Nursing Education

ANA Attending:
Beverly Malone - President
Chris Devive - political director
Margorie Vanderbuilt - govt relations

We should let them talk about their concerns and give them a sense of where we're going without talking specifics.

Three Issues They Care About:

1. **Provide direct reimburse for services of all APN under Medicare and Medicaid**
   Good news here. Nurses would be reimbursed just like a doctor. Our budget will proposes this again year as it did last year.

   PSOs: Nurses are definitely included in our PSO proposal -- we changed the definition last year to clarify that they clearly are included.

   Medicare funding for nursing education: Our budget will not modify Medicare funding for nursing, although we reduce it for docs (GME). About $250 million of the $9 billion for Medicare GME is currently for diploma nursing education.

2. **Community Nursing Organziation**:
   No issue. We already extended the demo that was due to expire last December.

3. **Discretionary Funding for Nursing Education:**

- The authorization has expired and we have supported the reauthorization legislation, but it has been bogged down by extraneous issues.

Over the last 4 years:
- Overall funding for health professions has fluctuated from $257-$290 million.
- Funding for nursing education has been roughly level, ranging from $59-$63 million.
- This year funding funding will be focused on minority and disadvantaged education, which includes nursing.
- Funding will be reduced equally for nurses and primary care physicians.
- Funding for enhanced area health education centers will be reduced some. This links academic centers to local clinics, particulary in disadvantaged communities.

Rationale:
Nursing market no longer the same problem; focusing on minority and disadvantaged
Medicare provides $250 million for nursing education
We're doing alot for higher ed: $1,500 HOPE tax credit and $10,000 deduction, Pell Grants

Clustering: We will propose clustering health professions again, as we have since FY95, but it has not been enacted. [We have only successfully clustered health centers.]
Clustering would mean there would be one appropriation for all health profession grants. The spearate nursing education grant programs would still exist but share an application.

- Any nurse $ direct scholarship?
- Clustering? Why? react?
- Issue still? - #help
- Enhanced Area Health Ed Ctrs?
- Considerations for prof ed - stats?
- Nurse mkt?
- % of minority/disadd = nurses - recruit

FAX

FAX
6-2878

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To: Pauline Abernathy

From: Chin-Chin Ip

Number of Pages (excluding cover): 3

Note: FYI - Clusters were first proposed for Health Professions in FY 1995.

Attached are:
1. Health Professions clusters summary table, FY 93 - FY98
2. HP Detail (shows individual grants within each cluster) FY 96 & 97 & 98 proposed (An extra page; you do not yet have this)
3. Other HRSA Consolidation Proposals besides Health Professions
4. Justification for our FY98 Budget

Health Division (Front Office)	[illegible]
Health & Human Services Unit	202/395-4925
Health Programs & Services Branch	202/395-4926
Health Financing Branch	202/395-4930

Fax Numbers:

Health Division (Front Office)	202/395-3910
Health Division (Room 7001)	202/395-7840

The following table displays the five health professions clusters, as they are requested in FY 1998. They were not requested in clusters prior to FY 1996.

Clusters:	HEALTH PROFESSIONS ($ in millions)					
	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998
Nursing Education & Practice	$58.5	$61.5	$58.6	$56.2	$63.2	$7.7
Primary Care/ Public Health	$70.4	$80.9	$78.5	$74.8	$82.3	$7.7
Minority/ Disadvantaged	$91.2	$91.2	$91.2	$79.7	$89.3	$89.3
Enhanced Area Health Education Centers	$44.5	$46.8	$48.4	$46.4	$54.6	$24.7
Workforce Development	$1.8	$1.8	$1.1	$0.2	$0.7	$0.6
TOTAL	$266.4	$257.3	$276.7	$257.1	$290.1	$130.0

HRSA HEALTH PROFESSIONS - Detail

(BA in millions)

Grant/Cluster	FY 1996 Enacted	FY 1997 Enacted	FY 1998 Recomm
Enhanced Area Health Education Centers Cluster:			
Area Health Education Centers	23.1	28.5	
Health Education and Training Centers	3.4	3.8	
Geriatric Programs	7.9	8.9	
Rural Health Interdisciplinary Training	3.7	4.2	
General Dentistry Training	3.4	3.8	
Allied Health Special Projects	3.4	3.8	
Podiatric Primary Residency Training	0.6	0.7	
Chiropractic Demonstration Grants	0.9	1.0	
Cluster Subtotal	46.4	54.6	24.7
Minority/Disadvantaged Health Professions Cluster:			
Centers of Excellence	22.1	24.7	
Health Careers Opportunity Program	23.9	26.8	
Loan Repayment/Faculty Fellowships	0.9	1.1	
Scholarships for Disadvantaged Students	16.7	18.7	
Exceptional Financial Need Scholarships	10.1	11.3	
Financial Assistance for Disadvantaged H.P. Students	6.0	6.7	
Loans for Disadvantaged Students	0.0		
Cluster Subtotal	79.7	89.3	89.3
Primary Care Medicine and Public Health Cluster:			
Family Medicine Programs	44.0	49.3	
General Internal Medicine/Pediatrics Training	15.7	17.6	
Physician Assistant Training	5.7	6.4	
Public Health/Preventive Medicine Programs	7.1	8.0	
Health Administration Programs	1.0	1.1	
Pacific Basin Medical Officers Training	1.2	0.0	
Cluster Subtotal	74.8	82.4	7.7
Nursing Education/Practice Cluster:			
Strengthening Capacity for Basic Nurse Ed & Practice	9.4	10.6	
Nurse Practitioner/Nurse Midwives & Other APNs	43.3	48.8	
inst. - Advanced Nurse Education	(11.1)	(12.5)	
inst. Nurse Practitioners/Nurse Midwife Education	(15.5)	(17.6)	
inst. Professional Nurse Traineeships up to $8,800	(14.2)	(15.9)	
Nurse Anesthetist Training	(2.5)	(2.8)	
Nursing Workforce Diversity (disadvantaged assistance)	3.5	3.9	
Cluster Subtotal	56.2	63.2	7.7
Health Professions Workforce Development Cluster:			
Health Professions Data Systems	0.2	0.2	
Research on Certain Health Professions Issues	0.0	0.5	
Cluster Subtotal	0.2	0.7	0.6
HEALTH PROFESSIONS TOTAL	257.4	290.2	130.0

HRSA Consolidation Proposals

(1) **Consolidated Health Centers**

Purpose: To cluster Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Care for Residents of Public Housing programs and administer them through a flexible funding source.

Proposal: Consolidate Sections 329, 330, 340, and 340A of the Public Health Service (PHS) Act

Status of Proposal: Proposed in FY 1996 and FY 1997 Budgets; enacted in 1996 in P.L.104-299 for five years.

(2) **Programs for Special Populations**

Purpose: To consolidate operations of the Pacific Basin Initiative, the Native Hawaiian Health Services programs, the payment to the State of Hawaii Health Department for Hansen's Disease services, Black Lung Clinics, and the State Alzheimer's demonstration grant. The goal is to improve the health status of these populations through delivery of primary and preventive health care services, enabling and supportive services, and infrastructure development by administering them through a flexible funding source.

Proposal: Consolidate P.L. 101-527 (Section 10), the Native Hawaiian Health Care Act (P.L. 102-396), the Federal Mine, Health, and Safety Act of 1977 (Section 427 (a)), and Sections 398-399A and 320 of the PHS Act

Status of Proposal: Proposed in FY 1996 and FY 1997 Budgets; not proposed in FY 1998 Budget. (see #4 below for proposed consolidation of Hansen's Disease services)

(3) **Rural Health**

Purpose: To consolidate the Rural Health Outreach and Rural Health State Offices authorities in order to achieve administrative savings for both grant applicants and the Federal government through a flexible funding source.

Proposal: Consolidate Sections of the PHS Act and Section 711 of the Social Security Act

Status of Proposal: Proposed in FY 1996, FY 1997, and FY 1998; not yet enacted.

(4) **Hansen's Disease**

Purpose: To allow downsizing and re-configuration of the Hansen's Disease program by consolidating funding for the Hansen's Disease Center (Carville facility) and payments to the State of Hawaii Health Department for Hansen's Disease services. The goal is to achieve cost savings and reduced staff levels, although savings are not realized until after FY 1998.

Proposal: Consolidate Sections 338A, 338B, 338I, 338L, and 846 of the PHS Act

Status of Proposal: Proposed in FY 1998

January 22, 1997

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

Please route to:

Richard Turman
Barry Clendenin
Pauline Abernathy

Decision needed	___
Please sign	___
Per your request	X
Please comment	___
For your information	___

With informational copies for
HPS and HD Chrons, NEM, HPS,
Mark Miller

Subject: Health Professions Clusters
other HRSA Consolidation Proposals

From: Chin-Chin Ip

Phone: 202/395-4926
Fax: 202/395-3910
Room: #7002
E-mail: ip_c@a1.eop.gov

Attached is the justification of the Health Professions proposal, and a table showing annual funding for Health Professions in fiscal years 1993 through 1998.

If you have any other questions, please contact us. Thanks.

JUSTIFICATION - Health Professions Budget Proposal

For over 30 years, the Health Professions Curriculum Assistance Grants have attempted to address three primary aspects of the health care workforce: (1) overall physician supply, (2) specialty distribution, and (3) geographic distribution. There is little evidence that the Health Professions grants have made much headway in addressing problems (2) and (3), and it is generally agreed that (1) is no longer a problem. A GAO report published in July 1994 found it difficult to measure the direct impact of Health Professions grants on the national goals cited above because none of the programs reviewed had "specific outcome goals against which to measure progress".

Taking into account the goal of balancing the budget, and given the lower priority of these programs within HHS, proposed funding for these grants in FY 1998 is $130 million. Evidence shows that the marketplace is taking care of the first two issues (see Appendix), so the $130 million would be spent primarily on efforts that deal with the third issue, the problem of geographic distribution. To help alleviate the problem of geographic maldistribution, the Health Professions Curriculum Assistance Grants in FY 1998 focus on the areas where the marketplace has little likelihood to succeed and where government efforts have already been fruitful: 1) increasing the **diversity** of the health professions workforce; and 2) fostering more **community-based partnerships** through activities such as academic health education centers (AHECs).

1) **Diversity**: Research shows that providers are most likely to practice in needy areas if they were raised in these areas, and that Black and Hispanic health care providers are more likely to provide services to members of their own racial/ethnic minority group. An article in the *New England Journal of Medicine* of May 16, 1996, "The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations," found that communities with high proportions of black and Hispanic residents were far more likely to have a shortage of physicians -- regardless of the average income of residents -- than were other communities. Authors of the NEJM article also found that black and Hispanic physicians cared for significantly more black and Hispanic patients, as well as more Medicaid and uninsured patients, respectively, than did other physicians[1]. Since minorities are disproportionately represented within the medically underserved population, a more concentrated effort to recruit health professionals from minority and disadvantaged backgrounds should help to reduce the geographic maldistribution problem. Finally, the administrator of HRSA, Dr. Ciro Sumaya explained that "minority health care providers bring about a better understanding of the cultural and social context of illness and disability among minorities", arguably leading to more appropriate and effective care.

---

[1]The study also found the following: 1) Communities with large numbers of Black or Hispanic residents were four times more likely than other areas to have a shortage of physicians regardless of community income; 2) Black doctors care for nearly six times as many Black patients as do non-Black doctors, and Hispanic physicians care for more than twice as many Hispanic patients as do non-Hispanic doctors; 3) Black physicians practice in areas where Black residents average 32 percent of the population, while whites practice in areas where Blacks make up only 5 percent of the population. Hispanic doctors show a similar tendency, practicing in areas with considerably larger numbers of other Hispanics than do white doctors (43 percent versus 18 percent); and 4) On average, 45 percent of Black doctors patients were covered by Medicaid versus only 18 percent of white doctors patients. Hispanic doctors see 50 percent more uninsured patients than their non-Hispanic, white colleagues.

2) **Community-based interdisciplinary training programs**: These programs allow students to receive training in actual practice settings, while receiving the necessary support from partnering academic institutions through telecommunications technologies. When students are introduced to knowledge and skills that other health professionals bring to the health arena, they are better prepared to work effectively in teams and are more likely to stay in the communities they serve. By capitalizing on the combined knowledge of various groups (including the Federal government, state and local governments, health professions schools, professional organizations, and foundations), these programs also lend to the delivery of more efficient care and the maximization of resources, both of which are goals that ultimately can help assure adequate health care delivery in underserved areas. Some examples of such programs include Area Health Education Centers (AHECs) and the Interdisciplinary Rural Training Grants.

APPENDIX - Additional Information

Evidence of the Market at Work

Nurses >

Testifying before the House Labor/HHS Subcommittee during the FY 1997 appropriations process, HRSA Administrator Dr. Ciro Sumaya asserted his confidence in the marketplace's ability to handle the physician mix of generalists and specialists. One such example of the marketplace at work is the change in salaries paid to primary care physicians under managed care. The *Wall Street Journal* of October 22, 1996 reports that one-third of all physicians belong to managed care groups. The *Journal* also includes the results of a survey (conducted by the Medical Group Management Association) involving 28,000 doctors in group practices -- between 1991 and 1995, average earnings received in primary care fields of internal medicine, family practice, and pediatrics grew by 24%, 22%, and 18%, respectively, while specialty fields of invasive cardiology, urology, and anesthesiology changed by 9%, 5%, and -2%, respectively. Finally, the PPRC comments that several indicators (including relative incomes, the availability of jobs, and medical students' expressed specialty preferences) "provide evidence that the market is signaling a modest shift in demand toward generalist physicians."[2]

Another Factor in Provider Distribution: Medicare payments

In addition to the Health Professions institutional grants and loans, Medicare payments also have influence on provider distribution. In FY 1997, Medicare graduate medical education payments will total an *estimated* $8.7 billion, affecting more than 75,000 residents and interns at approximately 1,300 teaching hospitals nationwide. Of the total spent by Medicare on graduate medical education, roughly $250 million goes to nursing education[3], according to Polly Bednash, executive director of the American Association of Colleges of Nursing.

---

[2] Physician Payment Review Commission, Annual Report to Congress 1996, p. 309

[3] Bednash states that most of the $250 million is used specifically for diploma nursing education. From *State Health Notes* (September 30, 1996).

The following table displays the five health professions clusters, as they are requested in FY 1998. They were not requested in clusters prior to FY 1996.

Clusters:	HEALTH PROFESSIONS ($ in millions)					
	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998
Nursing Education & Practice	$58.5	$61.5	$58.6	$56.2	$63.2	$7.7
Primary Care/ Public Health	$70.4	$80.9	$78.5	$74.8	$82.3	$7.7
Minority/ Disadvantaged	$91.2	$91.2	$91.2	$79.7	$89.3	$89.3
Enhanced Area Health Education Centers	$44.5	$46.8	$48.4	$46.4	$54.6	$24.7
Workforce Development	$1.8	$1.8	$1.1	$0.2	$0.7	$0.6
TOTAL	$266.4	$257.3	$276.7	$257.1	$290.1	$130.0

Medicare Funding of Nurse Education

The Case for Policy Change

Linda H. Aiken, PhD, RN, Marni E. Gwyther

Objectives.—To determine the magnitude and distribution of US Medicare funding for nursing education and to assess the extent to which Medicare funding contributes to meeting national health care workforce priorities.

Data Sources.—Medicare Hospital Cost Report Information System, American Hospital Association Annual Survey of Hospitals, and National League for Nursing national surveys of schools of nursing.

Data Analysis.—Using hospital identifiers, data from three data sets were merged and analyzed to estimate percentage distributions of Medicare funding according to types of educational programs, hospital characteristics, and student enrollment.

Results.—Fifteen percent of direct Medicare graduate medical education funding goes to hospitals for the training of nurses and paramedical personnel. Totaling approximately $174 million in 1991, 71% of these funds went to hospitals for nursing education costs. Most of the nation's teaching hospitals (289 of 381 Council of Teaching Hospitals member hospitals) and nurse education programs (1112 of 1484) do not qualify under existing policies for Medicare nursing education reimbursement. Sixty-six percent of Medicare nurse training funds, totaling $114 million in 1991, went to 145 hospitals operating diploma nursing programs; these programs produce less than 10% of nurse graduates. Three states (Pennsylvania, New Jersey, and Ohio) received nearly one half (48%) of the $114 million for diploma nursing education.

Conclusions.—Medicare is the largest single source of federal support for nursing education. Yet, the majority of Medicare nursing education funding goes to hospitals affiliated with an increasingly smaller, idiosyncratic subset of nurse training programs. Unlike graduate medical education, Medicare supports primarily preprofessional education in nursing. Graduate education, including the preparation of nurse practitioners, does not generally qualify for reimbursement. Medicare reimbursement for nursing education must be retargeted.

(*JAMA* 1995;273:1528-1532)

CYCLICAL shortages of hospital nurses in the United States have long motivated public policies to maintain a large supply of registered nurses (RNs) for inpatient employment.[1] Indeed, the supply of nurses has grown steadily, far outstripping population growth. Nurse-to-population ratios increased from 246 nurses per 100 000 people in 1950 to 726 per 100 000 people in 1992.[2,3] An average of 50 000 nurses have been added to the workforce every year for the past decade.[4] Most of this increased supply has been absorbed by hospitals, where two thirds of nurses are employed. But the restructuring of the hospital industry raises important concerns regarding the likelihood that hospitals will continue to absorb new nurses at current rates of production.

In recent years, the rate of growth of employment in outpatient settings has outpaced growth of inpatient employment. Between 1988 and 1992, the employment of nurses in hospital outpatient settings and public health or community settings increased by 68% and 62%, respectively. During the same period, nurse employment in hospital inpatient settings grew less than 6%.[3,5] Anecdotal reports of hospital inpatient workforce restructuring, including reductions in RN positions, are numerous but comprehensive research is still lacking. Authors of a recent study that evaluated employment across eight occupations in hospitals, nursing homes, and other health care settings in New York City predicted that 7% to 15% of current acute care capacity could be eliminated by the year 2000, resulting in a significant decline in demand for nurses and other inpatient personnel.[6] Another recent study analyzed survey responses of chief nursing executives in 76 hospitals that had recently completed restructuring projects (executives from 68% of eligible hospitals responded). Ninety percent of responding chief nursing executives reported reductions in jobs resulting from restructuring and 87% of these hospitals had eliminated RN positions.[7]

In 1990, even before recent escalations in hospital restructuring, *The Seventh Report to the President and Congress on the Status of Health Personnel in the United States* concluded that the mix of nurses by educational level was out of balance with national needs.[8] According to this report, the nation will face a substantial shortage of nurses educated at the baccalaureate and graduate levels by the year 2000, while having an excess supply of nurses with less than a baccalaureate education. The need to

From the Center for Health Services and Policy Research, School of Nursing, University of Pennsylvania, Philadelphia.

Reprint requests to Center for Health Services and Policy Research, School of Nursing, University of Pennsylvania, 420 Guardian Dr, Philadelphia, PA 19104-6096 (Dr Aiken).

ID: JAN 24'97 10:29 No.001 P.03

increase production of advanced practice nurses to meet the demands created by the growth in managed care has received attention from several recent workforce policy reports.[8-11]

From its inception, Medicare has reimbursed eligible hospitals for a portion of the costs associated with the training of nurses and paramedical personnel, in addition to physicians. Yet, little is known about the magnitude and nature of Medicare expenditures for nursing education, or the effect of these expenditures on the composition of the health care workforce. Attention to Medicare policies and expenditures for nursing education has been notably absent from assessments of the adequacy of the health care workforce and from recent legislative proposals to modify Medicare graduate medical education (GME) policies. In an era of increasingly constrained resources, and in view of the need to restructure the health care workforce for the future, an appraisal of Medicare nursing education expenditures is overdue.

BACKGROUND

The organization and financing of nursing education differs in important ways from that of medical education. Three different kinds of education programs (3-year hospital diploma, 2-year associate degree, and 4-year baccalaureate degree programs) prepare RNs. These program types vary in length, content, and financing. The last comprehensive study of sources of revenue for nursing programs was conducted in 1974; thus, there is no detailed information available to compare nursing and medical school financing.[12,13] There are, however, several obvious differences. First, all three types of nursing schools depend more on tuition than do medical schools. Data in the Table from institutions of higher education where about 90% of nursing programs now reside suggest that tuition constitutes between 17% and 40% of revenues,[14] compared with about 4% for the revenues of medical schools.[12] Service revenues from practice plans and hospitals, including Medicare payments for GME, are the most important source of financing for medical schools, accounting for 48% of total revenues. In contrast, patient care funds are an important source of nursing education funding primarily in hospital-based diploma nursing programs.[15]

Since established by the Social Security Amendments of 1965 (Public Law 89-97), the Medicare program has reimbursed hospitals for a portion of the educational costs of training physicians, nurses, and certain paramedical personnel. The original aim of this funding was the promotion of high-quality inpatient

Distribution (%) of Total Revenues of Institutions of Higher Education Compared With Medical Schools

	Tuition	State/Local Government	Federal Research	Services		Other
				Hospital†	Other‡	
Medical schools§	4	12	19	12	36	17
Institutions of higher education‖						
Public universities	17	37	12	13	14	8
Public 2-year colleges	20	64	5	0	7	4
Private universities	40	3	16	11	13	18

*Not specific to nursing schools.
†Medicare educational revenues are included under the hospital category.
‡Other services for medical schools are primarily practice plan revenues; for institutions of higher education, other services include educational activities and auxiliary enterprises.
§Data from Ganem et al.[12]
‖Data from National Center for Education Statistics, US Department of Education.[14] Totals may exceed 100% because of rounding.

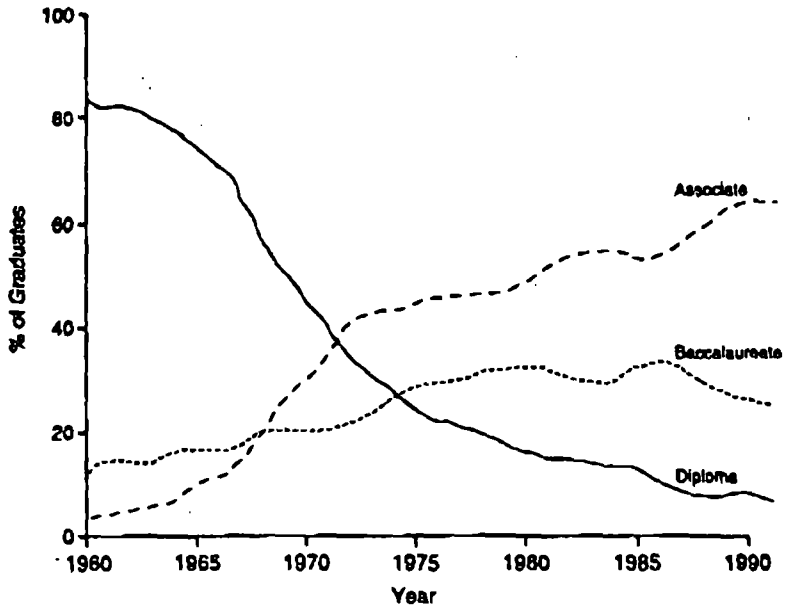

Figure 1.—Nurse graduates by type of education program, 1960 through 1991. Data from National League for Nursing, Division of Research.[16,17]

care for Medicare beneficiaries, as put forth in the following legislation:

> Many hospitals engage in substantial educational activities, including ... the training of nurses and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities ... should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the Hospital Insurance program (S. Rep. No. 404, 89th Congress, 1st Sess. 86 (1965); H.R. Rep. No. 213, 89th Congress, 1st Sess. 32 [1965]).[15]

Providers are defined in the legislation to include hospitals, skilled nursing facilities, home health agencies, and other health care facilities; however, hospitals are the institutions receiving payment.

In contrast to Medicare's policy of supporting postgraduate clinical training of physicians, Medicare's support of nursing education goes to hospitals for preprofessional programs preparing RNs. Medicare reimbursement regulations pertaining to nursing education have been revised repeatedly, creating confusion among fiscal intermediaries, hospital officials, and training programs, as well as inconsistencies in reimbursement. According to current regulations, Medicare reimburses hospitals that legally operate approved nurse education programs for a share of their classroom and clinical costs, based on the proportion of the hospital's patients who are Medicare beneficiaries. Hospitals may receive reimbursement for clinical costs incurred in association with nonprovider-operated nursing education programs only if (1) the provider was reimbursed for clinical training costs during the latest cost-reporting period ending on or before October 1, 1989; (2) the provider's portion of allowable clinical costs does not exceed the previous period's portion; (3) the provider shows benefits

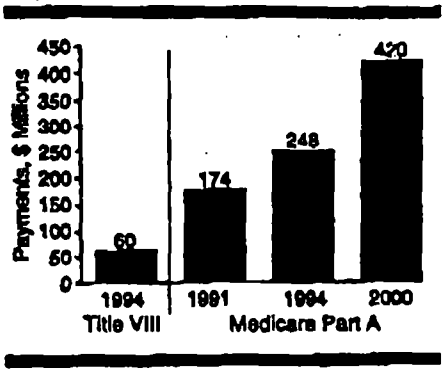

Figure 2.—Actual and projected Medicare payments to hospitals for nursing education, 1991 through 2000, compared with present Title VIII funding. (Data sources: Medicare 1994 and 2000 estimates from the Office of the Actuary, Health Care Financing Administration, unpublished data; 1991 Medicare data from Medicare Hospital Cost Report Information System files; and Title VIII funding information from Division of Nursing, Bureau of Health Professions.)

from the support it furnishes through the provision of clinical services by students; and (4) the associated costs to the provider do not exceed those that would accrue if the provider legally operated the program.[15]

The net result of the "provider-operated" provisions is the exclusion of most nursing education programs conducted under the aegis of institutions of higher education—2- and 4-year colleges and universities where approximately 90% of nurses currently receive their education (Figure 1).[16,17] In 1960, more than 900 hospital-based diploma programs produced 83% of the nation's nurses; by 1991, only 145 diploma programs remained in operation, producing less than 10% of nurse graduates.

The original legislation's focus on the quality of care for Medicare beneficiaries continues to provide the rationale for Medicare's support of health professions training. Yet, in the case of nursing, changes in hospital staffing and education since the passage of Medicare substantially altered the role of students in patient care. In the pre-Medicare hospital, fewer graduate nurses were employed than is the case today, and students were an important source of supplemental labor. Medicare, with its cost-based reimbursement scheme, facilitated the creation of new positions for graduate nurses.[1,18] Between 1972 and 1993, the ratio of graduate nurses to patients in community hospitals increased from an average of 50 to 106 nurses per 100 patients in keeping with an increase in the average acuity levels of patients.[19,20] With a larger cadre of fully trained nurses, hospitals became less reliant on students to provide patient services. Additionally, current hospital accreditation guidelines do not permit student nurses to be counted in the computation of nurse staffing, and the accrediting body for nursing education programs limits the amount of time students can be required to provide patient care. These changes, in addition to accreditation requirements for increased classroom preparation, significantly increased the costs to hospitals to operate nursing schools. Moreover, the rapid growth of community college programs in the 1970s and 1980s provided an adequate supply of nurses in most communities, giving hospitals less of an incentive to operate their own programs.

DATA SOURCES AND ANALYSIS

Three data sources were used in conducting our analyses: the Health Care Financing Administration (HCFA) Hospital Cost Report Information System (HCRIS), which provides Medicare cost and reimbursement information by hospital; the American Hospital Association Annual Survey, which provides details on the characteristics of hospitals; and the National League for Nursing nursing school enrollment statistics. The HCRIS contained data from the eighth year of the prospective payment system, a period beginning and ending anywhere from September 1990 to October 1992 depending on a hospital's fiscal year. For the sake of simplicity, hereafter we refer to prospective payment system year 8 as 1991.

Using individual hospital identifiers, we merged the HCRIS dataset with the American Hospital Association 1991 survey data to inform our analyses with further details on the characteristics of hospitals receiving Medicare reimbursement for nursing education programs. For hospitals with programs approved by the National League for Nursing, we added nursing school enrollment data for 1991 to the merged data files. Our analysis is descriptive and reports percentage distributions of Medicare funding by program type, hospital type, and estimates of per student Medicare funding for diploma nursing programs.

RESULTS

Types of Programs Funded

In 1991, 750 hospitals received an estimated $245 million for educational programs for nurses and paramedical personnel, accounting for about 15% of Medicare direct GME payments. Comparing our estimates of 1991 expenditures with those from an earlier study,[21] Medicare payments to hospitals for nurse and paramedical personnel education has increased while the number of hospitals receiving Medicare funding has decreased. Between 1985 and 1991, the number of hospitals receiving Medicare reimbursement declined by 10%, from 885 to 750, while the average payment per hospital rose by 17%.

Thirteen types of nonphysician training programs are approved for Medicare funding: professional nursing, practical nursing, nurse anesthesia, medical technology, medical records, x-ray technology, physical therapy, occupational therapy, pharmacy residencies, inhalation therapy, hospital administration, dietetic internships, and cytotechnology. Other types of programs may be considered for funding on a case-by-case basis.

Our analysis of HCRIS data from 1991 shows that hospitals received a total of $174 million, or 70% of nonphysician GME expenditures, as reimbursement for the costs of nursing education (professional and practical). The remaining funds, totaling $71 million in 1991, reimbursed hospitals for costs associated with paramedical training (including nurse anesthesia). The HCRIS dataset does not include information on the type of paramedical programs for which hospitals receive Medicare reimbursement, and a special study is required to compute this information directly from Medicare hospital cost reports. The last such study, reported in 1988, found that radiography and medical technology programs accounted for the largest Medicare expenditures for paramedical personnel.[21]

According to recent unpublished projections from HCFA, hospitals will receive approximately $248 million in Medicare support for nursing education in 1994, rising to some $420 million by the year 2000 (oral communication with John Wandishin, HCFA Office of the Actuary, March 1995). By comparison, as illustrated in Figure 2, Title VIII Public Health Service monies, which constitute most of the other federal support for nursing education, now total roughly $60 million a year. Medicare is thus the single largest federal source of support for nursing schools. In addition, an important distinction between these two sources of funding is that Medicare funding for nursing education has been a stable and reliable resource, increasing from year to year because it is an entitlement, and thus not subjected to the congressional appropriations process as is Title VIII. However, Title VIII monies go directly to educational programs, whereas Medicare funds accrue to hospitals' general revenues and are not specifically earmarked for education.

Of the 1484 nursing education programs, 372 programs received Medicare support indirectly through their affili-

ated hospitals. The majority of programs received no such support. Hospitals with diploma nursing programs received 66% of the total Medicare nursing education funds. Some 145 hospitals associated with 144 diploma programs received an estimated $114 million in Medicare funding, more than twice the amount for all nursing programs supported by Title VIII funds. This finding is particularly noteworthy in light of the steady decline in diploma schools over the past decade, from 303 in 1981 to 145 in 1991, despite these programs' favorable reimbursement status.

Nurse anesthesia is the only type of graduate nurse training receiving Medicare reimbursement under current policy (and is categorized by Medicare as paramedical training rather than nursing). In a survey of the 92 operational nurse anesthesia programs, the American Association of Nurse Anesthetists documented that 31 hospitals associated with nurse anesthesia programs received an estimated $2.2 million in Medicare reimbursement in 1992. Reimbursement amounts per program were modest, varying from a low of $15 390 to a high of $126 000.[32]

Characteristics of Hospitals Funded

More than 90% of Medicare funding for nursing education went to private, nonprofit hospitals. Most of the public hospitals receiving funding were state-owned teaching hospitals; these institutions received less than 4% of the funds. City and county public hospitals received approximately 8% of funding. Hospitals with more than 300 beds garnered 70% of nursing education reimbursement. Among the 145 hospitals supporting diploma programs funded by Medicare, only 13 were located in rural areas.

Only 24% of Council of Teaching Hospitals (COTH) member institutions received any Medicare reimbursement for nursing education in 1991; funds to these hospitals accounted for only 28% of all Medicare nursing education funding. Hospitals that belong to COTH received significantly lower average reimbursement amounts for their nursing programs than non-COTH hospitals, explained by the fact that the largest payments were directed to hospitals with diploma nursing schools. Most COTH hospitals are affiliated with university-based nursing schools, and are therefore generally ineligible for substantial Medicare funding.

Geographic Distribution of Medicare Reimbursement

Medicare reimbursement of nursing education is clustered geographically. Three states—Pennsylvania, New Jersey, and Ohio—account for one half of the total Medicare payments for diploma nursing education. Pennsylvania gets $1 of every $5 Medicare spends on nursing education. The clustering is explained by the location of the few remaining hospital diploma nursing programs. Sixty-six of the 144 funded diploma programs are located in these three states.

Hospital Variations in Medicare Reimbursement

Medicare reimbursement for nursing education also varies across hospitals. On the one hand, one third of hospitals receiving any reimbursement for nursing education averaged only $32 400, amounts quite small relative to the size of their operating budgets. On the other hand, 54 hospitals, accounting for 15% of all hospitals receiving Medicare funding, each received in excess of $1 million in 1991. Forty of these 54 hospitals had diploma nursing programs. Thus, the fact that 372 hospitals and their affiliated nursing programs received some Medicare payment for nursing education overstates the number of hospitals and programs substantially benefiting from current policy, since a large share received relatively small amounts.

Medicare Payment per Student Enrolled

The hospitals that benefit most from existing Medicare policy are those operating diploma nursing schools. Given the substantial resources directed to these few hospitals, we calculated the average Medicare payment per student to assess the relative efficiency of this type of educational investment. We estimated the average per student reimbursement amount for every diploma program by dividing total Medicare payments for nursing education by student enrollment figures (as reported by the National League for Nursing).[33] This is a rough estimate since Medicare funds do not pay nursing student stipends as is the case for Medicare funding of medical residents. The average per student annual Medicare payment to hospitals for diploma schools of nursing was $5028 in 1991, ranging from a low of $751 to a high of $22 876. Medicare reimburses only a portion of the costs of educational programs, generally around 30% depending on what proportion of a hospital's patients are Medicare beneficiaries. Hence, just as Mullan et al[34] estimated mean Medicare payments per resident physician at $18 600 but the mean rate of payment at $48 900,[34] the mean annual payment rate for diploma nursing students could be estimated to average approximately $15 000.

Our analysis has several limitations. First, it was not possible to conduct meaningful trend analyses of HCRIS data given the numerous changes in Medicare payment policy over time. Second, HCRIS data lack specificity on the types of programs for which hospitals report costs, categorizing these amounts into two broad categories: nursing or paramedical. Third, while hospitals calculate reimbursement for nursing and paramedical education as part of the cost-reporting process, it was difficult to estimate the actual payment amounts received by hospitals using the national HCRIS data elements. Currently, HCFA uses a crude estimation method, whereby a direct medical education payment is calculated that includes the costs of educating interns and residents, nurses, and paramedical personnel. This total is then broken down into nursing, paramedical, and intern/resident reimbursement figures based on the ratio of costs attributable to any one of these three program types over the calculated total direct medical education payment. We used this method in constructing our estimates. Finally, one must hold suspect the exactness of the costs reported, as these data are revised quarterly and are rarely audited for validity.

Even given these limitations in the data, our findings are straightforward enough to raise serious concerns about the appropriateness of current Medicare reimbursement policy for nursing education. First, we have confirmed that Medicare payments to hospitals for nursing education constitute the largest source of federal support for nursing education. Hence, Medicare is an important potential policy vehicle for shaping the nurse workforce to meet the needs of the nation's health care system in the 21st century. Medicare payments for nursing education are too large to be treated with the benign neglect that has characterized policies to date.

Second, our findings suggest that by biasing funding eligibility to hospital-operated programs, Medicare has become a source of unrestricted support for an increasingly smaller subset of hospital-based programs that lie outside the mainstream of health professions education. Only 372 of the 1484 nursing education programs training future RNs received any Medicare support. Hospital diploma programs, which received the majority of these funds, had enrollments of less than 23 000 out of a total enrolled nursing student population of 287 598, and were clustered in two regions of the country.

Third, Medicare's nursing education funding policies are at odds with na-

tional health care workforce priorities. Shortages have been projected for nurses trained at the graduate level in advanced clinical practice[18,19] and at the baccalaureate level for roles in out-of-hospital settings.[10] Such programs receive little support from Medicare. Indeed, Medicare funds support the education of a type of nurse estimated to be in excess supply.[8] Moreover, Medicare funds go entirely to hospitals—a questionable setting for educating nurses for ambulatory care. Finally, Medicare's policies are contrary to the recommendations of the Goldmark report[27] of 1922—which is to nursing education what the Flexner report[28] is to medical education. The Goldmark report recommended that the education of professional nurses take place in institutions of higher education.

CONCLUSION

At the approach of a new century, 65% of all new nurses in the United States are trained at less than the baccalaureate level despite much evidence that nurses' roles will be ever more complex and demanding. Other countries, including Australia, Spain, Portugal, Denmark, the Philippines, Ecuador, and Chile, have already shifted basic nursing education to the baccalaureate level.[29,30] If Medicare reimbursement policy for nursing education is to have an effect on national workforce goals and priorities, it must be retargeted. Graduate level clinical education and baccalaureate education would be targets consistent with the assessed needs of the nurse workforce of the future.

This research was supported by the Office of the US Department of Health and Human Services Assistant Secretary for Health. The views contained herein are those of the authors and do not necessarily reflect the policies of the funding agency. The authors gratefully acknowledge the cooperation of Gerard F. Anderson, PhD, and the National League for Nursing in the provision of data, and to Linzhu Tian, MA, for her assistance in data analysis.

References

1. Feldstein PJ. *Health Care Economics*. New York, NY: John Wiley & Sons; 1979.
2. *Statistical Abstract of the United States: 1993*. 113th ed. Washington, DC: US Bureau of the Census; 1993.
3. *The Registered Nurse Population: Findings From the National Sample Survey of Registered Nurses, March 1992*. Washington, DC: US Dept of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing; 1994.
4. *Final Report: Registered Nurse Chartbook*. Washington, DC: Office of the Assistant Secretary for Health; 1994.
5. *The Registered Nurse Population: Findings From the National Sample Survey of Registered Nurses, March 1988*. Washington, DC: US Dept of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing; 1990.
6. Berliner HS, Kovner CT, Goldman F, Balinksky W, Rosado T, Cook S. *The Supply and Demand for Health Workers in New York City: 1985-1997*. New York, NY: New School for Social Research; October 1994.
7. APM Management Consultants. *The Effect of Hospital Restructuring on Nursing: Executive Summary*. Chicago, Ill: APM Management Consultants; 1994.
8. *Seventh Report to the President and Congress on the Status of Health Personnel in the United States*. Washington, DC: US Dept of Health and Human Services, Public Health Service, Health Resources and Services Administration; 1990.
9. *Health Personnel in the United States: Eighth Report to Congress, 1991*. Washington, DC: US Dept of Health and Human Services, Public Health Service, Health Resources and Services Administration; 1992.
10. Pew Health Professions Commission. *Health Professions Education for the Future: Schools in Service to the Nation*. San Francisco, Calif: Pew Health Professions Commission; 1993.
11. *Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis (Health Technology Case Study 37)*. Washington, DC: Office of Technology Assessment; 1986.
12. Ganem JL, Krakower JK, Beran RL. Review of US medical school finances, 1992-1993. *JAMA*. 1994; 272:705-711.
13. Institute of Medicine. *Report of a Study of the Costs of Education in the Health Professions*. Washington, DC: National Academy of Sciences; 1974.
14. National Center for Education Statistics, US Dept of Education. *Current Funds Revenues and Expenditures of Institutions of Higher Education: Fiscal Years 1984-1992*. Washington, DC: National Center for Education Statistics, US Dept of Education; 1994:8, 10.
15. Health Care Financing Administration. Medicare program: payment for nursing and allied health education. *Federal Register*. September 22, 1992; 57:43659-43673.
16. National League for Nursing, Division of Research. *Nursing Data Review: 1994*. New York, NY: National League for Nursing Press; 1994.
17. National League for Nursing, Division of Research. *Nursing Data Review: 1991*. New York, NY: National League for Nursing Press; 1991.
18. Yett DE. *An Economic Analysis of Nurse Shortage*. Lexington, Mass: Lexington Books; 1975.
19. American Hospital Association. *AHA Hospital Statistics, 1972*. Chicago, Ill: American Hospital Association; 1972.
20. American Hospital Association. *AHA Hospital Statistics, 1994-95 Edition*. Chicago, Ill: American Hospital Association; 1994.
21. *Report to the Congress on Nursing and Other Nonphysician Health Professions Educational Programs Reimbursed Under Medicare*. Washington, DC: US Dept of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Professions; 1988.
22. American Association of Nurse Anesthetists. Statement of the American Association of Nurse Anesthetists before the Physician Payment Review Commission regarding Issues to be Addressed in PPRC's 1994 Annual Report (testimony presented by Linda L. Callahan, AANA President); November 29, 1993.
23. National League for Nursing, Division of Research. *State Approved Schools of Nursing: RN, 1993*. New York, NY: National League for Nursing Press; 1993.
24. Mullan F, Rivo ML, Politzer RM. Doctors, dollars, and determination: making physician workforce policy. *Health Aff (Millwood)*. 1993;12(suppl): 136-151.
25. Aiken LH, Salmon ME. Health care work force priorities: what nursing should do now. *Inquiry*. 1994;31:318-329.
26. Clawson DK, Osterweis M, eds. *The Roles of Physician Assistants and Nurse Practitioners in Primary Care*. Washington, DC: Association of Academic Health Centers; 1993.
27. Goldmark J. *Nursing and Nursing Education in the United States: Report of the Committee for the Study of Nursing Education*. New York, NY: Garland; 1984. Reprint of 1922 publication.
28. Flexner A. *Medical Educations in the United States and Canada*. New York, NY: Carnegie Foundation; 1910.
29. Fagin C. *Nursing Leadership: Global Strategies*. New York, NY: National League for Nursing; 1990. Publication 41-2349.
30. *Nursing in the World: The Facts, Needs, and Prospects*. 3rd ed. Tokyo, Japan: The International Nursing Foundation of Japan; 1993.

FAX TRANSMITTAL # of pages ▶ 11
To Jennifer Klein From D. England
Dept./Agency Phone # 301 443-2186
Fax # 202-456-2878 Fax #
NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

CHAPTER 2

The Social Mandate and Historical Basis for Nursing's Role in Health Promotion

Julie Cowan Novak, RN, MA, CPNP, DNSc

Nursing is concerned with the adaptation of individuals and groups to actual as well as potential health problems, the environments that influence the individual's health, and the nursing interventions that promote health.[1] Schlotfeldt[2] defines nursing as "assessing and enhancing the general health status, health assets, and health potentials of human beings." Both definitions of nursing emphasize the promotion of health, which is defined by Pender[3] "as activities directed toward developing resources of clients that maintain or enhance well being and self actualization." Nursing's renewed emphasis on health promotion had its roots in the teachings of Florence Nightingale. However, in the 20th century, this unique concern was preempted by an illness orientation that was dependent on other professions for existence and on hospitals for training (education) and sustenance. This article documents the social mandate and historical basis for nursing's role in health promotion from the mid-19th century to the present.

Florence Nightingale's Views on Health Promotion

Historians acknowledge Florence Nightingale as the founder of modern nursing and one of the world's greatest humanitarians.[4] Nursing's tradition of espousing health promotion is directly attributable to her. She clearly articulated nursing's practice domain.[5] Nursing's basic philosophy was defined by Nightingale[6] as "the same laws of health or of nursing, for they are in reality the same, obtain among the well as among the sick. . . ." She believed nurses must put the patient in the best condition for nature to act upon him or her.[7] Nightingale identified basic principles of nursing, such as creating those conditions in which the restoration and preservation of health and the prevention of disease and injury were possible.[4] She stated that "health is not only to be well, but to use well every power that we have."[6] She perceived the nurse as the key to establishing a healthy, disease-free citizenry. "She visualized the nurse as primary care agent, the nation's first bulwark in health maintenance, in the promotion of wellness, and in the prevention of disease."[4] Nightingale stated, "One duty of every nurse certainly is prevention."[6]

Nightingale's early interest in the prevention of disease transmission among the troops of the Crimea raised important questions about the impact of the environment and the prevention of ill health in the nonaffected. When she was called to the Crimean War in 1854 by Sir Sidney Herbert, the British Secretary of State for War, the death rate in the military hospitals was 42 per cent. In six months, she, her group of nurses, and others, including the Sanitary

Reprinted from *Journal of Professional Nursing*, Vol. 4, No. 2, with permission of W.B. Saunders Co. © 1988.

JUN-17-1996 17:52 DHHS/PHS/HRSA/BHPR P.02/11

Commission, had reduced the death rate to 2.2 per cent.[8] She established programs directly affecting the health and welfare of the British soldiers. The initiation of effective laundry, housing, nutrition, physical fitness, and recreational facilities for the British soldiers was among her far reaching reforms. Her Crimean experience forged her belief in the value of cleanliness into a "rigid, inflexible dogma of sanitation."[1] She proposed that nursing was a significant way to improve the health of the British population, which was the source of the British Army.[9]

In her writings on rural nursing, Nightingale, an early proponent of health as a rightful sphere for women, contended that "since God did not mean mothers to be always accompanied by doctors the health of the nation depended on womankind, that women should be instructed in the 'art of health' and the person to best accomplish this instruction was the nurse in the home."[7] She wrote of the importance of teaching the cottage mothers specific, proper sanitation methods, and she discussed child health teaching that could be done by the "health missioners" under the supervision of the district nurse. She spoke of the importance of removing the things that cause disease: dirt, drink, diet, damp draughts, drains. She demonstrated a knowledge of child development, a field not yet in existence, with her statement that "a child learns before it is three whether it shall obey its mother or not. And before it is seven its character is a good way to being formed."[8]

Nightingale's concern for all aspects of environmental health was exemplified when she advocated, "As for the workshops, work people should remember health is their only capital, and they should come to an understanding among themselves not only to have the means to secure pure air in their places of work, which is one of the prime agents of health. Denial would be worth a 'trade union,' almost worth a strike."[8]

Nursing's Social Mandate for Health Promotion

In the latter part of the 19th century, three forces stimulated interest in community health throughout Western Europe and the New World. First among these movements was a deepening consciousness and a spirit of reformism on the part of social philanthropists to the problems affecting the lives of many people. Social problems such as poverty, inadequate housing, evils of the industrial revolution, child labor, deplorable prison conditions, and lack of opportunity for education for the general public were paramount. Another major force was the development of medicine from an emphasis on cure to the beginnings of disease prevention. The third significant movement was the development of nursing as a profession and a discipline.[6] Brainerd[10] asserted that the "new humanity" taught disease is not a visitation from an angered God but is the result of people's own carelessness in not following the right principles of hygiene, sanitation, and healthful living.

In the 18th century, health care in the original colonies was provided by wives and mothers in their own homes and by untrained servants in hospitals.[5] Lemuel Shattuck (1793-1859) was an early American public health reformer and a former teacher who sold books. In 1842, he was instrumental in achieving the passage of a law in Massachusetts that resulted in statewide registration of vital statistics. In 1845, he compiled and published a census of Boston that encouraged and stimulated accurate reporting of statistics in the United States. His census presented the shocking facts of a high mortality rate with an extremely high infant and maternal mortality rate.[11]

Shattuck's greatest achievement came in 1850, when his report was published by the Massachusetts Sanitary Commission.[11] The Shattuck Report, one of the first public health documents in the United States, was an important milestone in the evaluation of the field of public health. It earned Shattuck the title, Father of Public Health. He recommended state and local health departments or boards of health be organized, he established the need for sanitary surveys, and he recommended that Massachusetts General Hospital and other similar institutions educate nurses to care for the sick.[11] There was no immediate societal response to the recommendation about educating nurses, although there had been earlier efforts to train women as nurses. American-trained nurses emerged as a formalized system of work in 1873, as part of the reform era that followed the Civil War.[12] Many socially responsive upper-class reformers, with the leadership of Shattuck and others, enhanced an

JUN-17-1996 17:52 DHHS/PHS/HRSA/BHPR P.03/11

upsurge in the social consciousness during a period of enormous social change in America. The events of the previous ten years—the Crimean War, the educational endeavors of Florence Nightingale, and the Civil War with the development of the Sanitary Commission in 1861—had also focused attention on the necessity for nurses and on the importance of an educational system in which to prepare them (Palmer I, personal communication, 1987).

Early images of public health nurses, conducting infant immunization clinics, case finding, and providing health education for the prevention of tuberculosis and other diseases are also part of nursing's rich heritage in health promotion. In the United States, visiting nursing began its development in Philadelphia in 1839.[13] In 1877, the Women's Branch of the New York City Mission sent its first trained nurses into the homes of the indigent. In 1890, 21 cities used visiting nurses.[8] By 1892 the Nurse's Settlement House in New York City was serving people from all socioeconomic and ethnic groups. In 1892, because of a large volume, the Settlement House was moved to Henry Street with the help of philanthropist Jacob Schiff and others. Soon nine graduate nurses were living at Henry Street, including Lavinia Dock.[14] In the first five years, the staff at Henry Street, led by Lillian Wald and Mary Brewster, cared for over 196,000 persons.[15]

The extensive absenteeism of children from school due to illness and their readily correctible health problems led Lillian Wald in 1902 to conduct a school nurse experiment. Wald believed that nurses could help improve the health and attendance of school children.[16] School nursing was institutionalized soon thereafter. Statistical comparison of the numbers of students excluded with communicable disease in the New York City Schools before and after the hiring of school nurses revealed a 90 per cent decrease in the number of necessary exclusions.[17] This experiment had a dramatic impact on the school budget at the time and still has implications today.

By 1909, the Henry Street Settlement had grown from two nurses to a large organization with many departments.[18] In the same year, at the suggestion of Wald, who was concerned with the health of the worker, the Metropolitan Life Insurance Company organized its Visiting Nurse Department and entered into an agreement with the Henry Street Settlement. After a successful three-month trial period, policy holders in 14 cities were receiving the services of the visiting nurses. By 1912, 589 Metropolitan Nursing Centers were established[8] for the purpose of preventing disability or premature death. These programs continued after World War II, when changing social, economic, and health conditions made them no longer feasible. Many communities, however, had learned the value of nursing services and took over their support through public and private means.

Progressive reform also steered public health fervor toward an intense concern for child welfare. The 1909 White House conference produced disturbing data on infant and maternal mortality rates in the United States. It was estimated that 300,000 children under one year of age died each year in the United States, and at least half of these deaths were preventable. By 1910, milk stations for the distribution of clean, safe milk existed in 31 cities. From milk dispensaries, these stations often evolved into health promotion centers as the emphasis on health education and screening examinations grew.[5]

The public's concern with disease control and the widely accepted germ theory spawned a number of lay organizations that took up battle against single diseases. These associations offered new opportunities in health promotion. Antivenereal disease campaigns stressed health education, case finding, and treatment. Public health reformers began to shift attention from the larger urban environment to the home setting.

Restraining legislation for child labor was also initiated. The Children's Bureau, founded in 1912 through Lillian Wald's influence, gave organizational form and tax funding to child welfare services.[19] Later that year, the National Organization of Public Health Nursing was formed with Wald as its first president.

The growing sense of social injustice was exemplified in the development of the Red Cross at the Geneva Convention, and the establishment of the American Red Cross in 1881 led to the care of the sick at home. In 1912, at Lillian Wald's suggestion, the Red Cross established a rural nursing service to provide nurses to care for the sick and to give instruction in sanitation and hygiene in the homes of people living in rural areas. Wald secured financial support for this program. As a result of these health

promotion efforts, areas served by rural nurses showed decreases in infant mortality and the general death rate, as well as improvements in sanitation, hygiene, and nutrition.[8]

Industrial nursing was also created at the turn of the century. In 1895, Proctor, the Governor of Vermont, who held a high regard for visiting nursing services, introduced "district nursing" into several villages whose residents comprised employees of his Vermont Marble Company. In its early form, industrial nursing placed minimal emphasis on the care of injuries, but rather stressed health promotion activities implemented in the employees' homes.[20]

By 1912, the public health nursing movement could look with pride to two decades of major impact on the health of the nation's citizens. Because of their efforts, there were significant declines in the incidence of tuberculosis, diarrheal diseases of children, and typhoid fever — campaigns in which public health nurses had played an active role.

Inadequate maternity care and actions taken to improve this care greatly influenced the development of nurse-midwifery in this country.[21] In 1910, nurse Margaret Sanger began her historic fight for the right of families to limit their size, the rights of women to health care and personal choice, and the rights of children to be loved and wanted. Sanger[22] stated, "The first right of every child is to be wanted — to be desired with an intensity of love that gives it its title of being and joyful impulse of life." In 1916, Sanger organized the Planned Parenthood Foundation of America, which established hundreds of family planning centers throughout the United States.[21]

The War Effort

Although involvement in World War I checked most progressive health reform, it gave the movement a message of urgency. The health status of recruits provided a snapshot of the health of the nation. Physical examination of these recruits on induction revealed that 29 per cent were physically unfit for military duty. Epidemiologic studies revealed a high rejection rate from rural areas due to a higher incidence of tuberculosis and typhoid.[19] The war also spurred efforts to confront venereal disease, with ever vigilant public health nurses playing the major role in case finding. At the time, the incidence of gonorrhea was estimated to be in the range of 40 to 60 per cent in the entire male population. In response to this staggering finding, Congress passed the Chamberlain-Kahn Act of 1918, which provided funding to state-administered programs of education, case finding, and treatment.[19]

Adelaid Nutting, Annie Goodrich, and Lillian Wald met in 1917 to determine methods of providing effective nursing service to the military. Twenty-two thousand nurses entered the nursing corps from 1917 to 1919. Goodrich[15] wrote if this number could be "encompassed for the service of preventive medicine, one might predict as remarkable an influence upon community health, as the introduction barely a half a century ago of the service of the student nurse into the hospital."[16] Although nurses would never forget the nightmare of treating mass casualties of the fighting and diseases abroad, as well as the influenza epidemic at home, they would remember their crucial battles to save lives and "lighten the toll of war and pestilence."[3]

Health Promotion in the 1920s and 1930s

During the 1920s, the primary duties of the public health nurse moved to advising and instructing people on how to avoid illness through personal hygiene. Large-scale health demonstrations, supported by philanthropic foundations, insurance companies, or state funds, provided intensive programs of health education. The goal was to impress upon communities the importance of health promotion so that the program might be permanently adopted by the demonstration community. In 1921, Congress passed the Sheppard-Towner Act for federal aid for maternal and child health.[21] The funding was distributed nationwide through the state departments of health. Supporters of the bill reminded their audiences that 29 per cent of military inductees were unfit for military service and pointed out that healthy children would grow into healthy adults, the mothers and soldiers of the next generation. This approach, reminiscent of Nightingale's, was successful and resulted in organized prenatal and infant care programs in 45 states.

This constituency provided an excellent audience for the health promotion message. The focus on child

JUN-17-1996 17:54 DHHS/PHS/HRSA/BHPR P.05/11

rearing gave nurses access to entire families, which improved opportunities for case finding and health education. As a result, maternal and infant welfare programs became the primary activity of public health nurses through the 1920s and 1930s. Throughout the lifetime of this legislative act, three million home visits were made to 700,000 expectant mothers and four million infants. The infant mortality rate dropped from 100/1000 live births in 1915 to 69/1000 live births in 1926. Opposition to the program was led by Senator Reed of Missouri and others, who were supported by the American Medical Association. These opponents asserted that the program was "unsound in policy, wasteful, extravagant, and promoted communism" (Palmer I, personal communication, 1986). Sadly, the program was not renewed after the Congress allowed it to lapse in 1929.[8]

In 1925, Mary Breckenridge, a nurse-midwife, organized the Frontier Nursing Service in southeastern Kentucky. Because no quality nurse midwifery programs were available in the United States until the 1930s, the early nurses received their training in England and Scotland. The nurse-midwives gave antepartal, intrapartal, and postpartal care and provided child health visits. During these visits, diet, cleanliness, sanitation, and preventive care were discussed. In 1932, Dr. Louis Dublin,[23] of Metropolitan Life, studied the first 1000 deliveries of the Frontier Nursing Service. He concluded that none of the women had died as a direct result of pregnancy or labor. The two deaths in the series were secondary to chronic heart disease. He asserted, "If such a service were available to the women of the country there would be a saving of 10,000 mothers' lives a year in the United States; there would be 30,000 less stillbirths and 30,000 children alive at the end of the first month of life."[23]

Unemployment, increasing rapidly after the stock market crash of 1929, created a major relief problem in the United States. In 1930, almost four million people were unemployed, and the failure of over 1400 banks by 1932 created major financial crises. People, including nurses, had no money for food, clothing, shelter, or health care. Payment for nursing care in the home was recognized as a legitimate relief expenditure under the Federal Emergency Relief Administration (FERA) in consultation with the United States Public Health Service. In West Virginia, the Relief Nursing Service began in 1933 to meet the nursing care needs of families on relief and to meet the employment needs of nurses. This was essentially a visiting nurse program. Fundamental services included bedside nursing care, health supervision for the family, arrangement of medical and hospital care for emergencies and obstetrical cases, health supervision of children in relief nurseries, and caring for patients with tuberculosis. In many counties, classes were offered in parenting, home care, and first aid.[8]

The Social Security Act of 1935 and its amendments in succeeding years included provisions for public assistance, social services, and a means of strengthening family life. The provisions affected maternal and child health programs throughout the country, rural and urban. A number of nurses who were involved in the work relief projects were eager to acquire formal public health training. During the first year of the Social Security program, 1100 nurses received stipends to study at universities offering public health nursing programs. In 1934, only 7 per cent of the more than 5000 employed public health nurses had completed an approved postgraduate program. Within two years after the implementation of the Social Security Act, 2304 public health nurses received postgraduate training in public health nursing.[8]

With the heightened attention to health promotion and preventive care, nurses aligned with the public health movement looked toward a promising future. The traditional conception of nursing as Christian service was recalled. One manual urged nurses to lead the great procession toward the "promised land of municipal health." During this era, public health nurses described their relationships with patients in terms reminiscent of traditional private duty nurses' sense of womanly duty and intimate involvement with patients.[24] The language also reflected the growing professionalism of reform. Nurses sought a more scientific method, a rational approach to the goal of better health. In its funding and philosophy, health promotion programs moved from their charitable origins toward a view of health as a concern of the state, a method of ensuring national productivity and security.[19] Manuals emphasized health education as the special contribution of the public health nurse, minimizing the traditional tasks of bedside nursing:

"The nurse who tends the sick only, and teaches nothing and prevents nothing, is abortive in her work."[24]

Public health nurses and private physicians were divided by fundamentally different social visions. Many physicians clung to a paternalistic approach to reform. The 1934 National Organization of Public Health Nursing survey explored physician's objections to public health programs. The data revealed that medical resistance was strongest against staff-supported boards of education. School nurses attended to students of all income levels, arousing the doctors' age-old fears of competition for the health care dollar. School nursing programs, funded by local governments, were also a red flag to physicians. Doctors reacted more favorably to visiting nurses associations, which serve predominantly poor clientele, dependent on private sources of funding, and frequently based on standing orders from physicians.[25]

The 1920s and 1930s was a time of delicate balance for public health nurses. The distance of public health from mainstream medicine had revealed opportunities. The success of the public health movement undermined its special character in the 1940s and 1950s. As public health became more acceptable, it was absorbed into the growing hospital system and into the philosophy of mainstream curative medicine. With this cooptation in public health, many nurses lost autonomy; they were forced to return to subordinate positions in a bureaucratic system of delivery.[19] Once powerful, nursing departments of public health were absorbed into the larger umbrella department of health under physician control.

The Nation's Health in the 1940s

During the period from 1923 to 1943, the average life expectancy in the United States rose from 55 to 65 years. The average newborn baby could expect to live a decade longer than a child born during World War I. Despite this achievement, the results of the local Selective Service Boards and induction centers indicated that the health of the nation's young men was no better at the start of World War II than it had been during World War I.[8]

World War II, like World War I, led to centralization of medical services in support of the military. Servicemen's families became eligible for a broad program of maternity and infant care. In 1941, an emergency health and sanitation bill was passed that provided funds to supplement public health nursing services for the families of workers in major defense industries.[8] Nurses played important roles both at home and abroad throughout World War II.

Federal Mandate for Health Promotion

Recent trends in legislation at the national level are part of the press and priority both nurses and our nation face in the current and coming century. A national agenda identifies goals of reducing morbidity and premature mortality in all age groups. Nursing's heritage in health promotion has affected our current health priorities. It is from history that we gain our vision and mission of our future. Green[26] organized recent history into four eras of federal investment in health. Era one, the 1940s and 50s, was characterized by resource development with federal government resources such as personnel, facilities, and knowledge. Personnel were developed through the provision of the health manpower and public health manpower training acts and facilities development through the Hill-Burton Act. Emphasis was on medical or disease care, not health care or health promotion. Knowledge was developed through the establishment of the National Institutes of Health in 1945. Today, the National Institutes of Health constitute the most powerful and most generously budgeted institution within the Public Health Service. Once again, however, knowledge development within this institution was primarily biomedical.[26] The dominant medical ideology in the United States in the 40 years following World War II has focused on cure rather than prevention or health promotion.

Era two, the 1960s, was an age of ferment, with the federal government fighting poverty with visions of a Great Society.[26] Emphasis turned to redistribution of resources. Medicare and Medicaid were passed, greatly improving the health-purchasing power of the poor and medically indigent. Neighborhood health centers sprang up, and "comprehensive" health planning occurred along with comprehensive mental health centers. This was an era of consumer involvement and consumer advisory groups. Era two inflated

JUN-17-1996 17:56 DHHS/PHS/HRSA/BHPR P.07/11

the medical (not health) care dollar higher than the general inflation rate.[26]

Cost containment is central to the third era, the 1970s and 80s, as health care is big business in the United States.[26] "Capping" medical care spending has become a primary objective. The significance of patient education was rediscovered in the 1970s as an alternative regulatory approach to cost containment. In 1971, the President's Commission on Health Education was appointed to advise the Administration on health education. Multiple task forces and committees between 1972 and 1976 culminated in the passage of the National Health Information and Health Promotion Act of 1976.[26] In the same era, the Health Maintenance Organization Act was passed, which specified that preventive and educational services were formally required for health maintenance organizations receiving federal certification. Again, in 1971, the President's Commission on Health Education recommended the establishment of the National Center for Health Education.[27] In 1974, the National Health Planning and Resource Development Act declared public health education a national health priority. The Office of Health Information and Health Promotion in the Department of Health, Education, and Welfare was established by PL-317. Interestingly, a century ago, Florence Nightingale advocated health education for the public, control and prevention of disease, sanitation, and the institutionalization of health agencies as a governmental obligation.

During the 1970s, the maturation of nursing saw a growing emphasis on theory development, research, and doctoral education. A developing segment of the profession saw itself as entirely different from the nurse of the previous era. No longer did they accept the widespread assumption that nursing was a lesser profession than medicine and subservient to it.[8]

An evolving role that placed an emphasis on health promotion, autonomy, and advanced education for nurses was that of the "nurse practitioner." This title was first used in a demonstration project at the University of Colorado, codirected by Loretta Ford, RN, and Henry Silver, MD. This grant-funded project was designed to prepare nurses to give comprehensive well-child care, to give anticipatory guidance and health promotion in ambulatory settings, and to make sophisticated clinical judgments when seeing children with common childhood illnesses.[28]

A study to evaluate the pediatric nurse practitioner program confirmed the value of the new role. By the late 1960s and early 1970s, nurse practitioners had assumed national visibility to consumers, other health professionals, and legislators. Practice patterns regained some of the autonomy enjoyed by early public health nurses and the Frontier Nursing Service. As the movement gained momentum, Elliott Richardson, Secretary of the Department of Health, Education, and Welfare, requested a group of leaders in health care to examine the possibilities of nursing role expansion. The resulting report, Extending the Scope of Nursing Practice, concluded that enlarging the nurse's role was essential for providing equal access to health services for all citizens. The committee urged establishment of curricular innovations by health education centers and increased financial support for nursing education.[29]

Era four, the 1980s, is the era of disease prevention and health promotion in the United States.[26] Marked by the publications of Healthy People and Objectives for the Nation, this is the era of not only promise but also of fruition for primary health promotion in our country.[30] After years of a disease-oriented health care system in this country, nursing's ongoing commitment to health promotion is receiving increasing support due to consumer demand.

Conclusion

Nightingale's strong foundation, the impressive accomplishments of the public health nursing leaders, and extensive community nursing services, have all contributed to nursing's role in health promotion. Nursing's emphasis must be on comprehensive health promotion rather than on patchwork remedies.[31] Nursing is on its way toward becoming recognized as a well-defined, academic discipline whose practitioners are making significant contributions toward improving the health status of all persons, thus attaining the health objectives of the nation. The Surgeon General in 1980 asserted that half of the mortality in the United States is due to an unhealthy lifestyle. Our nation needs a cadre of professionals whose role is to appraise and enhance the health status, health assets,

and health potentials of all humans.[32] Nurses are the health professionals to take that role.

Acknowledgment

The author thanks Irene Palmer, RN, PhD, University of San Diego Phillip Hahn School of Nursing, for her review and editorial assistance with this article.

REFERENCES

1. American Nurses' Association: Social Policy Statement. Kansas City, American Nurses' Association, 1980
2. Schlotfeldt R: Nursing in the future. Nurs Outlook 29:295-301, 1982
3. Pender N: Health promotion and illness prevention. *In* Werley H, and Fitzpatrick J (eds): Annual Review of Nursing Research. New York, Springer, 1984, p 84
4. Palmer I: From whence we came. *In* Chaska N (ed): The Nursing Profession: A Time to Speak. New York, McGraw-Hill, 1983
5. Schlotfeldt R: Critical issues in nursing practice, education, and research. Occup Health Nurs 32:11-16
6. Nightingale F: Notes on Nursing: What It Is and What It Is Not. London, Harrison, 1860
7. Seymer L: Selected Writings of Florence Nightingale. New York, MacMillan, 1954, pp 353-386
8. Kalisch P, Kalisch B: The Advance of American Nursing, ed 2. Boston, Little Brown & Co, 1986
9. Palmer I: Florence Nightingale: reformer, reactionary, researcher. Nurs Res 26:84-89, 1977
10. Brainerd A: The Evolution of Public Health Nursing. Philadelphia, Saunders, 1922, p 102
11. Shattuck L: Report of the Sanitary Commission of the State of Massachusetts. Boston, Massachusetts Sanitary Commission, 1850, p 228
12. Baer E: Nursing's divided house—an historical view. Nurs Res 34:32-38, 1985
13. Palmer I: Origins of the education of nurses. Nurs Forum 22:102-110
14. Wald L: Windows on Henry Street. Boston, Little, Brown & Company 1934
15. Goodrich A: The social and ethical significance of nursing. New York, MacMillan, 1932
16. Dock L: School nurse experiment in New York. Am J Nurs 2:108-110
17. Gardner M: Public Health Nursing, ed 2. New York, MacMillan, 1926
18. Wald L: House on Henry Street. New York, Holt, 1934
19. Melosh B: The Physician's Hand. Philadelphia, Temple University, 1982
20. Brown M: Nursing in occupational health. Public Health Rep 79:967-972, 1964
21. Varney H: Nurse Midwifery, ed 2. Boston, Blackwell, 1987
22. Sanger M: The New Motherhood. London, Jonathan Cape, 1922, p 58
23. Dublin L: The Effect of Life Conservation on the Mortality of the Metropolitan Life Insurance Company. New York, Metropolitan Life Insurance Company, 1917, p 11
24. Gardner M: Public Health Nursing, ed 3. New York, MacMillan, 1936
25. National Organization of Public Health Nursing: Survey of Public Health Nursing: Administration and Practice. New York, Commonwealth Fund, 1934, p 131
26. Green L: Emerging Federal Perspectives on Health Promotion. Health Promotion Monographs. New York, Teachers College, 1981, pp 11-13
27. Green L, Drueter M, Deeds S, et al: Health Education Planning: A Diagnostic Approach. Palo Alto, CA, Mayfield, 1980
28. Silver H, Ford L, Stearly S: A program to increase health care for children: the PNP program. Pediatrics 39: 756-760, 1967
29. Department of Health, Education, and Welfare: Extending the scope of nursing practice. Washington, DC, Department of Health, Education, and Welfare, HSM 73-2037, 1971
30. Surgeon General: Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. Washington, DC, Department of Public Health and Human Service, 1980
31. Murray R, Zentner J: Nursing Concepts for Health Promotion. Englewood Cliffs, NJ, Prentice Hall, 1979, p 17
32. Schlotfeldt R: A brave new nursing world. AACN-NLN 82:1-13, 1982

DIVISION OF NURSING

DATE:	JUN 13 1996		
TO:	Molly Brostrom Domestic Policy Council The White House	**FROM:**	Marla E. Salmon, ScD, RN, FAAN Director, Division of Nursing Parklawn Bldg., Rm. 9-35 5600 Fishers Lane Rockville, MD 20857
TEL:	~~443-2714~~	**TEL:**	301-443-5688
FAX:	~~443-8151~~ 202-456-7028	**FAX:**	301-443-8586
Number of Pages (Including Cover):			

Molly,

Per our conversation from yesterday see attached information.

Marla

P.S. The President may have signed a proclamation for AMA — there is also one in the works for the 50th anniversary of the Division of Nursing (am not sure of its status) — I could include any thing on these points — but you might need to know anyway)

ANA Talking Points

6/13/96

1. Celebration of two major milestones:

   -100 Years of service as nursing's professional organization
   -50 Years representing nursing in collective bargaining

2. Recognition of ANA's important contributions to the health of American's

   -History of working to improve nursing care
   -History of working to assure that all peoples receive nursing and health care
   -History of advocating for the rights of patients and underserved peoples

3. Recent contributions to Administration's work in improving health care for American's

   -ANA led the way in developing "Nursing's Agenda for Health Care Reform", which was adopted by numerous nursing and other organizations in 1991 (see attached)

      - universal access
      - community involvement and personal responsibility
      - reduction of health care costs
      - insurance reform
      - establishment of quality assurance mechanisms

   -ANA worked in partnership with the Administration to achieve reforms in health care, both in the Health Care Reform Taskforce activities and specific legislative and programmatic initiatives

4. ANA plays a critical role today in the rapidly changing health care system

   -Advocates for the safety and wellbeing of patients, families and communities
   -Advocates for improvement of the health care system toward the shared goals of reduced cost, improved quality and universal access
   -Serves as the lead voice for nurses at the bedside and in communities who work hard to assure the best patient care possible for all people

5. The Clinton Administration has a special regard for ANA and all of nursing

-Views nursing as the backbone and heart of the health care system
-Has made important commitments of resources and opportunities to assure that nursing care is available to all people

-Increased the Division of Nursing's Budget by 14 million dollars to enhance nursing education and practice
-Made possible the Institute of Medicine Study on the Adequacy of Nurse Staffing
-Is developing a research agenda to help "capture" nursing's contributions to the the care of people
-Has appointed nurses to key positions, including naming Shirley Chater to head the Social Security Administration and two nurses as the Administrators for two of the Federal Regions

6. Very special time for nursing nationally and in the Federal Government

-Along with ANA's 100th Anniversary, it is the Federal Division of Nursing's 50th Anniversary

-Division of Nursing is the key federal focus for nursing education and practice

-Year of celebration and recognition for the important work that the Division has done - which has in some way touched the lives of every nurse in this country

-Geri Marullo, ANA's Executive Director, is a member of the National Advisory Council on Nurse Education and Practice, which advises the Division of Nursing and the Secretary for HHS

-Along with the 50th Anniversary of the Division of Nursing is a reaffirmation of the commitment of the Federal Government to nursing - as the Division of Nursing's motto says: "Caring for the Nation through Nursing"

Nursing's Agenda for Health Care Reform

EXECUTIVE SUMMARY

America's nurses have long supported our nation's efforts to create a health care system that assures access, quality, and services at affordable costs. This document presents nursing's agenda for immediate health care reform. We call for a basic "core" of essential health care services to be available to everyone. We call for a restructured health care system that will focus on the consumers and their health, with services to be delivered in familiar, convenient sites, such as schools, workplaces, and homes. We call for a shift from the predominant focus on illness and cure to an orientation toward wellness and care. The basic components of nursing's "core of care" include:

- A restructured health care system which:
  - -- Enhances consumer access to services by delivering primary health care in community-based settings.
  - -- Fosters consumer responsibility for personal health, self care, and informed decision making in selecting health care services.
  - -- Facilitates utilization of the most cost-effective providers and therapeutic options in the most appropriate settings.

- A federally-defined standard package of essential health care services available to all citizens and residents of the United States, provided and financed through an integration of public and private plans and sources:
  - -- A public plan, based on federal guidelines and eligibility requirements, will provide coverage for the poor and create the opportunity for small businesses and individuals, particularly those at risk because of preexisting conditions an those potentially medically indigent, to buy into the plan.
  - -- A private plan will offer, at a minimum, the nationally standardized package of essential services. This standard package could be enriched as a benefit of employment or individuals could purchase additional services if they so choose. If employers do not offer private coverage, they must pay into the public plan for their employees.

- A phase-in of essential services, in order to be fiscally responsible:
  - -- Coverage of pregnant women and children is critical. This first step represents a cost-effective investment in the future health and prosperity of the nation.
  - -- One early step will be to design services specifically to assist vulnerable populations who have had limited access to our nation's health care system. A "Healthstart Plan" is proposed to improve the health status of these individuals.

- Planned change to anticipate health service needs that correlate with changing national demographics.

- Steps to reduce health care costs include:
  - -- Required usage of managed care in the public plan and encouraged in private plans.
  - -- Incentives for consumers and providers to utilize managed care arrangements.
  - -- Controlled growth of the health care system through planning and prudent resource allocation.
  - -- Incentives for consumers and providers to be more cost efficient in exercising health care options.
  - -- Development of health care policies based on effectiveness and outcomes research.
  - -- Assurance of direct access to a full range of qualified providers.
  - -- Elimination of unnecessary bureaucratic controls and administrative procedures.

- Case management will be required for those with continuing health care needs. Case management will reduce the fragmentation of the present system, promote consumers' active participation in decisions about their health, and create an advocate on their behalf.

- Provisions for long-term care, which include:
  - -- Public and private funding for services of short duration to prevent personal impoverishment.
  - -- Public funding for extended care if consumer resources are exhausted.
  - -- Emphasis on the consumers' responsibility to financially plan for their long-term care needs, including new personal financial alternatives and strengthened private insurance arrangements.

- Insurance reforms to assure improved access to coverage, including affordable premiums, reinsurance pools for catastrophic coverage, and other steps to protect both insurers and individuals against excessive costs.

- Access to services assured by no payment at the point of service and elimination of balance billing in both public and private plans.

- Establishment of public/private sector review -- operating under federal guidelines and including payers, providers, and consumers -- to determine resource allocation, cost reduction approaches, allowable insurance premiums, and fair and consistent reimbursement levels for providers. This review would progress in a climate sensitive to ethical issues.

Additional resources will be required to accomplish this plan. While significant dollars can be obtained through restructuring and other strategies, responsibility for any new funds must be shared by individuals, employers, and government, phased in over several years to minimize the impact.

Copyright 1991, American Nurses Association (PR-12-91). Order 1-800-637-0323.

AMERICAN NURSES ASSOCIATION

600 Maryland Avenue SW
Suite 100 West
Washington, DC 20024-2571
202 651-7000 • Fax: 202 651-7001

Virginia Trotter Betts, JD, MSN, RN
President

Geri Mesaglio, MS, RN
Executive Director

TEN IMPERATIVES FOR ADMINISTRATION 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.

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.**

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.**

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.**

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.**

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.

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.**

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 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.**

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.

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.

For Internal Use Only

ANA IMPERATIVES
Summary of Status

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

Summary Response: Yes, the Administration has opposed threats to patient safety and quality -- in particular in the fight to maintain nursing home standards.

Breakdown of Imperative:

a) Request for Administration support for legislation (working with Wellstone on; not yet introduced) that would:

i) require providers to make available to the public certain information regarding nurse staffing and patient outcomes;

Doubtful, given VP's regulatory reform.

ii) protect "whistleblowers" employed by a health plan, who point out dangerous or potentially dangerous conditions;

HCFA strongly supports protection for whistleblowers; ANA given HCFA contact: Judy Berrick, HCFA

iii) require HHS to review merger applications to determine impact on patient care

Would add extra layer of regulatory review to DOJ and FTC merger reviews. Spoke to Bob Potter, Head of DOJ Antitrust Policy Office (514-2512) about consideration given to patient care -- they do consider quality and price in developing "efficiency" criteria. ANA given Bob Potter to discuss their concerns further.

b) Nurse involvement in HCFA managed care quality initiatives

HCFA would welcome. ANA given contact: Barbara Gagel, Director of Health Standards and Quality Bureau (410/786-6841)

c) Hold firm on current health and safety regulations, including those issued under OBRA 87's nursing home reform provisions.

Yes. *The President fought hard to protect nursing home standards. HCFA has conducted extensive monitoring of the implementation of the OBRA 87 nursing home enforcement regulation (implemented 7/1/95).*

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.

(a) Yes (b) No.

a) Our Medicare proposals allow nurse practitioners and clinical nurse specialists to bill directly, and list nurses as providers for provider-sponsored networks.

[The imperative requested support for specific legislation -- HR 1750/S 864 (Medicare Reimbursement) and HR 1339/S 972 (Medicaid reimbursement). HCFA's response was the following:

"Expanding direct reimbursement for advanced practice nurses and physician assistants would increase utilization of these services, and thereby increase Medicare costs. Neither HCFA nor CBO has estimated the cost of HR 1339/S 972, but CBO scored a similar provision in the Republican Conference agreement that increased costs by $300 million from FY 1996-2002. The President's proposal does not include this provision."]

b) Reject Medicaid waivers --Unlikely, although HCFA does encourage reform that increases access and quality: "Before approving any 1115 or 1915(b) waiver, HCFA requires states to demonstrate the capacity to ensure that all required services are available and accessible to Medicaid beneficiaries, and that the services provided are of high quality. Certain services provided by advanced practice nurses, including nurse practitioner services and certified nurse midwife services, are mandatory services. In reviewing states' waiver applications and contracts with managed care plans, HCFA encourages states to contract with managed care plans that include nurse practitioners and other advanced practice nurses as primary care providers. However, the states, not HCFA, regulate health plans' contracts with advanced practice nurses. Further regulation of health plan contracts by HCFA may conflict with the Administration's policy of promoting state flexibility in Medicaid."

3. Increase number of nurses appointed to visible federal positions.

(Yes). *Bob Nash asked Peg Clark to monitor: Recently, Virginia Betts was offered a spot on OPM's Federal Salary Council; she suggested that ANA Executive Director Geraldine Marullo would be better. While the President has not yet signed off on it yet, she is expected to be named soon (there are 3 vacancies being filled; the other 2 are taking more time to clear).*

In addition, Helen Maramontes (an ANA pick) was named to the AIDS Commission . Peg has pushed HHS, but very few hires. ANA has been told to forward names to Peg Clark (6-7831).

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

Yes. Just today (1/24), the Division of Nursing received a funding certification for $650,000 for the survey. $250,000 was committed last year to fund and conduct the initial stage of survey. This next amount will allow all of the data collection to occur. A final installment will be needed sometime in 1997. (At a meeting with the ANA and other associations, Ciro suggested they assist in funding and/or assist in securing funding in appropriations--did anything come of this?).

The National Sample Survey is the only tool currently available to determine the status of the nursing workforce; the ANA believes tool particularly important given changes in health care industry.

5. Reich should allow H-1A Visa Program to sunset.

Yes. (The INS may allow a few nurses in under more restrictive requirements -- such as only allowing advanced practice degrees.)

The H-1 Visa Program allows nurses to enter the U.S. to work for a specific employer if they are licensed and if the employer meets seven specific criteria (e.g., the employment is temporary; the employer has not laid off any American citizens for a number of years). The program ended on August 31, 1995.

6. USTR should initiate discussions with Canada and Mexico to remove registered nurses and other health professionals from Appendix 1603.D.1 of the NAFTA.

Yes, *discussions have been initiated. DOL made a presentation at the November meeting of the Temporary Entry Working Group. DOL is now gathering further data for future discussions (may be problematic since INS either does not have good data or does not collect data on this workforce).*

Canada in particular is resistant to the proposed change. Reportedly, there are also differences of opinion within the Administration: USTR and Commerce generally oppose changes to the NAFTA; DOL, INS, and State support this change.

Appendix 1603.D.1 of the NAFTA concerns "cross-border movement of professionals." Members of professions listed in the Appendix are eligible for expedited entry into the other NAFTA countries to practice their profession for a limited amount of time. Canada pushed for the inclusion of registered nurses on this list (approximately 25% of the Canadians who enter the U.S. pursuant to this Appendix are nurses).

NAFTA establishes a Temporary Entry Working Group in which all three countries participate. Adding or subtracting professions from the Appendix can be negotiated within the Working Group.

7. Provide vocal support for funding of nurse education, including full reauthorization and full funding of the Nurse Education Act (S 555); continuation and funding of the Division of Nursing at HRSA, the National Institute of Nursing Research, AHCPR, and public health programs under HRSA.

(The general concerns are that there be some federal presence in the development of the nurse workforce and some nurse involvement in developing overall health policy at HHS.)

General response: Yes.

a) Full reauthorization and full funding of the Nurse Education Act (S 555)

Don't consolidate! Need support

S.555 (Nurse Education Act/Reauthorization of Title VIII) was held up in Senate because of a Coats abortion amendment. Sec. Shalala sent a letter to Sen. Kassebaum expressing support of S. 555 in March.

b) continuation and funding of the Division of Nursing at HRSA (administers Title VIII),

Yes. Originally HHS zeroed out Title VII and VIII; but OMB pass back restored (to level requested by President in FY 96).

c) continuation and funding of the National Institute of Nursing Research

NINR is the smallest institute at NIH and none of the institutes get a specific allocation in the budget. However, NIH will fare relatively well in the budget process (the President requested a 4.4% increase).

A related concern is consolidation of the institutes within NINR. Conversations between NINR Director Pat Grady and Sen. Kassebaum have eased these concerns.

d) Continuation of funding for AHCPR.

AHCPR was funded at $159 million in FY 95. The FY 96 House-passed appropriations bill recommends $66 million; the Senate Committee bill includes $127 million. OMB protested the House level in our SAP to the Senate (listed as item of concern). HHS' FY 97 budget submission calls for $202 million.

AHCPR is currently covered under a CR that expires February 26 (at the lower of: the '95 or the House enacted level).

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

No. HCFA cost estimates showed that it was too expensive.

HCFA guidelines for Medicare Part B regulate services provided "incident to" those of a physician. ANA believes that these guidelines are restrictive and archaic, such as requiring a physician's on-site presence when services are provided.

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

Too early to indicate definite support. Interim evaluation report due in early 1996. This evaluation will examine whether the combination of capitated payment and nurse case management promotes the appropriate use of community nursing and ambulatory care services and reduces the use of acute care services. The evaluation will also compare the health status of beneficiaries enrolled in the project with the health status of the general Medicare population. Preliminary descriptive information indicates that approximately 95% of current demonstration enrollees have 0 to 1 ADL impairment; however, because outcome data is not available yet, we do not know the costs and impacts of the demonstration.

→ Minn, Ill, N.Y., Arizona

10. Make Chiefs of military nursing services two-star flag officers instead of one-star. (Allow chiefs of the nurse corps to compete for promotion to two-star.)

Currently, the Chiefs of the military Nurse Corps are one-star officers. However, according to General Nancy Adams, Chief of the Army Nurse Corps, the Army nurses don't want to be merely ordained as two-star flag officers. Rather they want the opportunity to compete for promotion to two-star generalships after they have been Corps Chiefs (currently, Army nurses are not permitted to compete for two-star positions, although the Navy and Air Force Nurse Corps Chiefs are).

Today, the Chiefs of the Nurse Corps have significant responsibility that integrate them into higher levels of medical divisions. However, Nurse Corps Chief is only a four year position, and after leaving the Nurse Corps as a one-star general, there is unlikely to be another slot for a one-star general in the medical division. Because they cannot compete for two-star status (and jobs that require a two-star general), outgoing Nurse Corps Chiefs are often forced into retirement.

The Army Nurse Corps are trying to get the rules changed so that nurses can compete for two-star generalships. (According to Gen. Adams, the change is working well in the Navy and Air Force.) General Alcid LaNoe, the Surgeon General of the Army, is sympathetic to the nurses' situation.

Gen. LaNoe discussed the matter with Gen. Dennis Reimer, the new Army Chief of Staff, at a meeting late this fall. While not opposing the change, Gen. Reimer asked for further information.

At the suggestion of Gen. Adams, I have discussed the issue with Mrs. Sara Lister, Assistant Secretary of the Army for Manpower and Reserve Affairs. She is considering whether there is anything further to be done.

VA Dissolving the Office of Nursing - Replaced by system heads - none of them nurses.

60,000 nurses in VA

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS FAX COVER SHEET

# of Pages: Cover + 2

DATE: 1/24/96

TO:
Jenn Kline
Fax:
Phone:

FROM:
Debbie Chang
Fax: (202) 690 - 8168
Phone:

REMARKS:

HEALTH CARE FINANCING ADMINISTRATION

Washington, D.C.

Subtitle B - Expanded Medicare Choice
Section 4202. BROADER CHOICE AMONG MANAGED CARE ORGANIZATIONS

Non-Technical

Page 7, line 9-14

Change: Strike and insert "(A) TYPE OF ENTITY. - The entity is a health care provider or group of affiliated health care providers, including one or more hospitals."

Explanation: PSOs could include groups of physicians, hospitals, nurse practitioners as well as other non-physician practitioners such as physicians assistants. The suggested change is cleaner than listing all possibilities.

Page 7, line 18-21

Change: Strike from "..or nurse practitioners' through line 21.

Explanation: Services provided by the PSO could also include nurse practitioners and other services, but at a minimum should include physician services. Only the change to (A) is required to open up the "membership" of the PSO.

Page 8, line 25 - Page 9, line 15

Change: Replace with " . . . requirements for licensure different from the requirement for a contract under this part. If the Secretary determines that the State has met the criteria for participation in the alternative certification and monitoring program described in 1851H(b), the Secretary shall require the organization to obtain a license from the State."

Explanation: Provides for a broader preemption of state law for PSOs.

Page 9, line24

Change: Insert before the period "either through the organizations under rules developed by the Secretary or as otherwise provided by the Secretary".

Explanation: Would allow enrollment and disenrollment both through the Secretary (as in the bill) and through the plans.

Page 59, line 12

Change - Insert after "the following" --- "adjusted by factor, if any, determined under paragraph

Section 8707 - Payments to Physician Assistants and Nurse Practitioners for Services Furnished in Outpatient or Home Settings

Currently, Medicare makes direct payments to nurse practitioners (NPs) in rural areas and in nursing facilities. Medicare also makes direct payments to physician assistants (Pas) (payments go to the employer) in hospitals, nursing facilities, and in rural health professional shortage areas. This provision would allow physician assistants and nurse practitioners to be paid directly in all outpatient and home settings, as defined by the Secretary. Payment could be made directly to the NP or PA.

Under current law, Medicare also makes direct payments to clinical nurse specialists (CNSs) for services furnished in rural areas. CNSs, however, are not included in the provision above (section 8707). There does not appear to be a good reason for this exclusion. Under proposed regulations that are currently under development in HCFA, the qualifications for NPs and CNSs are stipulated, and they are essentially identical. The NP or CNS must--

> (1) be a registered nurse who is currently licensed to practice in the State where he or she practices, be authorized to perform the services of an NP (or CNS) in accordance with State law, and have a master's degree in nursing; or
>
> (2) be certified by a professional association recognized by HCFA that has, at a minimum, eligibility requirements that meet the standards in (1) above.

Thus, if Medicare payment is to be expanded to other settings for certain nonphysician practitioners, NPs and CNSs should be treated the same.

Section 8621- Medicare Coverage of Certain Anti-Cancer Drug Treatments

This provision would require Medicare to cover an oral drug that is an anticancer nonsteroidal antiestrogen for the treatment of breast cancer. The manufacturer of the drug must have a rebate agreement in effect which has substantially the same terms and conditions as the Medicaid drug rebate agreements.

This provision would cover tamoxifen for the treatment of breast cancer. Preliminary CBO estimates score this provision as a slight savings ($97 million over 7 years). This estimate is based on evidence that tamoxifen (if taken by estrogen-receptor positive breast cancer patients) would prevent a recurrence in 20 percent of the women who would otherwise have gotten a recurrence. Preliminary HCFA OACT estimates show a large cost ($3.8 billion over 7 years) and do not include a savings component.

Providing for coverage of tamoxifen would provide a valuable benefit for certain women with breast cancer. It perpetuates the piecemeal drug coverage that is currently in title 18, but nonetheless is one step toward broader coverage of outpatient prescription drugs. The OACT estimate, however, would likely preclude its inclusion in a bill at this time.

ANA IMPERATIVES
Summary of Status

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

Summary Response: Yes, the Administration has opposed threats to patient safety and quality -- in particular in the fight to maintain nursing home standards.

Breakdown of Imperative:

a) Request for Administration support for legislation (working with Wellstone on; not yet introduced) that would:

i) require providers to make available to the public certain information regarding nurse staffing and patient outcomes;

Doubtful, given VP's regulatory reform.

ii) protect "whistleblowers" employed by a health plan, who point out dangerous or potentially dangerous conditions;

HCFA strongly supports protection for whistleblowers; ANA given HCFA contact: Judy Berrick, HCFA

iii) require HHS to review merger applications to determine impact on patient care

Would add extra layer of regulatory review to DOJ and FTC merger reviews. Spoke to Bob Potter, Head of DOJ Antitrust Policy Office (514-2512) about consideration given to patient care -- they do consider quality and price in developing "efficiency" criteria. ANA given Bob Potter to discuss their concerns further.

b) Nurse involvement in HCFA managed care quality initiatives

HCFA would welcome. ANA given contact: Barbara Gagel, Director of Health Standards and Quality Bureau (410/786-6841)

c) Hold firm on current health and safety regulations, including those issued under OBRA 87's nursing home reform provisions.

Yes. *The President fought hard to protect nursing home standards. HCFA has conducted extensive monitoring of the implementation of the OBRA 87 nursing home enforcement regulation (implemented 7/1/95).*

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.

(a) Yes (b) No.

Medicaid ?

a) Our Medicare proposals allow nurse practitioners and clinical nurse specialists to bill directly, and list nurses as providers for provider-sponsored networks.

[The imperative requested support for specific legislation -- HR 1750/S 864 (Medicare Reimbursement) and HR 1339/S 972 (Medicaid reimbursement). HCFA's response was the following:

"Expanding direct reimbursement for advanced practice nurses and physician assistants would increase utilization of these services, and thereby increase Medicare costs. Neither HCFA nor CBO has estimated the cost of HR 1339/S 972, but CBO scored a similar provision in the Republican Conference agreement that increased costs by $300 million from FY 1996-2002. The President's proposal does not include this provision."]

b) Reject Medicaid waivers --Unlikely, although HCFA does encourage reform that increases access and quality: "Before approving any 1115 or 1915(b) waiver, HCFA requires states to demonstrate the capacity to ensure that all required services are available and accessible to Medicaid beneficiaries, and that the services provided are of high quality. Certain services provided by advanced practice nurses, including nurse practitioner services and certified nurse midwife services, are mandatory services. In reviewing states' waiver applications and contracts with managed care plans, HCFA encourages states to contract with managed care plans that include nurse practitioners and other advanced practice nurses as primary care providers. However, the states, not HCFA, regulate health plans' contracts with advanced practice nurses. Further regulation of health plan contracts by HCFA may conflict with the Administration's policy of promoting state flexibility in Medicaid."

3. Increase number of nurses appointed to visible federal positions.

(Yes). *Bob Nash asked Peg Clark to monitor: Recently, Virginia Betts was offered a spot on OPM's Federal Salary Council; she suggested that ANA Executive Director Geraldine Marullo would be better. She will be named within a few weeks.*

In addition, Helen Maramontes (an ANA pick) was named to the AIDS Commission . Peg has pushed HHS, but very few hires. ANA told to forward names to Peg Clark (6-7831).

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

(Yes, although funding not complete). Ciro Sumaya, head of HRSA, committed $200,000 to fund and conduct the initial stage of survey (with 1% funds). The next installment, $400,000 will need to be made in February or March if the survey is going to continue as planned. The final installment, also $400,000, will need to be paid in FY 97. At a meeting with the ANA and other associations, Ciro suggested they assist in funding and/or assist in securing funding in appropriations.

The National Sample Survey is the only tool currently available to determine the status of the nursing workforce; the ANA believes tool particularly important given changes in health care industry.

5. Reich should allow H-1A Visa Program to sunset.

Yes. (The INS may allow a few nurses in under more restrictive requirements -- such as only allowing advanced practice degrees.)

The H-1 Visa Program allows nurses to enter the U.S. to work for a specific employer if they are licensed and if the employer meets seven specific criteria (e.g., the employment is temporary; the employer has not laid off any American citizens for a number of years). The program ended on August 31, 1995.

6. USTR should initiate discussions with Canada and Mexico to remove registered nurses and other health professionals from Appendix 1603.D.1 of the NAFTA.

Yes, *discussions have been initiated. DOL made a presentation at the November meeting of the Temporary Entry Working Group. DOL is now gathering further data for future discussions (may be problematic since INS either does not have good data or does not collect data on this workforce).*

Canada in particular is resistant to the proposed change. Reportedly, there are also differences of opinion within the Administration: USTR and Commerce generally oppose changes to the NAFTA; DOL, INS, and State support this change.

Appendix 1603.D.1 of the NAFTA concerns "cross-border movement of professionals." Members of professions listed in the Appendix are eligible for expedited entry into the other NAFTA countries to practice their profession for a limited amount of time. Canada pushed for the inclusion of registered nurses on this list (approximately 25% of the Canadians who enter the U.S. pursuant to this Appendix are nurses).

NAFTA establishes a Temporary Entry Working Group in which all three countries participate. Adding or subtracting professions from the Appendix can be negotiated within the Working Group.

7. Provide vocal support for funding of nurse education, including full reauthorization and full funding of the Nurse Education Act (S 555); continuation and funding of the Division of Nursing at HRSA, the National Institute of Nursing Research, AHCPR, and public health programs under HRSA.

(The general concerns are that there be some federal presence in the development of the nurse workforce and some nurse involvement in developing overall health policy at HHS.)

General response: (Yes.)

a) Full reauthorization and full funding of the Nurse Education Act (S 555)

S.555 (Nurse Education Act/Reauthorization of Title VIII) was held up in Senate because of a Coats abortion amendment. Sec. Shalala sent a letter to Sen. Kassebaum expressing support of S. 555 in March.

b) continuation and funding of the Division of Nursing at HRSA (administers Title VIII),

Yes. Originally HHS zeroed out Title VII and VIII; but OMB pass back restored (to level requested by President in FY 96).

c) continuation and funding of the National Institute of Nursing Research

NINR is the smallest institute at NIH and none of the institutes get a specific allocation in the budget. However, NIH will fare relatively well in the budget process (the President requested a 4.4% increase).

A related concern is consolidation of the institutes within NINR. Conversations between NINR Director Pat Grady and Sen. Kassebaum have eased these concerns.

d) Continuation of funding for AHCPR.

AHCPR was funded at $159 million in FY 95. The FY 96 House-passed appropriations bill recommends $66 million; the Senate Committee bill includes $127 million. OMB protested the House level in our SAP to the Senate (listed as item of concern). HHS' FY 97 budget submission calls for $202 million.

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

No. HCFA cost estimates showed that it was too expensive.

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

Too early to indicate definite support. Interim evaluation report due in early 1996. This evaluation will examine whether the combination of capitated payment and nurse case management promotes the appropriate use of community nursing and ambulatory care services and reduces the use of acute care services. The evaluation will also compare the health status of beneficiaries enrolled in the project with the health status of the general Medicare population. Preliminary descriptive information indicates that approximately 95% of current demonstration enrollees have 0 to 1 ADL impairment; however, because outcome data is not available yet, we do not know the costs and impacts of the demonstration.

10. Make Chiefs of military nursing services two-star flag officers instead of one-star. (Allow chiefs of the nurse corps to compete for promotion to two-star.)

Currently, the Chiefs of the military Nurse Corps are one-star officers. However, according to General Nancy Adams, Chief of the Army Nurse Corps, the Army nurses don't want to be merely ordained as two-star flag officers. Rather they want the opportunity to compete for promotion to two-star generalships after they have been Corps Chiefs (currently, Army nurses are not permitted to compete for two-star positions, although the Navy and Air Force Nurse Corps Chiefs are).

Today, the Chiefs of the Nurse Corps have significant responsibility that integrate them into higher levels of medical divisions. However, Nurse Corps Chief is only a four year position, and after leaving the Nurse Corps as a one-star general, there is unlikely to be another slot for a one-star general in the medical division. Because they cannot compete for two-star status (and jobs that require a two-star general), outgoing Nurse Corps Chiefs are often forced into retirement.

The Army Nurse Corps are trying to get the rules changed so that nurses can compete for two-star generalships. (According to Gen. Adams, the change is working well in the Navy and Air Force.) General Alcid LaNoe, the Surgeon General of the Army, is sympathetic to the nurses' situation. Gen. LaNoe discussed the matter with Gen. Dennis Reimer, the new Army Chief of Staff, at a meeting late this fall. While not opposing the change, Gen. Reimer asked for further information.

Gen. Adams suggested I discuss the issue with Mrs. Sara Lister, Assistant Secretary of the Army for Manpower and Reserve Affairs.

ANA Meeting

- Did they arrange a meeting with Vladek? Good communication?

- Possible follow up if we need to be more responsive:

  -Funding for National Sample Survey
  -Appointments? Director, Bureau of Health Professions open
  -Our own Title VIII Reauthorization bill

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR
1998

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

Nursing Education/Practice Cluster

Authorizing Legislation - Sections 820, 821, 822, 827, 830, and 831 of the Public Health Service Act.

	1996 Actual BA	1997 Appropriation BA	1998 Estimate BA	Increase or Decrease BA
Nursing Ed/Pract Cluster.....	$56,187,000	$63,188,000	$7,700,000	-$55,488,000
Strengthening Capacity for Basic Nurse Education and Practice.....	(9,436,000)	(10,564,000)		
Nurse Pract/Nurse Midwives & Other Adv Pract Nurses:				
Nurse Pract/Midwives....	(15,460,000)	(17,586,000)		
Advanced Nurse Educ.....	(11,134,000)	(12,467,000)		
Nurse Anesthetist Trng..	(2,469,000)	(2,765,000)		
Prof Nurse Traineeships.	(14,235,000)	(15,941,000)		
Increasing Nursing Workforce Diversity.....	(3,453,000)	(3,865,000)		

1998 Authorization. . . Legislative authority is being proposed.

Purpose and Method of Operation

The HRSA proposes to consolidate Title VIII nurse education authorities to provide for a comprehensive, flexible, and effective authority for Federal support of nursing workforce development. The programs affected are Nursing Special Projects, Advanced Nurse Education, Nurse Practitioner/Nurse Midwife Education, Professional Nurse Traineeships, Nurse Anesthetist Training, and Nursing Education. The nursing programs would be clustered under the following three headings:

- Strengthening Capacity for Basic Nurse Education and Practice;
- Nurse Practitioners, Nurse Midwives, and Other Advanced Practice Nurses; and
- Increasing Nursing Workforce Diversity.

The Strengthening Capacity for Basic Nurse Education and Practice program replaces the existing Nursing Special Projects program (Sec. 820 of the PHS Act) and would provide a stimulus for innovative approaches to strengthening basic nurse education and practice not only in the specific areas identified in the existing law but also in such priority areas as:

- provision of nursing services in schools and other community settings;
- care of underserved populations and other high-risk groups such as the elderly, individuals with HIV-AIDS, substance abusers, and battered women;

- case management, quality improvement, and other skills needed under new systems of organizing health care;
- development of cultural competencies among nurses;
- provision of emergency health services; and
- promotion of career mobility for nursing personnel in a variety of training settings.

The Nurse Practitioners, Nurse Midwives, and Other Advanced Practice Nurses program replaces the following existing nursing programs in the PHS Act: Advanced Nurse Education (Sec. 821), Nurse Practitioner/Nurse Midwife Training (Sec. 822), Professional Nurse Traineeships (Sec. 830), and Nurse Anesthetist Training (Sec. 831). This broader authority would allow the support of nursing programs that offer preparation that is appropriate for advanced practice nurses in our developing health care environment, but which can not technically be supported under current legislation. These include case management, nursing informatics and nursing management/administration, which is critical for the many nurses who are in decision making positions.

The Increasing Nursing Workforce Diversity program would support activities similar to those now receiving aid under the existing Nursing Education Opportunities for Individuals from Disadvantaged Backgrounds program (Sec. 827 of the PHS Act). Grantees would have increased flexibility in the use of funds for the development of a variety of approaches to enhancing ethnic and racial diversity in nursing education and practice.

Funding for the Nursing Education/Practice Cluster program for the last five years has been as follows:

	$
1993	58,487,000
1994	61,487,000
1995	58,640,000
1996	56,187,000
1997	63,188,000

Program Accomplishments

The nursing education programs currently supported by Title VIII have had the following impact on the nation's nursing workforce, including:

- To date, Title VIII funded more than 60 percent of all current nurse practitioner programs in the United States;

- Approximately 50 percent of the graduates of these programs are employed in inner city and rural areas.

- Title VIII has provided support to over 83 percent of the existing nurse-midwifery programs over the past 20 years.

- Programs receiving support from Title VII funding for minority and disadvantaged students have enrollments in which 75 percent of students are from minority groups, compared to the 16 percent average.

- Title VIII established and/or expanded over 50 percent of the currently operating nurse managed clinics providing care to high risk and vulnerable populations.

Rationale for the Budget Request

The FY 1998 request of $7,700,000 is a decrease of $55,488,000 below the FY 1997 appropriation given that market forces are already reconfiguring the nursing workforce. At this funding level, funds would be used to support innovative demonstration projects to assist in restructuring the basic nurse workforce to meet the future health care needs of the population. These demonstration projects could support innovative arrangements and programs to expand existing baccalaureate programs to underserved areas; phase out diploma programs; establish collaborative arrangements between community colleges and universities to prepare baccalaureate nurse graduates; and increase diversity in the nurse workforce through effective recruitment, retention, and graduation strategies.

Some funds could be used to support nursing clinics, which provide access to primary care services for underserved and unserved high risk populations. These clinics serve as faculty practice sites as well as clinical sites for baccalaureate and graduate level students.

Funds would be available to support analytic and planning activities to yield essential information on the status of the nurse workforce.

Outcomes:

Under the proposed flexible authority and current FY 1998 budget proposal we would anticipate carrying out analytic studies and innovative demonstration projects targeted toward restructuring the nurse workforce to meet the health care needs in a rapidly changing environment. The outcomes of these projects would be related directly to the nature of these activities.

FAX

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

62878

To: Pauline Abernathy

From: Chin-Chin Lo

Number of Pages (excluding cover): 4

Note: Feel free to call me at 57797 if you need anything more. Thx.

Voice Numbers:

Health Division (Front Office)	202/395-4922
Health & Human Services Unit	202/395-4925
Health Programs & Services Branch	202/395-4926
Health Financing Branch	202/395-4930

Fax Numbers:

Health Division (Front Office)	202/395-3910
Health Division (Room 7001)	202/395-7840

American Nurses Association
600 Maryland Avenue SW
Suite 100 West
Washington, DC 20024-2571
TEL 202 651 7000
FAX 202 651 7001

NEWS RELEASE

FOR IMMEDIATE RELEASE
February 7, 1997

CONTACT: Sara Foer, 202-651-7023
sfoer@ana.org
Joan Meehan, 202-651-7020
jmeehan@ana.org
http://www.nursingworld.org

CLINTON BUDGET CONTRADICTS STATE OF THE UNION MESSAGE, SAYS AMERICAN NURSES ASSOCIATION

Abandons nurse education, patient access and protection

WASHINGTON, DC – Calling proposed cuts in funding for health care programs alarming and contradictory to the priorities he articulated in his State of the Union address, the American Nurses Association (ANA) today denounced President Clinton's attempt to balance the budget by slashing critical programs in his Fiscal Year (FY) 1998 budget.

ANA was particularly appalled to learn that one of the ways Clinton is planning to implement his $1.7 trillion budget and move towards a balanced budget is by gutting funding for the Nurse Education Act (NEA). Funding for FY '98 is proposed at $7.7 million – down from $63 million for FY '97.

"We are extremely disappointed by the president's budget proposal," said ANA President Beverly L. Malone, PhD, RN, FAAN. "Without stable funding to support graduate-level education for nurses, we'll enter the 21st century ill-prepared to provide adequate health care to aging baby boomers and their grandchildren.

MORE...

ANA
AMERICAN NURSES ASSOCIATION

"The administration has promoted excellent public policy through greater use of advanced practice nurses as a cost-effective way to increase access to primary and preventive health care services, yet this budget proposal would force some programs to close completely and it would dramatically affect some 4,000 students who rely on trainee ships to make their education possible," she said.

"Thousands of today's registered nurses, including many single mothers and those who came from low-incomes families, relied upon NEA funds in order to become professional nurses," explained Malone.

"Given President Clinton's emphasis on improving access to health care for children and the elderly, his obsession with education, and his commitment to helping the unemployed, particularly welfare mothers, move to gainful employment, we are absolutely stunned by his abandonment of nurse education," said ANA Executive Director Geri Marullo, MSN, RN.

Despite the unanticipated setback, ANA and its state nurses associations plan to take their message to Congress, where the association has received bipartisan support for its priority issues, particularly support for NEA funding.

The Nurse Education Act, funded under Title VIII of the Public Health Service Act, provides the lion's share of federal support for nurse education, the largest of the health professions. These funds support graduate-level programs primarily, which enroll approximately 30,000 students annually. These programs prepare registered nurses to assume advanced practice roles. Advanced practice registered nurse (APRN) is an umbrella term given to a registered nurse (RN) who has met advanced educational and clinical practice requirements beyond the 2-4 years of basic nursing education required for all RNs. The four principal types of APRNs are nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife.

MORE...

In addition, monies in Title VIII fund nurse-managed clinics affiliated with university schools of nursing. Last year, these clinics, staffed by nursing students and faculty, provided more than 32,000 primary care visits to a range of underserved populations, such as poor children and elderly in many inner cities.

According to the Bureau of Labor Statistics demand for health care professionals is expected to grow by 47 percent by the year 2005, with the need for APRNs among the greatest. APRNs, such as nurse practitioners and clinical nurse specialists, are increasingly in demand to meet the broad health care needs of Medicare beneficiaries. An Institute of Medicine report on the role of nursing staff in hospitals and nursing homes released last January found that "more advanced, or more broadly trained, RNs will be needed in the future.....Such training is essentially like that now provided for RNs who receive certification as, for example, advanced practice registered nurses."

Funding for other health professions education was also slashed. Funding for primary care and allied health professions education was cut, by 90 and 56 percent respectively. "The education of future health professionals has always been a sound investment of federal funds," said Marullo. "Yet, according to the explanation that accompanied this budget, the Clinton Administration no longer believes the federal government has a role in preparing the care givers of tomorrow."

Furthermore, ANA is also distressed that the administration proposes to cut Part A (hospital reimbursement) of the Medicare program by $45 billion over six years without providing needed mechanisms for holding hospitals accountable for providing safe patient care, such as requiring public disclosure of nurse staffing levels and patient outcomes.

MORE...

"Several recent consumer surveys echo the concerns expressed by nurses during the past two years about the current direction of health care, where quality of care -- and the nurses who provide it -- are sacrificed in the name of cost-containment," said Marullo. "Medicare cuts of this magnitude, without patient protections, will exacerbate an already dangerous trend where hospitals substitute cheaper, minimally-skilled technicians for registered nurses in a short-sighted attempt to cut costs."

On a positive note, the administration included a provision to provide direct Medicare reimbursement to all clinical nurse specialists and nurse practitioners, a long-standing goal of ANA, which will increase consumers' access to health care services.

###

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

g:\releases.97\budget2 distribution: entire

DOM-55 ELIMINATE SUBSIDIES FOR HEALTH PROFESSIONS EDUCATION

	Annual Savings (Millions of dollars)						Six-Year Cumulative Total
	1997	1998	1999	2000	2001	2002	
From the 1996 Funding Level							
Budget Authority	256	256	256	256	256	256	1,536
Outlays	90	179	256	256	256	256	1,293
From the 1996 Funding Level Adjusted for Inflation							
Budget Authority	263	270	277	284	292	300	1,686
Outlays	92	186	270	278	285	292	1,403

The Congress provided about $257 million to the Public Health Service in 1996 to subsidize education for physicians, nurses, and public health professionals. Those funds primarily furnish institutional support through grants and contracts to schools for designated training programs in the health professions. A limited amount of the assistance is provided through loans, loan guarantees, and scholarships for students. The programs promote training in primary care for physicians and other health professionals, advanced nursing education, and increased enrollment of minority and economically disadvantaged students:

- *Primary care training.* Several programs provide federal grants to medical schools, teaching hospitals, and other training centers to develop, expand, or improve graduate medical education in primary care specialties and other allied health fields and to encourage practice in rural and low-income urban areas. Funding for 1996 is $121 million.

- *Nursing education.* The subsidies to nursing schools are meant to increase graduate training for nurse administrators, educators, supervisors, researchers, and nursing specialists, including nurse-midwives and nurse-practitioners. Funding for 1996 is $56 million.

- *Support for minority and economically disadvantaged students.* Over half of these funds go to professional schools for recruiting, training, and counseling minority and economically disadvantaged students. The remaining funds are for student loans and scholarships. Funding for 1996 is $80 million.

Eliminating all of these subsidies would save over the 1997-2002 period, about $1.3 billion measured from the 1996 funding level and about $1.4 billion measured from the 1996 level adjusted for inflation. The principal justification for this option is that market forces provide strong incentives for individuals to seek training and jobs in the health professions. Over the past several decades, physicians--the principal health profession targeted by the subsidies--have rapidly increased in number, from 142 physicians in all fields for every 100,000 people in 1950 to 161 in 1970 and 244 in 1990. Projections by the American Medical Association indicate that the total number of physicians per capita will continue to rise through 2000. In the case of nurses, if a shortage indeed existed, higher wages and better working conditions would attract more people to the profession and more trained nurses to nursing jobs, and would encourage more of them to seek advanced training.

Moreover, because the subsidies go mainly to institutions, they may have little effect on the numbers or characteristics of people studying to be health professionals. For example, most of the subsidies for nurses' training are directed toward increasing skills through baccalaureate degree programs and advanced

education in nursing, rather than raising the number of new entrants into the profession. Similarly, over half of the funds for increasing enrollment of minority and economically disadvantaged students are used to support schools' recruitment, training, and counseling efforts. Many critics of the subsidies contend that schools in the health professions have a strong commitment to recruiting students from diverse backgrounds. Given that commitment, schools would probably continue much of their recruiting and training efforts even if the subsidies were eliminated.

The major disadvantage of eliminating the subsidies is that the incentives supplied by market forces may not be sufficient to entirely meet the goals of these health professions programs. For example, third-party reimbursement schedules for primary care may not encourage enough physicians to enter those specialties and may not include financial inducements sufficient to increase access to care in rural and inner-city areas. In addition, fewer people might choose advanced training in nursing, which could limit the opportunities for the use of relatively inexpensive physician substitutes. Another drawback relates to the goal of increasing enrollment of minority and economically disadvantaged students. To the extent that schools did not fully offset the cut in federal funds for scholarships, fewer such students might enter the health professions, possibly exacerbating the problem of access to care in medically underserved areas.

AMERICAN NURSES ASSOCIATION

600 Maryland Avenue SW
Suite 100 West
Washington, DC 20024-2571
202 651-7000 • Fax: 202 651-7001

Virginia Trotter Betts, JD, MSN, RN
President

Geri Marullo, MSN, RN
Executive Director

TO: Jennifer Klein, Office of Domestic Policy
Chris Jennings, Special Assistant to the President for Health Policy Development
Marilyn Yager, Deputy Assistant to the President for Public Liaison

FROM: Marjorie Vanderbilt
Director, Federal Government Relations
American Nurses Association

DATE: January 16, 1996

RE: Reimbursement for Advanced Practice Nurses

The American Nurses Association (ANA) is most appreciative of your efforts to ensure that the President's budget proposal of January 6 included a provision to provide direct Medicare reimbursement for nurse practitioners in all outpatient settings. However, we would like to bring to your attention two areas of concern to us:

1. The lack of any reference to direct Medicare reimbursement for clinical nurse specialists -- the other group of advanced practice nurses who are currently reimbursed only in rural areas. Medicare reimbursement for both clinical nurse specialists and nurse practitioners was included in the President's "Health Security Act".

2. The failure of the President's package to include a proposal to provide direct Medicaid reimbursement for nurse practitioners and clinical nurse specialists. This is a proposal that has been sponsored in the Senate by Minority Leader Tom Daschle in the 102nd, 103rd and 104th Congresses.

Medicare and Medicaid reimbursement for nurse practitioners and clinical nurse specialists has been a key part of ANA's legislative agenda for many years.

For your reference, I am attaching the legislative language on both Medicare and Medicaid reimbursement for nurse practitioners and clinical nurse specialists that is supported and lobbied for by ANA.

We look forward to having the opportunity to discuss these critical issues with you at your earliest convenience. I can be reached at (202)651-7085.

G:\Grel\mwv\whreimbmem.wpd
1/16/96

S.972 As introduced in the Senate, June 27, 1995

II

104th CONGRESS
1st Session

S. 972

To amend title XIX of the Social Security Act to provide for medicaid coverage of all certified nurse practitioners and clinical nurse specialists services.

IN THE SENATE OF THE UNITED STATES

June 27 (legislative day, June 19), 1995

Mr. Daschle (for himself, Mr. Inouye, Mr. Harkin, Mr. Hollings, Mr. Bingaman, Ms. Boxer, and Mr. Akaka) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend title XIX of the Social Security Act to provide for medicaid coverage of all certified nurse practitioners and clinical nurse specialists services.

==========

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. MEDICAID COVERAGE OF ALL CERTIFIED NURSE PRACTITIONER AND CLINICAL
NURSE SPECIALIST SERVICES.

(a) In General.--Section 1905(a)(21) of the Social Security Act (42 U.S.C. 1396d(a)(21)) is amended to read as follows:

"(21) services furnished by a certified nurse practitioner (as defined by the Secretary) or clinical nurse specialist (as defined in subsection (t)) which the certified nurse practitioner or clinical nurse specialist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified nurse practitioner or clinical nurse specialist is under the supervision of, or associated with, a physician or other health care provider;".

(b) Clinical Nurse Specialist Defined.--Section 1905 of such Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

"(t) The term 'clinical nurse specialist' means an individual who--

"(1) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

"(2) holds a master's degree in a defined area of clinical nursing from an accredited educational institution.".

(c) Effective Date.--The amendments made by this section shall become effective with respect to payments for calendar quarters beginning on or after January 1, 1996.

104TH CONGRESS
1ST SESSION

S. 864

To amend title XVIII of the Social Security Act to provide for increased medicare reimbursement for nurse practitioners and clinical nurse specialists to increase the delivery of health services in health professional shortage areas, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 25 (legislative day, MAY 15), 1995

Mr. GRASSLEY (for himself and Mr. CONRAD) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend title XVIII of the Social Security Act to provide for increased medicare reimbursement for nurse practitioners and clinical nurse specialists to increase the delivery of health services in health professional shortage areas, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Primary Care Health Practitioner Incentive Act of 1995".

SEC. 2. INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

(1) IN GENERAL.—Section 1861(s)(2)(K)(ii) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)(ii)) is amended to read as follows:

"(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as so defined) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service;".

(2) CONFORMING AMENDMENTS.—

(A) Section 1861(s)(2)(K) of such Act (42 U.S.C. 1395x(s)(2)(K)), as amended by paragraph (1), is amended—

(i) in clause (i), by inserting "and such services and supplies furnished as in-

cident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service." after "are performed, and"; and

(ii) by striking clauses (iii) and (iv).

(B) Section 1861(b)(4) of such Act (42 U.S.C. 1395x(b)(4)) is amended by striking "clauses (i) or (iii) of subsection (s)(2)(K)" and inserting "subsection (s)(2)(K)".

(C) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking "section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)".

(D) Section 1866(a)(1)(H) of such Act (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking "section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)".

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Section 1833(a)(1)(O) of the Social Security Act (42 U.S.C. 1395*l*(a)(1)(O)) is amended to read as follows: "(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid

shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist; or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, and".

(2) CONFORMING AMENDMENTS.—

(A) Section 1833(r) of such Act (42 U.S.C. 1395*l*(r)) is amended—

(i) in paragraph (1), by striking "section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)," and inserting "section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services),";

(ii) by striking paragraph (2);

(iii) in paragraph (3), by striking "section 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)(ii)"; and

(iv) by redesignating paragraph (3) as paragraph (2).

(B) Section 1842(b)(12)(A) of such Act (42 U.S.C. 1395u(b)(12)(A)) is amended in the matter preceding clause (i), by striking "clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to a physician assistants and nurse practitioners)" and inserting "section 1861(s)(2)(K)(i) (relating to physician assistants)".

(c) DIRECT PAYMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.—

(1) IN GENERAL.—Section 1832(a)(2)(B)(iv) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking "provided in a rural area (as defined in section 1886(d)(2)(D))".

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) of such Act (42 U.S.C. 1395u(b)(6)(C)) is amended—

(A) by striking "clauses (i), (ii), or (iv)" and inserting "clause (i)"; and

(B) by striking "or nurse practitioner".

(d) BONUS PAYMENT FOR SERVICES PROVIDED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—Section 1833(m) of such Act (42 U.S.C. 1395*l*(m)) is amended—

(1) by inserting "(1)" after "(m)"; and

(2) by adding at the end the following new paragraph:

"(2) In the case of services of a nurse practitioner or clinical nurse specialist furnished to an individual, described in paragraph (1), in an area that is a health professional shortage area as described in such paragraph, in addition to the amount otherwise paid under this part, there shall also be paid to such service provider (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 10 percent of the payment amount for the service under this part.".

(e) DEFINITION OF CLINICAL NURSE SPECIALIST CLARIFIED.—Section 1861(aa)(5) of such Act (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by inserting "(A)" after "(5)";

(2) by striking "The term "'physician assistant'" and all that follows through "who performs" and inserting "The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this title, a physician assistant or nurse practitioner who performs"; and

(3) by adding at the end the following new subparagraph:

"(B) The term 'clinical nurse specialist' means, for purposes of this title, an individual who—

"(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

"(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.".

(f) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after July 1, 1995.

○

Question: Why doesn't your Medicare proposal provide for reimbursement for nurse practitioners and clinical nurse specialists?

Answer: I put a Medicare proposal on the table that will preserve the Medicare program and keep it financially secure, while not adding new costs for people on Medicare. I vetoed the Republican budget bill because it would threaten the Medicare program, beneficiaries access to care, and the quality of health care for everyone in this country. I very much appreciated your support for that veto and for all the work you have done to bring health care to all Americans.

As you pointed out, a provision to reimburse nurse practitioners and clinical nurse specialists would have some costs associated with it. At a time when we were trying to cut as little as possible from the Medicare program, we did not include the provision. However, we are more than happy to work with you on it.

FAX COVER SHEET

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS

Number of pages: Date:

To:	From:
Jennifer Kline	JOAN STIEBER Medicare Part B Analysis Division (for Debbie Chang)
Fax: (202) 456-2878	Fax: (202) 690-8168
Phone:	Phone: (202) 690-6884

REMARKS:

Language in conference report re:
physician assistants & nurse
practitioners

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

Subtitle H – Rural Areas

PROVISIONS	CONF. AGREEMENT (H.R. 2491)	COALITION (H.R. 2530)	ADMINISTRATION
Floor on area wage index	Sec. 8705 After October 1, 1995, the area wage index for hospitals located in urban areas cannot be less than the average rural wage index in the State.	Sec. 8505 Same.	No provision.
Additional payments for physician's services furnished in shortage areas	Section 8706 ♦ Increases the bonus payment for primary care services furnished in rural health professional shortage areas (HPSAs) from 10% to 20% effective 10/1/95. Effective 10/1/96, for three years, maintains the bonus payments for areas that are removed from the HPSA list. ♦ Requires carriers to provide information on the program's providers to the Secretary. ♦ No provision. ♦ No provision.	Sec. 8511: ♦ Same. ♦ Same. ♦ Requires the Secretary to study the effectiveness of HPSA bonus payments on recruiting and retaining physicians in HPSAs and report to Congress in one year. ♦ Requires the Secretary to develop a model State scope of practice law.	No provision.
Physician assistant and nurse practitioner payments in outpatient or home settings	Sec. 8707 Effective on 10/1/95, physician assistants (PAs) and nurse practitioners (NPs) would be paid directly for services in outpatient and home settings at 85% of the physician fee schedule. Payments for PAs and NPs serving as assistants-at-surgery for services furnished in outpatient and home settings would be 85 percent of the fee schedule amount that would be paid for physicians serving as assistants-at-surgery.	No provision.	No provision.

JAN-05-1996 15:52 OLIGA 202 690 8168 P.02

services" the following: "consisting of primary care services (as defined in section 1842(i)(4))".

(c) EXTENSION OF PAYMENT FOR FORMER SHORTAGE AREAS.—

(1) IN GENERAL.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking "area," and inserting "area (or, in the case of an area for which the designation as a health professional shortage area under such section is withdrawn, in the case of physicians' services furnished to such an individual during the 3-year period beginning on the effective date of the withdrawal of such designation),".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to physicians' services furnished in an area for which the designation as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act is withdrawn on or after January 1, 1996.

(d) REQUIRING CARRIERS TO REPORT ON SERVICES PROVIDED.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (I); and

(2) by inserting after subparagraph (I) the following new subparagraph:

"(J) will provide information to the Secretary (on such periodic basis as the Secretary may require) on the types of providers to whom the carrier makes additional payments for certain physicians' services pursuant to section 1833(m), together with a description of the services furnished by such providers; and".

(e) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (d) shall apply to physicians' services furnished on or after October 1, 1995.

SEC. 8707. PAYMENTS TO PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS FOR SERVICES FURNISHED IN OUTPATIENT OR HOME SETTINGS.

(a) COVERAGE IN OUTPATIENT OR HOME SETTINGS FOR PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS.—Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended—

(1) in clause (i)—

(A) by striking "or" at the end of subclause (II); and

(B) by inserting "or (IV) in an outpatient or home setting as defined by the Secretary" following "shortage area."; and

(2) in clause (ii)—

(A) by striking "in a skilled" and inserting "in (I) a skilled"; and

(B) by inserting ", or (II) in an outpatient or home setting (as defined by the Secretary)," after "as defined in section 1919(a)".

(b) PAYMENTS TO PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS IN OUTPATIENT OR HOME SETTINGS.—

(1) IN GENERAL.—Section 1833(r)(1) (42 U.S.C. 1395l(r)(1)) is amended—

(A) by inserting "services described in section 1861(s)(2)(K)(ii)(II) (relating to nurse practitioner services furnished in outpatient or home settings), and services described in section 1861(s)(2)(K)(i)(IV) (relating to physician assistant services furnished in an outpatient or home setting" after "rural area),"; and

(B) by striking "or clinical nurse specialist" and inserting "clinical nurse specialist, or physician assistant".

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended by striking "clauses (i), (ii), or (iv)" and inserting "subclauses (I), (II), or (III) of clause (i), clause (ii)(I), or clause (iv)".

(c) PAYMENT UNDER THE FEE SCHEDULE TO PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS IN OUTPATIENT OR HOME SETTINGS.—

(1) PHYSICIAN ASSISTANTS.—Section 1842(b)(12) (42 U.S.C. 1395u(b)(12)) is amended by adding at the end the following new subparagraph:

"(C) With respect to services described in clauses (ii)(IV), (ii)(II), and (iv) of section 1861(s)(2)(K) (relating to physician assistants and nurse practitioners furnishing services in outpatient or home settings)—

"(i) payment under this part may only be made on an assignment-related basis; and

"(ii) the amounts paid under this part shall be equal to 80 percent of (I) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist; or (II) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery.".

(2) CONFORMING AMENDMENT.—Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended in the matter preceding clause (i) by striking "(i), (iii)," and inserting "subclauses (I), (II), or (III) of clause (i), or subclause (I) of clause (iii)".

(3) TECHNICAL AMENDMENT.—Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended in the matter preceding clause (i) by striking "a physician assistants" and inserting "physician assistants".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1995.

SEC. 8708. EXPANDING ACCESS TO NURSE AIDE TRAINING IN UNDERSERVED AREAS.

(a) IN GENERAL.—Section 1819(f)(2)(B)(iii)(I) (42 U.S.C. 1396r(f)(2)(B)(iii)(I)) is amended in the matter preceding item (a), by striking "by or in a nursing facility" and inserting "by a nursing facility (or in such a facility, unless the State determines that there is no other such program offered within a reasonable distance, provides notice of the approval to the State long term care ombudsman, and assures, through an oversight effort, that an adequate environment exists for such a program)".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to nurse aide training and competency evaluation programs under section 1819 of the Social Security Act which are offered on or after October 1, 1995.

NURSES

Molly Brostrom and Jennifer Klein have been working with Marilyn Yager to respond to the American Nurses Association's request for greater responsiveness to their concerns from this Administration. Monday, they will meet with ANA representatives to discuss progress the Administration has made on a list of "Imperatives" they asked us to consider.

An item the ANA will be particularly pleased with is our agreement to allow direct reimbursement to nurse practitioners and clinical nurse specialists under Medicare. Other issues they have asked us to work on include: patient safety and quality initiatives (the President's fight against repeal of nursing home standards is a key response to this concern); greater nurse representation in federal hiring; sunsetting of a DOL Visa program that allowed nurses to enter the country (Reich allowed program to sunset); and support for nurse education (reauthorization of the Nurse Education Act was held up in the Senate this year).