatricians. Many elderly and disabled persons with chronic medical conditions receive their primary care services from sub-specialists, such as rheumatologists and cardiologists, concurrent with treatment of their chronic medical problems. The State may permit sub-specialists to serve as primary care providers for this population, in order to ensure ready access to treatment for chronic medical conditions, as well as to promote continuity of care.

Primary care providers will be directly responsible for primary care office visits and any ancillary services included in their capitation. These providers will also be responsible for making referrals to specialists and other providers/services as medically necessary (with some exceptions, as noted below) and authorizing hospital admissions. In addition, they will be required to offer twenty-four hour coverage, either directly or through coverage arrangements made with other providers and/or local hospitals.

Primary care providers will be paid a fixed, monthly fee per enrolled member. Capitation rates will be determined through actuarial analysis of historical utilization and expenditure patterns of the population qualifying for medical assistance. Capitation rates for physicians and non-physician providers will be determined separately, based on their respective scopes of practice.

The State will continue to reimburse non-primary care providers on a fee-for-service basis. The State will also reimburse primary care providers fee-for-service when they deliver services outside of their capitation. However, primary care providers will not be permitted to bill for any service (e.g., a lab test) rendered in their office if they could have been capitated for that service under the Primary Care II option. This rule is intended to prevent providers from splitting the diagnostic portion of their practices into fee-for-

456-2578

Cost-Sharing Provisions

SoonerCare will include nominal cost-sharing requirements for Title XIX beneficiaries. The State believes strongly that enrollees assume greater responsibility for their health care decisions and actions when required to share in the cost of their health care. Co-payment amounts will be kept small enough to ensure that beneficiaries are never deterred from seeking medically necessary services. Specifically, the State will require nominal co-payments of $2.00 for all primary care physician office visits and $1.00 for prescriptions. A larger, but still nominal, co-payment of $5.00 will be assessed for inappropriate use of the emergency room by children (use of the emergency room by adults for non-emergent care is not a covered benefit). These provisions will be identical in urban and rural portions of the State.

III.3 Supporting Initiatives for Rural Managed Care Development

Concurrent with establishing the above rural capitation models, the State will implement several initiatives specifically designed to enhance the provider infrastructure in rural areas. Specifically:

- Expanded use of nurse practitioners and physician assistants to meet the primary care needs of rural Oklahomans.
- Special reimbursement arrangements for traditional, safety-net providers in rural Oklahoma (federally-qualified heath centers and rural health clinics).
- Integration of managed care program with related Oklahoma Department of Health initiatives.
- Inclusion of the Indian population and the existing Indian health delivery system into managed care.
- Development of a Statewide, telecommunications network for medical data exchange.
- Development of a Statewide rural transportation network.

Each of these initiatives is described in more detail below.

Nurse Practitioners and Physician Assistants

The number of nurse practitioners and physician assistants in Oklahoma has grown in recent years, and an increasing share of primary care services are being rendered by these two non-physician provider groups. Like physicians, nurse practitioners and physician assistants are located disproportionately in urban areas. However, both groups are beginning to penetrate rural portions of Oklahoma, where the need for their services actually is most acute. The State will encourage this trend by offering special primary care

capitation options for physician assistants and nurse practitioners caring for patients in medically underserved areas (the options will be variants of the Primary Care I model).

Nurse practitioners and physician assistants will be required, beyond, to operate in collaboration with licensed primary care physicians who are Medicaid providers. In addition, they will be required to have immediate consultation and referral mechanisms to the primary care physician with whom they collaborate.

The State will closely monitor the impact of non-physician providers on primary care capacity in remote areas of Oklahoma. If the results are positive, the State will explore other strategies to further increase the number of non-physician primary care providers in rural areas. The State will also explore mechanisms to coordinate this initiative with the telemedicine initiative, in order to bolster off-site physician support for nurse providers.

Federally-Qualified Health Centers and Rural Health Clinics

Oklahoma currently contains five federally qualified health centers (FQHCs) and 58 rural health clinics. These providers fill an essential need in non-urban areas and it is the State's intent to work collaboratively with them during the transition to managed care.

Non-urban FQHCs and rural health clinics will have two participation options from which to select[3]:

- Centers and clinics will be free to serve as primary care providers in a program model that would limit their risk to the cost of federally-qualified primary care and gatekeeping services. A special, broadened capitation rate would be established (as a variant of the Primary Care II model), but no cost-based reimbursement guarantees would be provided for the capitated services.

- Centers and clinics will also be permitted to assume risk for a broader range of outpatient health care services, similar to the Outpatient Network model. Under this option, all services provided by the center/clinic would be included under a single capitation rate. During the first three years of the program, the State would establish a "floor" on total reimbursement, based on a declining percentage of actual audited costs (determined on reasonable cost principles).

  For instance, in year one, the State could guarantee that centers and clinics receive, in capitation payments, no less than 95 percent of their reasonable costs. In year two, the "floor" would decline to 85 percent and in year three, to 75 percent. In year four, the "floor" would be eliminated. To the extent that the centers realize profit from the

[3] Chapter IV describes participation options for urban FQHCs. The reader should note that while the options for urban and rural facilities are similar, they are not identical.

IMMIGRATION NURSING RELIEF ADVISORY COMMITTEE

DISSENTING VIEW
February 27, 1995

Jack Golodner
Department for Professional Employees
AFL - CIO

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RECOMMENDATION

Jack Golodner, representative from the Department for Professional Employees, AFL-CIO, Barbara Nichols, MS, RN, FAAN, the American Nurses Association (ANA) representative, and Luisa Blue, RN, the Service Employees International Union (SEIU) representative, believe that the H-1A Visa program should be allowed to expire. Furthermore, we oppose the recommendation by other members of the Immigration Nursing Relief Advisory Committee (INRAC) to retain a H-1A Visa program that is weakened by the removal of provisions requiring health care facilities to attest to steps taken to decrease their dependence on H-1A nurses and to actively work to recruit and retain domestic nurses.

The overwhelming preponderance of evidence indicates that the nursing shortage of the 1980s was a transitory phenomenon. If anything, today there is a slight oversupply of nurses and that oversupply is likely to increase in the future.

- At the time INRA was under consideration, no attention was given to the likely impact of the free trade agreement with Canada -- now expanded as the North American Free Trade Agreement (NAFTA) to include Mexico -- which has since become a principal entry mechanism for non-immigrant registered nurses and which may soon be expanded with the addition of Chile and other countries.

- The resulting influx of Canadian nurses and the potential for entry from Mexico should be adequate to meet the industry's needs.

- NAFTA temporary entry will be unaffected by the fate of INRA and international treaty obligations prevent Congress from making unilateral changes to the laws governing NAFTA temporary entry.

- Add to this the permanent visa program which allows for immigrant foreign nurses to enter this country.

- Consider that the H-1A Visa program is primarily an urban phenomenon, where we are seeing the most dramatic restructuring and downsizing of the nursing workforce.

Therefore, no justification exists for continuing the H-1A Visa program, particularly a weakened H-1A Visa that fails to maintain adequate recruitment and retention measures for domestic nurses. It is also noteworthy that four of the six researchers, commissioned by INRAC, recommended that INRA be allowed to sunset.

CURRENT NURSING WORKFORCE

The health care industry is different today from what it was in the 1980s. During the 1980s, according to the Inspector General of the Department of Health and Human Services, hospitals had on average twice the rate of growth in physical plant and equipment acquisitions as that of other businesses. In addition, hospital capital costs increased two to three times faster than the consumer price index for those same years. The legislative history of INRA makes clear that the intent of Congress was to address shortages in the hospital sector of the industry.

However, since 1990, the health care industry has been actively restructuring, a process that has been dominated by hospital downsizing. Today, hospitals are laying off nurses or restructuring their jobs to reduce or eliminate their bedside responsibilities. * *See Appendix for recent news stories.* Given the current environment of cost containment and managed care, there has been a decline in the number of patients admitted to hospitals. Because hospitals are encouraged to discharge patients as early as possible, there has been a drop in average length of stay and fewer beds are needed than hospitals are licensed to operate. According to the American Hospital Association's (AHA) annual survey of total number of hospital beds from 1990 to 1993, there has been a decline in the number of beds by 49,867 to 1,163,460 beds. When hospital units of institutions are removed, thereby isolating community hospitals, the numbers are even more dramatic, particularly when the 1994 data is taken into consideration. In community hospitals, from 1990 to 1993, the number of beds declined by 8,574 to 918,786 beds. With the 1994 figure added, which represents the total number of beds through September 30, there is a decline in number of beds by 26,660 to 892,126 beds. When the 1994 figure is annualized, the decreased number of beds is an estimated 35,544.[1] This current decline is tied to fundamental shifts in our country's health care delivery system. In a 1994 survey by the American Nurses Association, more than 68 percent of the 1,800 survey respondents report that their institutions have cut registered nurse positions in the past year.[2]

The major trends associated with restructuring are a movement toward managed care, fewer inpatient days, an increased use of outpatient services, and a resulting reduction in inpatient beds in hospitals. When bed loss is translated into numbers of registered nurse positions lost, the results are truly staggering. Recent research suggests that a restructured health care system will require roughly 900 hospital beds for every 450,000 covered lives or one bed for every 500 persons.[3] Data from the Employee Benefit Research Institute shows that there are currently 212,800,000 covered lives (i.e., insured persons) living in the United States. If we assume that there is no change in number of insured, the total number of beds required is 425,600. Achieving this figure will require the number of community hospital beds to decrease by 495,400 over the next several years, or 54 percent of their current bed capacity. We know that cutting beds means a decrease in the number of registered nurse positions. According to the 1992 AHA survey, there were a total of 858,909 registered nurse full-time equivalents in community hospitals, which represents a ratio of .93 registered nurses per

hospital bed. If the ratio of nurse to bed remains unchanged, we can anticipate a potential loss of 463,810 registered nurse positions in the community hospital setting.

Another skyrocketing trend in the shifting health care industry is the increasing numbers of mergers and acquisitions within the industry. According to a December 19, 1994 article in Modern Healthcare, "the merger frenzy that enveloped the industry this year touched more than 10% of the nation's hospitals." Over 650 hospitals were involved in mergers in 1994. For nonprofit hospitals, in 1994, 176 mergers had been completed compared to 18 recorded mergers in 1993 and 15 mergers in 1992.[4] This ongoing instability and downsizing adds to the overall industry uncertainty and potential loss of nursing positions.

In addition to the decreasing number of beds, mergers and acquisitions, and a movement of the provision of care from tertiary care facilities to more community settings, the work that nurses do within health care facilities is undergoing tremendous restructuring. Hospitals are reducing the size of their nursing staff and delegating hands-on work of patient care to lower paid unlicensed support personnel in order to decrease immediate costs and to position themselves better in a competitive health care market. Over 44 percent of the respondents in ANA's layoff survey reported that their institutions were increasingly using unlicensed support staff who have had minimal training -- about 4 to 6 weeks -- in providing direct patient care. As noted in the case study from Chicago, completed for the Committee by Holly Blais, RN, MHA, "...many of those interviewed noted a trend by local hospitals to change the skill mix of patient care providers currently being utilized to include a lower RN percentage and a higher proportion of patient care aides. Some interviewees noted hospitals were moving from a '70-30' skill mix to a '50-50' skill mix. Because of this, the demand for RN services has decreased and if the trend continues, it could significantly impact the overall demand for RNs in the Chicago hospital labor market."[5] The restructuring of nursing duties and the ongoing decline in the inpatient census have resulted in a decline in the number of hospital positions available for registered nurses.

As cited above, it is clear that the health care industry is restructuring. This is taking place at the same time as the nursing workforce is growing. According to a 1994 *American Association of Colleges of Nursing* survey of 522 schools, representing 80 percent of the schools of nursing in the United States, 35,217 nursing students graduated in 1993-1994. This represents a 16 percent rise in graduations from entry-level bachelor's degree nursing programs from the previous year. This corresponds with a 2.6 percent increase in 1994 student enrollments in entry-level bachelor's-degree programs.[6] Also in 1994, over 6,000 Canadian and Mexican nurses entered the country through NAFTA and this number will probably increase. In addition, 4,000 immigrant nurses entered through the permanent visa program. Clearly, there are multiple avenues for employers to fill their workforce needs. But if there is the potential for future shortages, as now appears unlikely, then it is time to address the problem and not rely on stopgap measures, such as the use of H-1A nurses.

The challenge we face at this time is to ensure not only good jobs for graduating nurses, but also the re-employment of registered nurses displaced because of massive restructuring of the

health care industry. This is a challenge that the Department of Labor needs to address in a comprehensive fashion. The H-1A program needs to be evaluated in the context of this looming displacement crisis in the health care labor market.

REVIEW OF CASE STUDIES

As noted in the Committee's report, H-1A nurses are concentrated in a relatively small number of metropolitan areas. The Advisory Committee chose the case study method as the most appropriate means, given time and monetary limitations, to assess the impact of INRA on six metropolitan areas: Boston, New York City, Tampa, Miami-Fort Lauderdale, Los Angeles, and Chicago. **The overarching recommendation of four of the six researchers was to allow INRA to sunset.** All six agreed that INRA did address the then perceived health care crisis. But beyond this, there was little evidence to suggest that INRA worked to achieve the other stated goals. Further findings from these case studies are cited below.

PURPOSES OF THE IMMIGRATION NURSING RELIEF ACT

The Immigration Nursing Relief Act (INRA), passed in 1990, established a five-year pilot project which created a mechanism for U.S. health care facilities to recruit non-immigrant foreign nurses to work on a temporary basis and it required employers to attest to measures to increase the supply of domestic nurses by protecting their salaries and working conditions. The **primary reason** for enactment of INRA was to provide immediate relief from potential disruption in health care services, particularly in New York City hospitals, where H-1 nurses were already employed and faced involuntary return to their home countries. A second reason for enactment was that at the time Congress believed that there was a shortage in the availability of domestic nurses and the use of H-1A nurses was a stop gap measure to address this shortage. In addition, Congress recognized that health care facilities were becoming too dependent on non-immigrant foreign nurses and put into place provisions to ensure recruitment and retention of domestic nurses and encourage employers to reduce this dependence and look for a more long term solution.

Through passage of INRA, which allowed temporary H-1 nurses to adjustment to permanent status and via the creation of the "attestation" process for employers, as noted in the INRAC draft report, Congress sought to:

1. prevent the severe nursing shortage from becoming even more severe as foreign workers' authorizations expired and they could no longer work as registered nurses in the United States;
2. encourage employers to reduce their dependence on H-1A nurses admitted for temporary work in this country;
3. provide protections for the wages and working conditions of United States nurses; and

4. develop and sustain a stable pool of domestic RNs so that future shortages would not occur, or, if they did occur, would be less severe than the current one.[7]

Implementation of INRA was successful in achieving goal #1 by allowing those H-1 nurses who were in the country as of September 1, 1989 to convert to permanent resident status. But an examination of INRA in light of the remaining goals shows that INRA has done little to encourage employers to reduce their dependence on H-1A nurses and has had a negligible impact - possibly even a detrimental effect - on the creation of a stable nursing workforce.

An examination of the number of attestations filed by employers reveals that employers continue to seek out H-1A nurses despite an increasing supply of experienced and new graduate domestic nurses in the market. From 1992 to 1994, the number of facilities filing attestations rose from 1,336 to 1,700.[7] Rick Mines, in his draft report "Patterns of HIA Use--Fiscal Years 1991-1994", an analysis of Immigration and Naturalization Service and State Department National Data Sets, concluded that "despite the widespread belief that the nurse shortage has abated, there is no indication that the size of the H1A program is declining."[8]

The data regarding the impact of INRA on the wages and working conditions of domestic nurses are limited and inconclusive. As noted in several case studies, there was an "unintended" impact on the use of domestic agency, float pool and per diem nurses. Virginia McLain Rusk, in her draft report entitled "Impact of the Immigration Nursing Relief Act of 1989: Final Report on a Case Study of the Los Angeles-Orange County Nursing Labor Market" noted:

> Although registry nurses usually fill only part-time positions and "holes" in staffing schedules, the presence of full-time H-1A nurses has resulted in an overall readjustment of staffing to fill FTE positions, and a reduction of registry needs. H-1A nurses were perceived as more stable temporary workers, and less costly than registry rates, which are often 40 percent or more above staff RN salaries. H-1A RNs, with their probable commitment to one-to-three years of employment, were cited by several respondents and key informants as preferable to reliance on external registry staffing.[9]

All six researchers also mentioned the probable impact of INRA on new graduate nurses who are looking to enter the workforce. Eleanor E. Glaessel-Brown, Ph.D., in her draft report entitled "The Impact of the Nursing Relief Act of 1989 in the Metropolitan Boston Area", states:

> While it would appear as if U.S. workers are protected, it is not that simple. There is a subtle erosion of opportunities for local candidates to the nursing profession when H-1A nurses are brought in large numbers, because the latter arrive with more

experience and/or higher degrees than local graduate nurses, with whom they compete.[10]

At the same time that Congress was considering INRA, other reports were identifying problems pervasive in the nursing workforce. A 1989 General Accounting Office (GAO) Report, presented to the Senate Subcommittee on Immigration and Refugee Affairs, detailed a number of problems in the registered nurse labor market. This report noted that according to Bureau of Labor Statistics' data registered nurse salaries are generally less than those received by individuals in positions requiring similar degrees of knowledge, responsibility, complexity, and so on.[11] Lack of Salary progression is another problem; the Secretary's Commission on Nursing found that, on average, career earnings for nurses increase only 39 percent as compared with salary increases ranging from 94 percent for a buyer to 193 percent for an accountant.[12] The GAO also described the deterioration in working conditions, including rising patient acuity, lack of authority, and the rising demands of non-nursing duties resulting from cutbacks in support staff. The GAO's findings suggest that gender discrimination and other factors acted to suppress registered nurse salaries to below market levels. These factors also compounded the difficulties faced by hospitals in recruiting registered nurses. Yet, there is no discussion in the Advisory Committee's report regarding efforts to address these ongoing problems which certainly affect the ability of employers to recruit and retain domestic nurses.

RECRUITMENT AND RETENTION

It is most distressing that the Advisory Committee voted, by a narrow margin, to remove the recruitment and retention provisions designed to decrease dependence on H-1A nurses. While the case studies and the findings of the Advisory Committee suggest that these provisions were not effective, their underlying purpose remains valid and if anything, the provision should be strengthened certainly not removed. Had employers truly implemented appropriate recruitment and retention programs the need for H-1A nurses would have diminished. But, as we have already noted neither the number of attestations nor the number of H-1A visa entrants has decreased. If the recruitment and retention provisions are removed, employers will be under no obligation to reduce their dependency on H-1A nurses and have no obligation to establish ongoing recruitment and retention programs which would help to establish and maintain a stable nursing workforce. Again, several of the researchers noted that the danger in this tightening market is that employers will reduce their efforts to maintain recruitment and retention programs even more.

RECOMMENDATIONS IF THE H-1A PROGRAM IS RETAINED

Despite a finding that the need for employers to hire non-immigrant nurses no longer exists except for limited, spot shortages, the Advisory Committee never the less recommends continuation of a H-1A program. We believe the Advisory Committee's recommendation

would have been more consistent with its own findings by recommending elimination of the H-1A visa program, as we do, or at least reforming the program by including the following:

1) While we strongly support the exclusion of contractors from eligibility, as the Advisory Committee is recommending, other exclusions should be considered. Given that hospitals were the original target industry for passage of INRA, nursing homes, in particular, should also not be eligible. Due to the staffing practices used by nursing homes, a facility may have four registered nurse slots with one empty, thus meeting the seven percent vacancy test. It is important to note that there has been a dramatic shift towards nursing homes filing attestations. Nursing homes filed 25 percent of attestations in fiscal year 1991 and 42 percent in fiscal year 1993. The use of H-1A nurses by the nursing homes must be evaluated.

2) The Advisory Committee agreed that the nursing shortage has essentially ended except for spot shortages. If the H-1A Visa program is retained then hospitals should be restricted to using H-1A nurses limited to those specific shortage areas or to meet special requirements, such as language ability. In addition, before utilizing H-1A nurses, employers should be required to attest that no lay-offs have occurred in their state in the previous year.

3) We believe that the Department of Labor must take a more active part in data collection, monitoring and enforcing, with strict monetary penalties, the H-1A Visa program.

4) There must be an ongoing Advisory Committee to the Department of Labor to continue to monitor the use of H-1A nurses and its impact on domestic nurses.

5) The recruitment and retention provisions must be retained and strengthened with some provision added to rigorously evaluate the program's effectiveness.

CONCLUSION

It is clear that the alleged shortage of the late 1980's no longer exists. Furthermore, there is no evidence that the domestic nurse hiring and promotion practices of the health care industry which are at the root of the recurring domestic nurse recruitment "crises" have been fully and adequately addressed. Therefore, we recommend that the H-1A Visa program be allowed to sunset. We recommend that H-1A visaholders currently in the United States be permitted to remain until their visas expire and that consideration be given to allowing these individuals to apply for permanent resident status.

In order to truly address the cyclical nature of the nursing workforce, the nursing community, unions, the Department of Labor and the Department of Health and

Human Services must work together to better anticipate the health and workforce needs of this country and prepare domestic nurses to adequately meet that need. We need to develop programs that seek to recruit individuals, particularly minorities, into the nursing profession. We need to develop educational programs that prepare nurses to enter a profession which offers a wide array of opportunities and settings in which to practice. We must establish programs to promote the re-employment of nurses laid off due to restructuring and downsizing, actions which contribute to the current turbulence in the health care sector. Employers must be encouraged to address the ongoing practice and work environment concerns that continue to contribute to the cyclical nature of supply and demand. The United States does not need to rely on a stop-gap measure, such as the use of H-1A nurses to meet the complex, changing health care needs of its people.

Attachments:

Andrews, G. (1995, February 10). Hospitals' Rx for high costs: Fewer nurses, more aides. The Wall Street Journal.

Colburn, D. (1994, November 22). Nurses' jobs are changing or disappearing And, some say, it may be the patients who suffer the most. The Washington Post.

Cowley, G., Miller, S., & Hager, M. (1995, February 13). Intensive care on a budget. Newsweek.

Goldstein, A. (1995, January 12). GU nurses confront life without a job 63 sudden layoffs come after many years of professional security. The Washington Post.

Gordon, S. & Baer, E. D. (1994, December 6). Fewer nurses to answer the buzzer. New York Times.

Van Gelder, L. (1994, December 1). 3,000 nurses are expected to lose hospital jobs by '97. New York Times.

Reference List

[1] American Hospital Association (AHA) (1992). Hospital Statistics (1991-1992 ed.). Chicago: AHA.

[1] AHA. (1993). Hospital Statistics (1992-1993 ed.). Chicago: AHA.

[1] AHA. (1994). Hospital Statistics (1993-1994 ed.). Chicago: AHA.

[1] AHA. (1995). Hospital Statistics (1994-1995 ed.). Chicago: AHA.

[2] Decision Data Collection, Inc. (1994). Report of survey results: The 1994 American Nurses Association layoffs survey (American Nurses Association). Washington, DC: ANA.

[3] Kronick, R., Goodman, D. C., & Wennberg, J. (1993). The marketplace in health care reform: The demographic limitations of managed competition. The New England Journal of Medicine, 2, 148-152.

[4] Lutz, S. (1994). Let's make a deal: Healthcare mergers, and acquisitions take place at dizzying pace. Modern Healthcare, December 19-26, 47-52.

[5] Blais, H. (1994). Report on the impact of the immigration nursing relief act of 1989 on the local nurse labor market of Chicago, Illinois. Draft report submitted to Immigration Nursing Relief Advisory Committee (INRAC). Washington, DC: Department of Labor.

[6] American Association of Colleges of Nursing (AACN). (1994). 1994-1995 enrollment and graduation in baccalaureate and graduate programs in nursing. Washington, DC: AACN.

[7] The Immigration Nursing Relief Advisory Committee (INRAC). (1994). Report to the Secretary of Labor on the immigration nursing relief act of 1989. Draft report for consideration by the INRAC. Washington, DC: Department of Labor

[8] Mines, R. (1994). Patterns of H1A use--fiscal years 1991-1994: An analysis of INS and State Department national data sets. Draft report submitted to the INRAC. Washington, DC: Department of Labor.

[9] Rusk, V. M., & Stecher, C. (1994). Impact of the immigration nursing relief act of 1989: Final report on a case study of the Los Angeles-Orange County nursing labor market. Draft report submitted to the INRAC. Washington, DC: Department of Labor.

[10] Glaessel-Brown, E. E., (1994). The impact of the immigration nursing relief act of 1989 in the metropolitan Boston area: A case study. Draft report submitted to the INRAC. Washington, DC: Department of Labor.

[11] United States General Accounting Office. (1989) Information on foreign nurses working in the United States under temporary work visas. (GAO/HRD-90-10) Report to the Subcommittee on Immigration and Refugee Affairs, Committee on the Judiciary, U.S. Senate.

[12] Secretary's Commission on Nursing. (1988) Final Report. Office of the Secretary, U.S. Department of Health & Human Services. Washington, DC: DHHS.

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