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FINDING A CURE TO KEEP NURSES ON THE JOB: THE FEDERAL GOVERNMENT'S ROLE IN RETAINING NURSES FOR DELIVERY OF FEDERALLY-FUNDED HEALTH CARE SERVICES

HEARING

BEFORE THE

OVERSIGHT OF GOVERNMENT MANAGEMENT, RESTRUCTURING, AND THE DISTRICT OF COLUMBIA SUBCOMMITTEE

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

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FINDING A CURE TO KEEP NURSES ON THE JOB: THE FEDERAL GOVERNMENT'S ROLE IN RETAINING NURSES FOR DELIVERY OF FEDERALLY-FUNDED HEALTH CARE SERVICES

WEDNESDAY, JUNE 27, 2001

U.S. SENATE,
SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT,
RESTRUCTURING, AND THE DISTRICT OF COLUMBIA,
OF THE COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:02 a.m., in room SD–342, Dirksen Senate Office Building, Hon. Richard J. Durbin, Chairman of the Subcommittee, presiding.

Present: Senators Durbin, Cleland (ex officio), and Voinovich.

OPENING STATEMENT OF SENATOR DURBIN

Senator DURBIN. Welcome to this hearing of the Oversight Subcommittee of the Committee on Governmental Affairs and my first hearing as Chairman, so please forgive me as I learn how to do this. I have usually been listening to gavels, and now I am banging one, so it is a little different role for me to play. I know that some of my colleagues are on their way to join us for this hearing this morning, and I thank all of you for joining us this morning.

This is a hearing that we have decided to kick off our Oversight Subcommittee with on the subject of the nursing shortage which faces our country. The Federal Government has an important role in retaining nurses for the delivery of federally-funded health care services and other services.

We have to face the possibility that America may ring for a nurse some day, and no one will respond. As our population gets older and fewer nurses are graduated and fewer stay in the profession, that is a very real possibility.

The issue and challenge for us is what we can do today to address this problem, and you will hear from witnesses on both panels that there are things that need to be done.

This issue defies any easy solutions. There is no magic switch that we can flip or handy button that we can push that will solve it. We have nearly half a million trained nurses in America who are no longer practicing their profession. In my home State of Illinois, over 19 percent of nurses are no longer working as nurses.

When I talk to nurses, including relatives of mine who are nurses, they tell me they are burned out, exhausted because of inadequate staffing levels; they are being asked to do double shifts and are unable to balance their nursing responsibilities with their personal and family commitments. I know that many nurses feel that all of the problems of our current health care system, including its finances, are being forced upon them, and it is really just too much to ask.

If their daughters or sons were to contemplate a career in nursing, many say they would advise against it—not because they do not love caring for patients, but because of all the stresses that are brought to bear on them today with inadequate compensation.

Since 1992, wages for nurses after inflation have risen by less than 1 percent. But managed care has pushed the finances of our hospitals to a near breaking point. This leaner face of health care is described by many nurses as both leaner and sometimes meaner.

A recent survey by the Federation of Nurses and Health Professionals found that half of the current employed nurses surveyed had considered leaving the patient care field for reasons other than retirement over the past 2 years. Of those thinking about leaving, 56 percent indicated that they wanted a less stressful and physically demanding job; 22 percent said they were concerned about the schedules and hours; and 18 percent sought higher pay. Annual turnover rates among hospital staff nurses have increased to 15 percent, up from 12 percent in 1996. A recent survey of nursing home chains found turnover among RN's and LPN's to be over 50 percent.

The situation is even more drastic in some of our Nation's poorest rural and inner city communities. They may soon have inadequate or no hospital health care because finding nurses who are willing to work in their neighborhoods is almost impossible. Some of these hospitals operate amid the harshest poverty and crime in our country. The employees of these hospitals often treat the worst and most troubling cases.

I recently supported the effort of a hospital in Chicago that was desperate for nurses to try to find some way to change the immigration law to deal with the issue. But generally, immigration is not a long-term solution to the underlying problem of poor workplace conditions and in some instances actually threatens patient safety, and at the very least drives more and more professionals away from the caring profession of nursing.

Last year, *The Chicago Tribune* ran a three-part series on medical errors caused by nurses. It was an eye-opener. And the Institute of Medicine released a sentinel report on medical errors throughout the health care system, reporting that annually, we might have almost 98,000 deaths due to medical errors. This can only be described as alarming and really points to the need to overhaul our health care system.

We will be hearing from several nurses today about the conditions under which they work which contribute in many cases to a less than safe environment for patients. I was shocked to learn recently that most nurses now work shifts of 10 to 12 hours and that some are forced to work double shifts even when they are exhausted. How could a 20-hour day be safe for patients, let alone

good for a nurse or his or her family? I will be very interested to hear from some of the nurses who are here today to testify as to how they deal with the care of their children and other family members if their schedule can be forced to change without notice.

If you think the situation is bad now, wait until we get to 2010. The nursing work force is aging just like the overall U.S. population is aging. Fewer and fewer young people are going into the career of nursing just as we move to a time when we need nurses more and more.

I had a recent visit from a head nurse in a nursing home in the Chicago area, and she told me a story which was incredible. She said, "I have been at this all my life"—she is about 60 years old—"I love nursing, and I love working with nurses. I recently had a surgery scheduled at a major hospital in Chicago, and before I went in for that surgery, I hired a private nurse to come with me."

It almost takes your breath away to think that that is a possibility. It really suggests that if we do not address this, we may reach a stage where we are dealing with graduated health care even within our hospitals. Who can afford to bring their own nurse or their own doctor to make sure they get the care they think they need? And certainly, when it comes to nursing, if this nurse, who has dedicated her life to it, thought she needed a private nurse to be by her bedside in a major hospital in Chicago, that is worrisome for all of us.

I have a chart here which shows the distribution of nurses in 1980 and then in the year 2000. If you took your statistics course, you can probably follow this a little more carefully. What it shows us is that the average age of nurses is 45 today; it was 37 in 1983.

A comprehensive approach is needed not only to attract more young people but also to improve the work environment. Retention is just as important as recruitment. I will be introducing a comprehensive bill to address the nursing shortage. It will focus on outreach to young people to encourage them to think about careers in nursing and other caregiving professions; scholarships and loans for those who serve in underserved areas, be they urban or rural; and financial incentives to address inadequate staffing levels that put the public in danger. The bill will also provide additional educational opportunities to those who are in the process of transitioning to the work force as the welfare reform bill is fully implemented.

But beyond recruitment and training, we really cannot solve this problem without looking at workplace conditions. Spending money on recruitment and training is wasted if health professionals quit early because they cannot live with the excessive hours, work load, and stress. We have rules in many other public safety-oriented professions. For instance, the Federal Government does not allow pilots to work continually. We have limits on truck drivers and train engineers. Shouldn't we also give protections to nurses so they are not forced to work hours that put them and their patients in danger due to fatigue?

Many other countries are experiencing similar demographic changes and are challenged to meet their own health and long-term caregiving needs. It is not at all clear that immigration can solve this problem given the global need for more caregivers.

As I said earlier, the issue defies easy solutions. However, what is clear is that we need to invest more significantly in recruitment, education, and retention if we are to address this long-term need.

At this point, I would like to recognize the ranking member of the Subcommittee, Senator Voinovich.

OPENING STATEMENT OF SENATOR VOINOVICH

Senator VOINOVICH. Thank you, Mr. Chairman.

I am pleased that the Subcommittee is holding this hearing today to examine the nursing shortage in the United States and how it is impacting federally-funded health care programs.

I would like to welcome our two panels of witnesses and thank them for being here today.

As you know, Mr. Chairman, over the past 2½ years, the Subcommittee has conducted a thorough examination of the human capital crisis confronting the Federal Government's work force. In profession after profession, the story is the same: A lack of skilled people, an aging work force, or both.

It would seem that this is a similar problem in the nurse work force—and not just those who work for the Federal Government or through federally-funded programs. Just as the average age of Federal employees has risen over the years, today's average registered nurse is 45 years old, up from 37 in 1983. This increase has taken place at the same time that the average age of Americans has risen.

With people living longer, the need for quality health care professionals will only increase with time. Exacerbating the problem is the fact that hundreds of thousands of nurses are no longer working in the field of nursing, and the number has increased 11 percent in the last 4 years. It will be interesting to discuss why that is and if there is a correlation with the fact that during the same period of time, nursing wages have remained stagnant, rising approximately 1 percent.

Mr. Chairman, we have two excellent panels of witnesses with us today. I am especially pleased to welcome Rear Admiral Kathleen Martin. As you know, Mr. Chairman, last year, Congress passed legislation that I sponsored to provide work force reshaping authorities in the Department of Defense. I will be interested in hearing Admiral Martin's testimony on what is being done to address the nursing shortage in the Armed Forces.

Thank you again, Mr. Chairman, for holding this hearing, and I look forward to the witnesses' testimony.

Senator DURBIN. Thank you, Senator Voinovich.

Senator Cleland.

OPENING STATEMENT OF SENATOR CLELAND

Senator CLELAND. Thank you very much, Mr. Chairman, and Senator Voinovich. It is nice to be with you, my dear colleagues, today, focusing on the nursing shortage and the challenge of being a nurse in America today.

I might say first off that nurses helped save my life. I would not be here were it not for nurses. The second person to me on the battlefield, Admiral Martin, was a Navy corpsman, and one of the first hospitals I was evacuated to was the Navy hospital in Danang. So

I have a special appreciation for nurses, especially Army dust-off pilots, Army medics, Navy medics, and Air Force medivac teams. So I want you to know that I am here today because of nurses and a whole complement of people who go out there and do an incredible job.

I again commend my colleague Senator Durbin and other Subcommittee Members for today's hearing on the critical role of nurses, particularly in the Federal health care system. I am a former head of the Veterans Administration, and I know the critical role that nurses play there.

In the Federal health care system, we have military and Veterans Affairs nurses. They are not only life-sustaining givers of care but also givers of hope. As someone who was in the military and VA health care system for more than a year and a half, I can certainly attest to that.

When I meet with health care groups from Georgia and across the Nation, the increasing need for nurses is always part of the discussion. At the June 14 Senate Veterans Affairs Committee hearing on the looming nursing shortage, I emphasized an alarming statistic—that the Federal health care sector, employing approximately 45,000 nurses, may be the hardest hit in the near future, with an estimated 50 percent of its nursing work force eligible for retirement by the year 2004—almost 50 percent of the nursing work force in the Federal Government and in the military eligible for retirement in 2004.

Current and anticipated nursing vacancies in all health care settings are attributed to a variety of factors, including more career choices for women and worsening workplace conditions with mandatory overtime and increasing patient care work loads. It sounds a little bit like what they said when I was in the Army, that "Good duty is rewarded with more duty." I think our nurses in America are in that position.

I believe that today we are really facing more widespread and complex challenge with the nursing shortage. There are no quick fixes, but I do think that part of the key to developing legislative initiatives and understanding this complex issue is the testimony we are going to hear today from our panelists. I think it is crucial that we have nurses recommend to us how they can take safe and effective care of their patients and for us to assist health care facilities in recruitment and retention of qualified nurses.

One answer that I have is some legislation that I have introduced, S. 937, which is a bill to amend Title 38 of the U.S. Code to prevent members of the armed services to transfer their Montgomery GI bill educational benefits to spouses and children, and that assistance could be used for undergraduate or graduate nursing education. It is an effort to retain service men and women, but it is also an effort to keep spouses and children in the military with their spouses and to give them an educational opportunity as well, and give them hope.

I have also introduced S. 1080, the Federal Nurse Retirement Adjustment Act, which will allow Federal nurses in the Federal Employee Retirement System to retain unused sick leave and retirement calculations comparable to nurses currently in the civil retirement system.

I urge my colleagues to carefully consider the testimony of today's witnesses as they develop initiatives to help recruit and retain qualified nurses.

Thank you all very much for being with us.

Thank you, Mr. Chairman.

Senator DURBIN. Thank you, Senator Cleland.

I would first like to introduce two people who will not be testifying on the first panel, but I want to acknowledge their presence and thank them for joining us.

Brigadier General Barbara Brannon [1] is commander of the 89th Medical Group at Andrews Air Force Base. Thank you for being with us today. She is the Assistant Air Force Surgeon General for Nursing.

And Brigadier General William T. Bester [1]——

Colonel GUSTKE. He is not here today, Mr. Chairman.

Senator DURBIN. Could you introduce yourself, please?

Colonel GUSTKE. I am Colonel Deborah Gustke. I am the Deputy Chief of the Army Nurse Corps, sir, representing General Bester.

Senator DURBIN. Thank you very much for joining us today.

I will now introduce the panel that will testify first.

Rachael Weinstein is a registered nurse and Director of the Clinical Standards Group at the U.S. Department of Health and Human Services.

Dr. Denise Geolot is a registered nurse and Director of the Division of Nursing at the U.S. Department of Health and Human Services. She administers the Federal program that enables national nursing work force development.

Admiral Kathleen Martin joins us from the United States Navy. She will deliver testimony on behalf of the Tri-Service Nurse Corps. She is a Rear Admiral and Director of the Nurse Corps.

Janet Heinrich is Associate Director of the Health, Education, and Human Services Division at the U.S. General Accounting Office.

Thank you all for coming. We are looking forward to your testimony.

It is the custom of this Subcommittee to swear in all witnesses; therefore, I will ask all of you to stand and raise your right hand as I give an oath for the first time in my life.

Do you swear that the testimony you are about to give before this Subcommittee is the truth, the whole truth, and nothing but the truth?

Ms. WEINSTEIN. I do.

Dr. GEOLOT. I do.

Admiral MARTIN. I do.

Ms. HEINRICH. I do.

Senator DURBIN. Thank you.

Let it be noted for the record that all witnesses answered in the affirmative.

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[1] The prepared statement of Brigadier General Barbara Brannon appears in the Appendix on page 73.

[1] The prepared statement of Brigadier General William T. Bester appears in the Appendix on page 85.

I would like to ask you to limit your oral statements to no longer than 10 minutes and remind you that your entire statement will be made part of the record.

Ms. Weinstein, please proceed.

TESTIMONY OF RACHAEL WEINSTEIN, RN,[1] DIRECTOR, CLINICAL STANDARDS GROUP, OFFICE OF CLINICAL STANDARDS AND QUALITY, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY THOMAS HOYER, DIRECTOR, CHRONIC CARE PURCHASING POLICY GROUP

Ms. WEINSTEIN. Chairman Durbin, Senator Voinovich, and distinguished Subcommittee Members, thank you for inviting me to discuss the need for adequate nurse staffing levels. Accompany me today is Tom Hoyer, Director of our Chronic Care Purchasing Policy Group, who is an expert in Medicare payment policy, who is with me to respond to your technical payment questions.

As a registered nurse, the issue of nurse staffing is important to me personally. It is a priority for Administrator Scully and Secretary Thompson, and we look forward to working with you to address this growing concern.

Nurses and nurse aides play a critical role in caring for Medicare and Medicaid beneficiaries, sometimes working more than the equivalent of two 8-hour shifts in 1 day. Their work can be exhausting, emotionally as well as physically, and too often they perform their duties without receiving the credit that they deserve.

Nursing requires great dedication, and research has shown that it is becoming more and more difficult to recruit and retain professionals to perform this difficult work. Moreover, studies continue to demonstrate that higher nurse staffing levels, especially registered nurse staffing levels, directly influence positive outcomes in patient care.

We recognize the important role that nurses play in our health care system, and we value their dedication and hard work. In our role as the largest health insurer in America, we need to ensure that we pay health care providers adequately and appropriately, and my written statement goes into the details of how we fulfill this responsibility.

Numerous objective observers including the General Accounting Office, the Health and Human Services Inspector General, and the Medicare Payment Advisory Commission have found that Medicare payment levels in the last few years are more than adequate to cover the costs of providing high-quality fare in hospitals, skilled nursing facilities, and home health agencies.

Despite the appropriateness of Medicare reimbursement levels, our country faces an emerging shortage. We are hearing that a higher proportion of patients with more complex care needs has expanded the need for nurses with specialized training. We also hear that the increased use of technology has driven up the demand for a higher skill level of registered nurses. And the expansion of care delivery settings has increased the demand for nurses in general.

[1] The prepared statement of Ms. Weinstein appears in the Appendix on page 49.

Job dissatisfaction, difficult working conditions, and low compensation may also contribute to the emerging nurse shortage. In fact, studies indicate that dissatisfaction with working conditions is a major source of frustration for nurses, both domestically and in foreign countries. This frustration has led to a decline in enrollment in nursing schools and an increase in the number of nurses leaving the profession. Additionally, the majority of actively employed nurses is aging.

We are analyzing the situation to determine the best way to ensure that our beneficiaries continue to receive the high-quality care they need, and we are committed to reducing unnecessary burdens and complexities in Medicare. We are sponsoring research into nurse staffing levels in nursing homes, and we are considering ways to guarantee that nursing homes provide the appropriate staffing levels based on the results of our research.

In addition, our current conditions of participation for home health agencies, skilled nursing facilities, and hospitals which these facilities must meet in order to receive Medicare reimbursement requires that they maintain adequate nurse staffing levels. And we propose a new hospital condition of participation that would ensure staffing levels reflect the volume of patients, patient acuity, and the intensity of the services provided to achieve desirable patient outcomes.

Additionally, we have been working with our partners, including the Health Resources and Services Administration, to sponsor nurse staffing studies. A study that we cosponsored with HRSA, "Nurse Staffing and Patient Outcomes in Hospitals," was just released a few months ago. The results of this study and other efforts will help inform the public and private sectors as we work collaboratively to find solutions to the emerging nurse shortage problem.

Nurses play a crucial role in caring for our beneficiaries, and we are concerned that the nurse staffing shortage could have a profound impact on the care that our beneficiaries receive. We must continue to be vigilant and ensure that we are paying health care providers appropriately so they can hire and retain adequate levels of nursing staff. We must continue to make the issue of the emerging nurse shortage a priority. We are working closely with our HHS partners, and we want to continue to work with you and others to find ways to address this growing concern.

Thank you for this opportunity to speak with you today about this important issue. I am happy to answer your questions.

Senator DURBIN. Thank you, Ms. Weinstein. Dr. Geolot.

TESTIMONY OF DENISE H. GEOLOT,[1] Ph.D., RN, FAAN, DIRECTOR, DIVISION OF NURSING, BUREAU OF HEALTH PROFESSIONS, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. GEOLOT. Good morning, Mr. Chairman and distinguished Members of the Subcommittee.

I am pleased to appear before you today to discuss issues related to the nurse work force. In my brief statement this morning, I will provide an overview of the characteristics of the nursing work

[1] The prepared statement of Dr. Geolot appears in the Appendix in page 58.

force, speak about the extent of current and projected nurse staffing levels, and review what the Health Resources and Services Administration is doing to plan for future nursing staff needs.

In March 2000, the Division of Nursing, Bureau of Health Professions, conducted the National Sample Survey of Registered Nurses, the seventh in a series of surveys on the characteristics of the nursing work force. The previous survey was completed in 1996.

This survey provides the latest and most comprehensive data on the characteristics of the registered nurse work force. The full report of this survey is to be released this summer. I will just mention a couple of points in terms of the data. The rest are in my testimony.

There are estimated to be 2.7 million registered nurses in the United States. This reflects a 5.4 percent increase between 1996 and 2000. Over 2.2 million of the 2.7 million nurses are employed in nursing. Nearly 72 percent of those nurses work full-time. Sixty-eight percent of the staff nurses working in hospital settings indicated that they were satisfied with their jobs.

When we looked at the educational preparation of registered nurses, we found that 23 percent had a nursing diploma as their highest level of preparation, 34 percent an associate degree, and 43 percent had a baccalaureate or higher degree.

The RN population is aging. Nine percent of nurses are under the age of 30, and 51 percent are over the age of 45.

Nursing students are also older. The average age for a basic nursing graduate is 30.5.

An estimated 12.3 percent of the RN population reported being from one of the racial and ethnic minority groups, up from 10.3 percent in 1996.

An estimated 5.4 percent of the RN population are men, up from 4.9 percent in 1996.

There are pockets of nursing shortages throughout the country, especially for registered nurses with clinical expertise and specialty preparation. Some hospitals are reporting that they must close beds and divert patients to other hospitals because of nursing shortages.

The aging of the nursing population, declining student enrollments in nursing schools, and the current working conditions may have an effect on future nurse staffing needs. Enrollment in all nursing programs has declined. Enrollment data from the American Association of Colleges of Nursing reveals that baccalaureate nursing program enrollments fell 4.6 percent in fall 1999—the fifth straight year of declining enrollments. Figures for 2000 revealed a slowing decline to 2.1 percent.

Graduation data from the National League for Nursing indicated that there was a 13.6 percent decrease in registered nurse graduates between 1995 and 1999.

The answer to whether there is a national nursing shortage is complex. No single direct measure exists for indicating a shortage of nurses at the national level. The Division of Nursing has historically used a comparison of the projected supply of nurses and the projected demand or requirements for nurses to assess imbalances.

Ideally, the number of nurses available to provide services in a given setting should be in balance with the requirements for nurs-

ing services in that setting. Based on outputs from the supply projection model and the demand projection model published in the mid-1990's, the supply of and requirements for full-time equivalent RN's is expected to be roughly in balance until the year 2010 at the national level. A projected leveling off of the supply and steep increases in demand over the years between 2010 and 2020 will result in a widening gap between the number of nurses expected to be required and the number of nurses expected to be available.

By the year 2020, the model indicates a shortfall in the number of nurses and the number of needed registered nurses. However, because of the recent rapid changes in the health care system, it is difficult to make precise predictions about what the demand for nursing services will be in the future.

Preliminary estimates from the revised demand forecasting model and supply projections indicate that at the national level, there is roughly a balance at this time. However, this does not negate reports from other sources of current shortages in specific areas, health care sectors, or types of registered nurses.

The demand forecasting model identifies a systemic problem that will continue to increase through 2020. If these current trends continue, all health care settings, all geographical areas, and all needed specialty nurses may experience nursing supply challenges. But there may also be advances in technology that may reduce future demands. HRSA will continue to monitor nursing data to chart future nurse staffing needs.

When we look at the RN-to-population ratio for the Nation as a whole, our data show that the overall ratio of employed RN's per 100,000 population has varied from 688 in 1988 during the previous shortage to 798 in 1996 and 782 in 2000. After more than a decade of increases, the rates appear to be dropping.

In addition, data show that the variation among States is considerable. The numbers range from a low of 520 employed RN's per 100,000 population in Nevada to a high of 1,675 in Washington, DC.

HRSA administers programs authorized under Title VIII of the Public Health Service, often referred to as The Nurse Education Act. Title VIII was instituted by the Nurse Training Act of 1964 in response to a qualitative and quantitative shortage of nurses as a key vehicle for Federal support for nursing work force development. Title VIII programs are primarily administered by the Bureau of Health Professions, Division of Nursing.

Specific activities helping to mitigate the shortage of nurses include: Support for basic and advanced nursing education programs; diversity programs targeting minority and disadvantaged students; scholarship, traineeships, and loans; and nursing work force analysis.

In fiscal year 2001, the budget for the Division of Nursing Programs is $76.5 million. The administration's fiscal year 2002 budget would increase the funding for HRSA's nursing programs by $5 million.

The Bureau's Division of Student Assistance provides $12.7 million in support to 3,600 nursing students through the Scholarships for Disadvantaged Students Program and $22 million in support

for 10,000 nursing students through the revolving Nursing Student Loan Program.

Within the Bureau of Primary Health Care, the Nursing Education Loan Repayment Program provides $2.3 million to assist 200 registered nurses by repaying up to 80 percent of their qualified educational loans in return for their commitment to work at health facilities in shortage areas. In addition, the National Health Service Corps Scholarship and Loan Repayment Program provides $6.3 million to support 94 nurse practitioners and 29 nurse-midwives providing services to people in underserved areas.

HRSA has been working with the Centers for Medicare and Medicaid Services to examine work force issues, and my colleague has mentioned them.

So in summary, Mr. Chairman, I appreciate the opportunity to share with you the latest information on the characteristics of the nursing work force, the status of what our data show from a national perspective, and the types of activities being undertaken in HRSA to address the needs of the nursing work force.

Senator DURBIN. Thank you very much, Dr. Geolot. Admiral Martin.

TESTIMONY OF REAR ADMIRAL KATHLEEN L. MARTIN,[1] NURSE CORPS, DIRECTOR, NAVY NURSE CORPS, U.S. NAVY

Admiral MARTIN. Good morning, Mr. Chairman and Senator Voinovich. It is my pleasure to testify today as the Director of the Navy Nurse Corps and the Commander of the National Naval Medical Center in Bethesda.

I am also here to speak on behalf of the Chief of the Army Nurse Corps and the Director of the Air Force Nursing Services.

My colleagues are here to answer specific questions.

Today I would like to discuss one of our principal concerns—the nationwide nursing shortage and its impact on the military health care system. I will address this in terms related to both military nursing and civil service nursing.

As you are well aware, the demand for professional nurses in America is increasing while the supply continues to decline. The impact of this diminishing pool affects health care delivery nationwide. Along with the civilian and Federal sectors, the military now finds itself in a critical struggle to attract and retain nurses for active duty, reserves, civil service, and contract positions.

Our nursing issues, such as compensation, job stress, quality of life and workplace, are similar to those in the civilian sector. However, due to the distinctive mission of the military, we are not equally affected by the same challenges.

I would first like to discuss factors having a positive effect on military nursing. Unlike our civilian and Federal counterparts, military nurses have long relied upon the medical enlisted forces to assist in the delivery of health care. These technicians, medics, and hospital corpsmen possess higher skill levels than their unlicensed civilian colleagues and are considered an integral part of the nursing team.

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[1] The prepared statement of Admiral Martin appears in the Appendix in page 64.

Additionally, staffing levels in military hospitals have a tendency to remain more stable. This can be attributed to the turnover rate for new military nurses and enlisted being controlled by obligated service contracts and predictable timing of change of duty assignments.

Additionally, on average, military nurses experience a higher nurse-to-patient ratio, greater collaborative nurse-physician relationships, additional leadership opportunities, diverse practice environments, and broadened career paths.

However, despite the unique military advantages, the effects of a dwindling supply of best qualified nurses have a detrimental effect on military nursing. Currently, our greatest challenges lie not only in recruiting new nurses but also in retaining junior to mid-grade level experienced nurses.

An adequate force structure is critical to maintaining a high quality of peacetime health care while ensuring that our fighting forces and operational commitments are fully supported.

Success with recruiting nurses into the military has varied among the services, but filling the Reserve Officer Training Command, or ROTC, billets has been difficult for all services. One reason for this could be that fewer high school graduates are choosing nursing as a career or seeking a military experience while in college. Additionally, nurses with 1 to 5 years of experience are becoming more difficult to attract to the military. This has a direct impact on health care delivery system and operational readiness because of the nursing shortfalls in critical specialties such as operating room, critical care, mental health and obstetrics, to name a few. In addition, the nurses who we are able to recruit are often 40 years and older, leading to an older, limited-term, non-career-track force.

A fundamental part of the recruiting strategy for all services is the current nurse accession bonus. Active-duty accession bonuses may attract individuals, but without additional incentives, it may be difficult to retain nurses after their initial commitment. Currently, only nurse anesthetists, nurse practitioners, and nurse-midwives are authorized to receive incentive special pay or a board certification pay. These programs have been successful retention tools thus far, but the civilian-military pay gap is rapidly widening for advanced practice nurses. Further, retention bonuses may be needed to retain all types of nurses as compensation for increasing the ever demanding supply.

Because up to half of the nursing force in the Navy and Army military treatment facilities is comprised of civilian nurses, it is also necessary to comment on the civil service or government service and contract nurse work force. Current vacancy and turnover rates vary between the services but are at levels that have a significant impact on mission capabilities. Because of considerable differences in compensation and hiring practices between the government and private sector, we cannot maintain an adequate level of civil service nurses to meet our needs.

Our civilian competitors are able to provide timely hiring actions in some instances in less than 1 week from application to first day in facility. Conversely, the average length of time to bring a new

civil service RN into a military treatment facility is as long as 93 days.

Government-civil service hiring practices and bureaucracy constraints entangle what must be an expeditious process.

To fill the needed vacancies in a timely manner, many military treatment facilities are forced to hire contract nurses, often at much higher salaries. Military and civil service nurses work side-by-side these higher-compensated peers, creating additional dissatisfaction for our military and civil service nurses.

Compensation is a powerful driver in the decision to remain with a military health care organization or to leave. Each of the services has established open communication and interviews with nurses to ascertain all reasons for departing military or government service. All services are instituting proactive initiatives within given constraints to enhance recruiting and retention.

Our military and civil service nurses are extremely dedicated to the success of the military health care system and our operational missions. They have been the backbone of our health care facilities and have served proudly for over 100 years. I truly believe that they are the finest professional nurses in the world.

Therefore, we must take action to ensure that our patients of the future will benefit from the services provided by these professional nurses.

In summary, I believe the main obstacles to first recruiting and then retaining quality nurse corps officers and civil service nurses are pay, benefits, and antiquated civil service hiring processes.

Mr. Chairman, on behalf of my colleagues, I thank you for allowing me to share this information and for your support in keeping military and Federal nursing strong for the future.

Senator DURBIN. Thank you, Admiral Martin.

I might add that there is a vote on, and Senator Voinovich has gone over to vote, and he will return, and then I will take off, and we will try to keep things moving.

Ms. Heinrich.

TESTIMONY OF JANET HEINRICH,[1] DIRECTOR, HEALTH CARE—PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Ms. HEINRICH. Thank you.

May I ask that we put the chart up, please?

Mr. Chairman, I also am pleased to be here today as you discuss issues related to the current difficulties in the recruitment and retention of nurses and concerns about the future supply.

My remarks will focus on what is known about the current supply of nurses, factors contributing to current recruitment and retention difficulties, and factors that will affect the supply of and demand for nurses in the future.

Yes, the U.S. health care system has changed dramatically in the last 2 decades, affecting the environment in which nurses provide patient care. Advances in technology and greater emphasis on cost-effectiveness have led to changes in the structure, organization, and delivery of health care services.

[1] The prepared statement of Ms. Heinrich appears in the Appendix in page 94.

We now see more patient care shifting to the ambulatory and community care settings, home care, and nursing homes. This has increased the demand for nurses outside the hospital. This change in service settings has also resulted in decreased lengths of patient stay in hospitals and a decline in the number of beds staffed.

At the same time, the acuity of patients increased as those patients remaining in hospitals were those too medically complex to be cared for in other settings.

National data are not adequate, as we have heard, to describe the extent of nurse work force shortages, nor are data sufficiently sensitive or current to allow a comparison of the adequacy of the work force across States, specialties, or provider types. Evidence suggests emerging shortages of nurses available or willing to fill some vacant positions in hospitals, nursing homes, and home care agencies.

The nationwide unemployment rate for RN's declined to 1 percent in 2000, the lowest level in more than a decade. Vacancy rates as reported by providers, often used as an indicator of possible excess demand, vary for all providers across all States, urban/rural areas.

For example, California reported a RN vacancy rate of 20 percent for hospitals in 2000, up from 9.6 percent in 1997. On the other hand, Vermont in a 2000 survey reported a RN vacancy rate of 4.8 percent in hospitals. It is difficult to understand what those vacancy rates really mean, because they are figured out in different ways in different facilities.

Job dissatisfaction may play a significant role in both current and future recruitment and retention problems. In all of the recent surveys we have reviewed, RN's reported themselves as "somewhat" or "very" dissatisfied with their jobs in a very high proportion. Inadequate staffing, heavy work loads, and the use of overtime to address staffing requirements were frequently listed as reasons. Nurses have also cited the lack of respect and recognition given them, along with their perceived lack of autonomy and ability to participate in decisionmaking, as areas of concern.

Overall compensation is also expressed as an area of concern. As we show in this chart, earnings have been relatively flat throughout the decade, with only a slight increase in recent years. While surveys indicate that increased compensation might encourage nurses to stay at their jobs, money is not always cited as the primary reason for job dissatisfaction. Often, it is the third or fourth issue that is reported.

Nurses also have expressed dissatisfaction with the decrease in the amount of support staff available to them. As reported by the American Hospital Association, current nurse work force issues are part of a larger concern for shortages of pharmacists, lab technicians, and others.

There is also a shortage of nurse aides who support nurses and assist patients with personal care. In the studies that we reviewed, we found that many of the factors that are concerns for nurses are also concerns for nurse aides and explain the problems that people experience with retention of nurse aides in all settings.

Growth in the number of new RN's has slowed, as we have heard. It is also interesting to hear that there has been a reduction

in the number of RN's taking and passing the licensing exam. This declined by 23 percent from 1997 to 2000—it was 96,679 in 1996, and it dropped to 74,787 in 2000.

Even with the relatively large increasing in the nursing work force over the 1990's—I think that 2.7 million figure is rather astounding—we can expect a serious shortage in the future as pressures are exerted on both demand and supply. The future demand for nurses is expected to increase dramatically when the baby boomers reach their 60's, 70's and beyond. During that same period, the number of women in the age groups who have traditionally formed the core of the nursing work force is expected to remain relatively unchanged. This mismatch between future supply and the demand for caregivers is illustrated in the change in the ratio of women age 20 to 54 to the population age 85 and older. That ratio will change from 16.1 in 2000 to 8.5 in 2030, and 5.7 in 2040.

In conclusion, providers' current difficulties recruiting and retaining nurses may worsen as the demand for nurses increases with the aging of the population. Certain changes in the current labor market are similar to those that occurred in past shortages. However, the impending demographic changes are widening the gap between the numbers of people needing care and those available as caregivers. Moreover, the current high levels of job dissatisfaction among nurses due to management decisions to restructure health care delivery and staffing may play a crucial role in determining the extent of future nurse shortages.

Efforts undertaken to improve the areas of workplace environment that contribute to job dissatisfaction may reduce the likelihood of nurses leaving the profession and increase the number considering it.

More data that can describe the scope and nature of the current problem is needed to assist in planning and targeting corrective actions.

Mr. Chairman, that concludes my statement. I would be happy to answer questions.

Senator DURBIN. Thank you.

I have a number of questions for the panel. First, for the record, Ms. Weinstein, CMS used to be HCFA.

Ms. WEINSTEIN. Yes. We have to get used to that as well.

Senator DURBIN. Right. For years, we have had hospital administrators coming to us from across the Nation saying that because of the cutbacks in Medicare reimbursement, many of them are facing some very serious budgetary problems. And many of my colleagues, including myself, did everything we could to increase hospital reimbursement from the Medicare program to deal with what we thought was an overreaction by Congress of cutbacks in Medicare.

What I would like to ask you is whether the money that we have been sending back to the hospitals has been reaching the nurses. Have they seen increases in their salaries and their wages as a result of this increased Medicare reimbursement?

Ms. WEINSTEIN. I would like to answer your question by saying that we do not earmark any of the dollars for any specific services provided by the providers. The providers are paid prospectively, and they are then charged with determining how they are going to allocate those resources.

I would like to defer to my colleague, Mr. Hoyer, to elaborate on the response.

Senator DURBIN. Mr. Hoyer.

Mr. HOYER. That gets to the response that we do not know. We do know the payment levels are adequate in all of the settings, but we do not know the extent to which the hospitals, SNFs, and home health agencies have used the money to hire nurses or raise salaries.

Senator DURBIN. My understanding is, and I think the testimony shows, that over the last decade, nurses really have not seen any substantial increase in their wages—I think it is less than 1 percent—but there has been in the last year, I think, an increase slightly higher. Are you aware of those statistics?

Mr. HOYER. I am not aware of the nurse salary statistics, Senator.

Senator DURBIN. Well, maybe we can get some of that information from the next panel.

Can you comment on what you are finding as to the profit margins in hospitals after the Medicare increases went into effect?

Mr. HOYER. Well, I can say that hospitals have done reasonably well. There was some concern after the Balanced Budget Act of 1997, but MedPAC's latest recommendations, with which we agree, are that hospital payments are on track, and there is no compelling reason to change the update.

Senator DURBIN. You have also testified, Ms. Weinstein, as to a study involving staffing ratios. Are you going to be publishing these recommended ratios for nurse-patient, doctor-patient treatment?

Ms. WEINSTEIN. Mr. Chairman, are you speaking of the study related to nursing home staffing or the study related to hospital nurse staffing?

Senator DURBIN. Nursing homes.

Ms. WEINSTEIN. Last summer, we completed the first phase of our nursing home staffing study, and that study did show that there was a link between nurse staffing levels and quality of care for nursing home residents. We are in the process of completing the second phase of that study. We expect it to be completed by the end of this calendar year. At that time, we will review the results, and it will inform us as to what direction we should take for policy in the long-term care setting.

Senator DURBIN. Will you also be addressing the issue of medical errors in relation to ratios?

Ms. WEINSTEIN. We have been looking at the issue of medical errors across the board. We have been working collaboratively with other HHS partners, looking at medical errors in all settings, and it is something that we will consider as we look at all the evidence.

Senator DURBIN. Good.

I am going to ask that the Subcommittee be in a short recess now, as I race over to try to make this vote. Senator Voinovich, if he returns, will ask his questions, and then I will resume.

Thank you.

[Recess.]

Senator VOINOVICH [presiding]. I will call the meeting to order. Senator Durbin will be back as soon as he casts his vote.

I would like to ask a few questions now. The first question that I have is for Ms. Weinstein and Dr. Geolot. How does the Bush Administration believe that we need to address the problem that the two of you have made mention of today? Is there anything that you have heard thus far from the administration in terms of what they think we ought to be doing about it?

Ms. WEINSTEIN. Senator Voinovich, I would like to address that question by saying that we believe that we have to continue to monitor the situation and to ensure that we are paying the providers adequately so that they can appropriately care for our beneficiaries.

We have to continue to collaborate with our colleagues in the Department, including HRSA, the National Institute for Nursing Research, the Agency for Healthcare Quality Research. We have to look at the studies that they are doing and try to convene partnerships, private and public together, where possible.

Senator VOINOVICH. One of the things that interested me in your testimony was that you indicated you really believe that Medicare adequately reimburses providers for nurses; is that correct?

Ms. WEINSTEIN. We had support for that in the recent MedPAC report, which showed that we are paying hospitals appropriately. We are in agreement with that report. Also, the Inspector General and the General Accounting Office have studied the nursing home issue and reimbursement in nursing homes and have concluded that we are paying adequately in nursing homes as well.

I would add that the payments we give to providers are not earmarked specifically for nursing services. It is up to the providers to determine how to use the dollars that they receive and provide services to beneficiaries, patients, and residents.

Senator VOINOVICH. Dr. Geolot, would you like to comment on that?

Dr. GEOLOT. Senator, we also think it is extremely important to continue to monitor the work force and intend to carry out the sample surveys which give us the national perspective.

In terms of specific programs to support the work force, the Title VIII programs address basic and advanced nursing education programs, diversity programs targeting minorities and underrepresented individuals, and we have scholarships, traineeships, and loans, and the administration has proposed an increase for funding of the programs under this authority in Title VIII.

Senator VOINOVICH. Do you think that is going to be adequate to deal with the current situation?

Dr. GEOLOT. Well, we realize that there are many competing priorities, and the administration did suggest increases for the Title VIII programs.

Senator VOINOVICH. So, if I heard you right, you are saying that on the national level, you think that the number of nurses is in balance with the demand for care and that should continue for the next several years but that you see a real problem from 2010 to 2020; is that correct?

Dr. GEOLOT. That is correct.

Senator VOINOVICH. So you would not say that on the national level you have a real problem right now; things seem to be in balance?

Dr. GEOLOT. Well, from a national perspective, our projections indicate that the supply and requirements from a national perspective look like they are in balance. However, I would also mention that does not negate the shortages that have been identified, and the national sample survey cannot necessarily get at what is happening at the local level.

Senator VOINOVICH. So that nationally, it looks like it is OK, but then, when you go back and look at regions, you find there is a problem. Is that what you are saying?

Dr. GEOLOT. What I am saying is that the national sample survey cannot necessarily capture that information, but we are certainly hearing that there are shortages in geographic areas, there are shortages for specialty nurses—there are shortages in certain types of settings, yes.

Senator VOINOVICH. The next question, then, you have just answered. You said you thought that what was being done by the government at the current time is adequately dealing with the problem. If the shortages are there, do you think we should be doing more?

Dr. GEOLOT. Well, I realize that there are really competing priorities in terms of dollars, and the administration has increased funding for nursing work force development, or has proposed to increase funding.

Senator VOINOVICH. So what you are saying is that they recognize that there is a problem, and they have increased the funding, but that it is not enough to deal with what some would say is a shortage around the country, and that more needs to be done?

Dr. GEOLOT. I am saying that the administration has proposed an increase in the nursing programs and recognized that there was a need to increase those programs.

Senator VOINOVICH. Would anyone else like to comment on my question?

Ms. WEINSTEIN. Yes, I would like to comment. We have heard through the testimony today that this problem is really multifaceted and that the solution to an emerging shortage is certainly going to require different types of interventions.

We believe that the Federal Government needs to continue to monitor the situation, sponsor research where we can, look at the results of that research, and then go ahead and make Federal policy with adequate data to address the concerns.

Senator VOINOVICH. Do you think, then, that we need to get more data in order to properly address the problem?

Ms. WEINSTEIN. More data will definitely help us address the problem, and then we can determine exactly what types of interventions are appropriate.

Most recently, the Centers for Medicare and Medicaid Services worked very closely with HRSA to sponsor a nurse staffing study in hospitals. That study was just released in February of this year, and the results of that study showed that there are strong links between adequate levels of nurse staffing and good patient outcomes. In fact, the higher numbers of RN's led to better outcomes for patients. We need to continue to sponsor such research in order to use the information to guide Federal policy, but I think we also

need to collaborate with our partners in the private sector, look at what they are doing, and work together to solve the problems.

Senator VOINOVICH. Senator Durbin has mentioned the fact that he is looking at some legislation, and I am sure he is going to be looking for cosponsors of that legislation. We should make sure that we have the information we need to make good decisions so that what we are doing on the national level is going to be responsive to the real problems and that if we are going to allocate resources, we are allocating them in areas where they will make the most difference.

You just alluded to the correlation between more nurses and fewer medical errors. Has there been any authoritative study done where people admit to medical error? Each year, I attend the John F. Kennedy School of Government's 2-day seminar for Members of Congress. I found it interesting that participants said that in the government-operated hospitals, there was more being done about the issue of medical error than in private hospitals because they were less vulnerable to potential lawsuits. This provides greater freedom to deal with some of the problems. But lawsuits are another issue. Do you know of any studies where they have identified medical error and have directly attributed it to the lack of nurses?

Ms. WEINSTEIN. Not specifically, but I can tell you that the Agency for Healthcare Research and Quality is funding numerous studies to look into the issue of medical errors as well as nurse staffing issues, and I believe that research will inform us on this issue.

Ms. HEINRICH. I could add something to that, Senator.

Senator VOINOVICH. Yes, Ms. Heinrich.

Ms. HEINRICH. Linda Aiken, from the University of Pennsylvania, has a team that has been doing work on hospital structure, organization, and staffing and linked it with patient outcomes, and part of that is error. That study is due to come out this summer.

The other thing you allude to is the program that is currently in place and being developed within the VA system in terms of identifying medical errors and then moving to the root cause, which I think is going to be interesting and could possibly be a model for the country.

The other information that I think is very interesting is from JCAHO, and their sentinel events. As they go in and do root cause analysis of those sentinel events, serious problems in patient care, they are finding that 24 percent of those are related and linked directly to nursing issues.

Senator VOINOVICH. Thank you. Senator Durbin.

Senator DURBIN. Thank you very much, Senator Voinovich.

May I ask Ms. Geolot to address the issue of scholarships and loans for nursing students? I noticed in your testimony that there are some 3,600 scholarships that we are making available and some 10,000 loans for nursing students. What is the population of nursing students in our country—the numbers—if you know.

Dr. GEOLOT. I do not know offhand, but I can provide that information to you.[1]

[1] The information provided by Dr. Geolot appears in the Appendix on page 00.

Senator DURBIN. Fine. Can you tell me if there has been a trend in this area as in other Federal reimbursement for education to provide more loans and fewer scholarships?

Dr. GEOLOT. I can provide that for the record as well.

Senator DURBIN. OK. I will just tell you that it has been a general trend over the last 10 or so years to provide more loans to the students, which of course means more indebtedness and affects their choice of jobs and where they are going to work. I think that when you consider nursing, it appears to be more difficult to attract students to nursing school. The ability to graduate them and attract them to rural areas or inner city areas or areas of special needs may be a decision that is often dictated by the level of their indebtedness and how quickly they can be making significant salaries in other places.

I know that nurses are in national demand. I met one at Georgetown University Hospital who has a very interesting life. She flies from one interesting part of the country to another interesting part of the country and works for 10 or 12 hospitals at a time. She is single, and she just got back from California, and wanted to see what Washington was like, so she ended up at Georgetown Hospital for several weeks, and then off again, always a pretty good contract waiting for her. But of course, she is single and is not raising a family and is in a different situation.

Let me ask you if you think the current nursing shortage is really driven more by a lack of retention than by a shortfall in the number of nurses who are being trained. Could you make that call as to what is the more dominant reason?

Dr. GEOLOT. I think we are seeing a combination of factors. We are seeing decreased enrollments in schools, and we are now seeing decreased graduations. So that has to do with the pipeline.

But I think that we are also very concerned about the working conditions and the need to focus on the retention of the nurses that we have. So it is essentially a three-prong approach—one that looks at improving the pipeline or focusing attention on the pipeline; another that focuses on the working environment; and the third is the retention of the nurses that we have.

Senator DURBIN. Let me ask you this, Ms. Heinrich, following up on that. If we are dealing with a national nursing shortage, and we have stagnant wages and deteriorating working conditions, should we be surprised?

Ms. HEINRICH. I think you have answered the question.

Senator DURBIN. I am afraid I have.

I would ask you, based on what you have seen, if you have any data on nurses' wages that we referred to earlier, as to what has happened to them in the last decade?

Ms. HEINRICH. It is actually very interesting to map that out, and at your request, we did develop this chart that actually shows what has happened. It appears that after the last shortage, there was an upswing in wages, and after that——

Senator DURBIN. And what happened in nursing schools?

Ms. HEINRICH. There was a dramatic increase in enrollments, yes.

Senator DURBIN. Cause and effect.

Ms. HEINRICH. Well, you know GAO; we are a little hesitant to——

Senator DURBIN. It is as close as I can pin you down.

Ms. HEINRICH. Right. Then, in the mid-90's, there was a leveling out and even a dip in adjusted earnings. And then, just in the last couple of years, there has now been an increase in average earnings.

Senator DURBIN. And were you able to pinpoint the current situation with managed care, where fewer people are being hospitalized, but when they are hospitalized, they have more acute and critical conditions and need more attention?

Ms. HEINRICH. We did not necessarily link it with managed care. Other researchers—Peter Buerhaus, for example, did do a very interesting paper that showed a link of nurse employment and wages with geographic areas that had more concentrated managed care.

I think what is interesting now is that we are seeing so much play in the industry, and I sometimes wonder if people know what to pay attention to in the market because there is such disequilibrium.

Senator DURBIN. I noted in your testimony that State legislatures have, in at least 10 States, entertained legislation to limit mandatory overtime to protect nurses. Is this one of the complaints that you have heard from the nurses in terms of their work conditions, the mandatory overtime requirement?

Ms. HEINRICH. In all of the surveys that we reviewed, that certainly is one of the top issues that the nurses in these surveys are concerned about.

Senator DURBIN. Let me ask you this. We will hear testimony later from the hospital association about paperwork burden that nurses face. Has this been a complaint that you have heard?

Ms. HEINRICH. That certainly is reported in the surveys, not to the same extent as some of the other issues around working conditions. Certainly, you hear a lot about the burden of paperwork, and some people say that IT, information systems, in the future will do a great deal to alleviate that. On the other hand, GAO, of course, feels very strongly about the fact that we have to be able to document and be accountable for the care that is being provided. So, of course, we always want better information on the patient care, the minimum data sets in nursing homes, for example, than we feel we have.

Senator DURBIN. Ms. Weinstein, have you looked at that issue in terms of the paperwork requirements coming out of the Federal Government imposed on hospitals and transferred ultimately to nurses and other medical professionals?

Ms. WEINSTEIN. I can tell you that this new administration is committed to reviewing paperwork requirements, to reviewing regulations and requirements for excessive red tape and burden. It is a top priority for Administrator Scully, and we are looking at that.

Senator DURBIN. Thank you.

Admiral Martin, let me close my questions by asking you this. You said that you have a higher nurse-patient ratio in the military. What is the ratio? Is there an established, published ratio?

Admiral MARTIN. No, sir. I cannot give you that. But generally, overall, it is felt that we have a higher nurse-patient ratio. Our staffing tends to be a little bit more predictable and stable.

Senator DURBIN. How does military nurse pay compare to civilian nurse pay?

Admiral MARTIN. We have a study going on right now by the Center for Naval Analysis to compare military and civilian nursing pay, and they are fairly close to publishing it.

Senator DURBIN. If you saw these figures here that have been given, the $41,000 as an average annual salary for nurses, by your experience—and I will not hold you to this as to an exact dollar amount—what is the average annual pay for nurses serving in the military?

Admiral MARTIN. That is about an average pay for our government civil service nurses that we hire. However, for military nurses, because we continue if we stay in to go up in rank, our average pay is probably either equal to or a little higher. However, it is the retention that we really have to work on.

Senator DURBIN. Do you have any rules in the military regarding the number of hours a nurse may work without rest?

Admiral MARTIN. No, sir.

Senator DURBIN. So a nurse in the military could be working more than one shift at a time and be asked to take overtime?

Admiral MARTIN. Well, active-duty military are obligated 24/7, and we all come in knowing that. However, I believe that you will find that in our military hospitals—I do not know of any Navy hospital that has mandatory overtime. Many of our military nurses are on call, so if they work one shift and go home and have the next day off, we might ask them to come in for several hours to relieve somebody. That is not mandatory or mandatory overtime.

Senator DURBIN. But they are expected to be there.

Admiral MARTIN. I would say we are very flexible now. As the Commander of Bethesda, if I called a nurse who said, "I have a child at home," we would call somebody else.

Senator DURBIN. OK. My last question is this. The civil service problems that you have talked about caught my attention, and I called them to the attention of Senator Voinovich, and this is something that we are both looking at. Ninety-three days to hire a nurse—is that what you are suggesting?

Admiral MARTIN. Yes, sir. Right now, at Bethesda, we have taken a considerable amount of action, and I have gotten it down to 45 days. But overall, it had been running 90 to 93 days, yes, sir.

Senator DURBIN. And in the private sector, it is a week or two; is that my understanding?

Admiral MARTIN. For many of the contract nurses, we can hire them in about a week or two.

Senator DURBIN. Thank you. Senator Voinovich, any other questions?

Senator VOINOVICH. Yes. In terms of hiring, you were able to bring it down from 93 to 45 days?

Admiral MARTIN. Yes, sir.

Senator VOINOVICH. So you had the discretion to do that—in other words, from a management point of view, you were able to do that. You did not need any legislation or regulatory changes;

you were able to just look at the system and streamline it and improve on it.

Admiral MARTIN. Sir, I believe that I screamed loud enough that individuals heard me and realized that it had not just an effect on the patients and patient care, but it had an effect on graduate medical education programs as well. A tiger team came to my rescue at Bethesda to the detriment of several other places.

Senator VOINOVICH. Who is in charge of that? Where do you have to go to deal with that kind of problem? Who handles that?

Admiral MARTIN. Our HRO, Human Resources Office.

Senator VOINOVICH. In the Navy?

Admiral MARTIN. Yes, sir. Each service has its own single HR branch.

Senator VOINOVICH. So you had the problem, you went to them and said this has to be taken care of, you screamed loud enough so that they got involved and looked at the situation, and they were able to, just by moving some things around, streamline the process.

Admiral MARTIN. Yes, sir. They put a small team together to come over to Bethesda to work. I established a small office space for them. However, there are other Navy commands, and therefore, their length of time to hire civil service, maybe not nurses but other employees, only lengthened because individuals came to Bethesda to assist me.

Senator VOINOVICH. So would you say they need more people in human resources?

Admiral MARTIN. I would say they are looking at the entire HR system in the Navy and trying to really put some corrective actions in place. It is truly a system problem.

Senator VOINOVICH. In terms of hiring civilians, do you think you have enough flexibility to do that? Does the private sector have more flexibility in hiring people?

Admiral MARTIN. I do not have as much flexibility as a civilian hospital because of some of our constraints. I am constrained in what level I can bring a civil nurse in at because of our classification system and then even retaining a nurse. We do not have a good career progression ladder for civil service nurses; they often get stuck at the level they come in at.

Senator VOINOVICH. So that has to be reviewed in terms of being competitive.

Admiral MARTIN. Yes, sir.

Senator VOINOVICH. I think I recently told Senator Durbin that one of our nurses here just got her graduate degree and wants to get a better job, and she applied for an opening at a Federal facility. She is a GS–12 and the job is a GS–14. She sent her application off on the internet to this place, and they sent her back a form letter saying, "I am sorry, we are not interested in you. In order to be hired, you have to be a GS–13."

Admiral MARTIN. It is an antiquated system. The same system has been in place every since I have come into the military. I understand that there is a whole task force looking to change the classification and hiring system. I have not heard any recent reports or read any recent reports on it, though.

Senator VOINOVICH. I would like to personally have you share with me in the next 2 or 3 months just how things are going in that regard, because this is kind of a cause célèbre for Senator Durbin and me. We just think the Federal Government's hiring process and human capital is in crisis, and we need to move very quickly if we are going to deal with these problems.

I have just a couple of other questions. One is getting back to the issue of paperwork. The kinds of complaints I get from nursing home staff and others who deal with the Federal Government are that the paperwork requirements are just crushing them, and in so many instances, the people who have to fill out the paperwork are the nurses. I hear from nurses who work in some of these facilities who say, "One of the things I do not like about my job anymore is that I spend all my time at a desk, filling out pieces of paper, and I do not really get a chance to get out and spend very much time with patients. One of the reasons I got into this business was to have a relationship with people and get that satisfaction. I did not come to work to be a secretary; I came to work to deal with patients." I would like you to comment on that.

Ms. WEINSTEIN. I will reiterate my earlier response, which is that we are looking at paperwork requirements for Medicare and Medicaid, and Administrator Scully is committed to trying to reduce the paperwork burden where possible. We are looking at things like the minimum data set for nursing homes, the OASIS document for home health agencies, and we are looking to see where we can reduce burden where possible.

Senator VOINOVICH. That is terrific. It would be unbelievable the burden that would remove in terms of hospital staff right across the board, because they are just bitter about it. I hear our hospital folks complain about Medicare and their reimbursement, by the way; they do not feel that it is adequate. Of course, when I talked to Donna Shalala, she said it was more than adequate. But then it is compounded by all the paperwork.

I do not know how it is in Chicago, but what I am hearing from our administrators in the Cleveland area is that nursing wages have gone up in the last couple of years pretty rapidly because of the lack of nurses. In order to attract people and keep people, they have had to increase wages.

Does anyone want to comment about where wages have been, say, in the last year or 2 years? The testimony I hear is that the wages have stagnated, and that is a longitudinal study, I think, over a period of time. Where are we right now on that issue?

Ms. HEINRICH. You are correct that in the last couple of years, the reports do show that on average, wages have gone up for nurses. I think it is hard to say, however, in terms of have they been adequate or are they enough to attract nurses into particular facilities, because it is very interesting to see that—wages are only one factor for nurses. There are other factors about the work environment that they are looking at and deciding whether they want to work in those environments, and those have to do with work load, work stress, and the other organizational factors that affect how nurses can provide patient care.

Senator VOINOVICH. So when you are talking about "environment," you are talking about the hours, the number of patients, physical facilities—could you elaborate on that a little bit more?

Ms. HEINRICH. Yes. And it also goes to other people who are there to support nurses in providing the patient care. Certainly we have heard testimonial evidence, but it was also shown in the AHA survey that they recently released, that there are shortages not only in nursing but across the board.

How that plays out is that if you are short a pharmacist, and a nurse on a medical/surgical floor needs a particular medication and is not getting it from the pharmacy, what often happens is that the nurse is filling in the gap there, and she is running to the pharmacy to pick it up. That should not be happening. Or, you have reports by nurses that they are passing out food trays and emptying the garbage, and they are also expected to be your hands-on, 24/7 surveillance system for these very complex patients.

Senator VOINOVICH. My sister-in-law had cardiac arrest during the Inauguration, and she went over to George Washington University Hospital, so I had the chance to talk with some of the nurses over there. The impression I got was that many of them were independent contractors; they are there, but they are not really on the hospital payroll.

Ms. HEINRICH. I think that is a very interesting phenomenon, and we have not done a study on it, but again, certainly testimonial evidence suggests that many of the young nurses have found it more beneficial to be in a temporary agency or a temporary pool. They are paid more, their benefits go with them wherever they go, they have a great deal of flexibility in terms of when they work and when they do not work. I think it would be very interesting to study that further.

Senator VOINOVICH. Getting back to what you mentioned, Senator Durbin, about the nurse that you ran into who can go wherever she wants to in the country and always find a job. It would be interesting to know if she works for an independent third-party organization that handles that.

Senator DURBIN. I think Mr. Mecklenburg can tell us about those nurses. I think that when hospitals face severe shortages, they sometimes hire contract nurses at considerably higher salaries to fill in, and we can learn about that.

Thank you all very much. I want to thank the panel for your testimony. We may be sending you some follow-up questions, and I hope that you will be able to respond to us in a few days.

Senator DURBIN. I would now like to introduce our second panel of witnesses and ask them to come forward.

Ann O'Sullivan, welcome. Ms. O'Sullivan is a registered nurse and President of the Illinois Nursing Association.

Gary Mecklenburg is President and Chief Executive Officer of Northwestern Memorial Hospital in Chicago. He is also Chairman of the American Hospital Association Board of Trustees. Gary, thank you for being here.

Carol Anne Bragg is a registered nurse and a member of the Service Employees International Union's Nurse Alliance, with the Professional Staff Nurses Association, and is President of SEIU Local 1998, from Maryland. Thank you for coming.

My former colleague from the U.S. House of Representative, the Congresswoman from the State of Illinois and City of Rockford, Hon. Lynn Martin joins us on behalf of the Labor Panel and the Nursing Institute at the University of Illinois. She is the chairman of the Panel on the Future of the Health Care Labor Force in a Graying Society. She is accompanied by Mary Jo Snyder, Director of the Nursing Institute at the University of Illinois-Chicago College of Nursing.

And J. David Cox is a registered nurse and Vice President of the National Veterans Affairs Council for the American Federation of Government Employees, AFL–CIO.

Thank you all for coming. We look forward to hearing from you, and now I am going to administer the oath. Prepare, if you will, by standing.

Do you swear that the testimony you are about to give before this Subcommittee will be the truth, the whole truth, and nothing but the truth?

Ms. O'SULLIVAN. I do.

Mr. MECKLENBURG. I do.

Ms. BRAGG. I do.

Ms. MARTIN. I do.

Ms. SNYDER. I do.

Mr. COX. I do.

Senator DURBIN. Thank you.

Let the record reflect the witnesses answered in the affirmative and therefore will be allowed to continue.

I would ask you to limit your oral statements to no more than 10 minutes and remind you that your entire statement will be made a part of the record.

Ms. O'Sullivan, please proceed.

TESTIMONY OF ANN O'SULLIVAN, RN,[1] PRESIDENT, ILLINOIS NURSES ASSOCIATION, ON BEHALF OF THE AMERICAN NURSES ASSOCIATION

Ms. O'SULLIVAN. Good morning, Mr. Chairman and Members of the Subcommittee.

I am Ann O'Sullivan, a registered nurse and President of the Illinois Nurses Association. I am pleased to be here today representing the American Nurses Association, or ANA, in support of your efforts to improve the recruitment and retention of America's registered nurses. ANA is the only full-service association representing the Nation's RN's through its 54 constituent member nurse associations.

As the Subcommittee is aware, health care institutions across the Nation are experiencing a health care crisis in nurse staffing, and we are facing an unprecedented nursing shortage. As RN's are the largest single group of health care professionals in the United States, the current and emerging nursing shortage poses a real threat to the Nation's health care system.

As you may remember, the last nursing shortage was just over 10 years ago. At that time, health care providers did respond by instituting aggressive recruitment campaigns and by increasing RN

[1] The prepared statement of Ms. O'Sullivan appears in the Appendix in page 107.

wages. In fact, the average real annual salary of all RN's employed full-time rose 33 percent between 1980 and 1992. At the same time, RN employment in hospitals grew by a steady rate of 2 to 5 percent annually. By the early 1990's, reports of nurse shortages had significantly diminished.

However, in the mid-1990's, the picture changed. During this time, the influx of managed care and changes to Medicare reimbursement began to exert downward pressure on provider margins. Providers responded by implementing cost containment programs.

As RN's typically represent the largest single budget item for a hospital, we were some of the first to feel the pinch. Between 1993 and 1997, the average wage of RN's employed in hospitals dropped by roughly $1 an hour in real terms. RN employment in the hospital sector significantly decreased, and lesser skilled, assistive staff were hired as our replacements. In addition, many providers eliminated positions for nursing middle managers and executive-level staff.

These staff reductions occurred at the same time that patient acuity increased, the use of sophisticated technology increased, and the length of stay deceased.

In the end, these changes increased the pressure on staff nurses who were required to oversee unlicensed aides while caring for a larger number of sicker patients. The elimination of management positions shortened the career ladder and decreased the support, advocacy, and resources necessary to ensure that staff nurses could provide adequate care.

Not surprisingly, these changes caused a downturn in the number of people working in the nursing profession and growing discontent among those who remain.

A recent ANA survey of 7,300 nurses across the Nation revealed that nearly 55 percent of today's nurses would not recommend the nursing profession to their children or friends. In fact, 23 percent of the nurses surveyed indicated they would actively discourage someone from entering the profession.

In fact, an alarming number of experienced RN's are opting to leave the profession. The 2000 National Sample Survey of Registered Nurses showed that half a million nurses who have active licenses, more than 18 percent of the nurse work force, are no longer working in nursing. In Illinois alone, the number of licensed RN's who are not working in nursing increased by 8 percent in the years between 1996 and 2000.

As you will hear today, the American Hospital Association reports that there are 126,000 current openings for RN's in hospitals across the Nation and that these positions are increasingly hard to fill. We maintain that the reason for these vacancies and for the recent exodus from nursing is dissatisfaction with the work environment.

The large number of nurses with active licenses who are no longer working in nursing indicates that there is not a current shortfall in the number of RN's per se. Rather, there is a shortage of positions that these nurses find attractive.

With that said, I would like to look forward to solutions to these problems. There are a number of initiatives that the ANA and I support to improve the environment of care for nursing.

The first of these is the need for adequate nurse staffing. More than a decade of research shows that nurse staffing levels and skill mix make a different in patient outcomes. In fact, four HHS agencies recently sponsored a joint study on this very topic. The resulting report found consistent and strong evidence that increased RN staffing is directly related to the decreased incidence of urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, and decreased hospital length of stay.

In addition to the important relationship between nurse staffing and patient care, several studies have shown that one of the primary factors for increasing nurse turnover is dissatisfaction with work load and staffing. Understandably, nurses do not want to work in environments with poor outcomes.

For these reasons, we support your efforts to require health care facilities to develop and use valid and reliable staffing plans.

Another problem that must be addressed is the use of mandatory overtime as a staffing tool. I have heard over and over again that mandatory overtime is being used regularly to cover staffing shortages. Many nurses report that employers insist they work an extra shift regardless of their level of fatigue. In these situations, nurses who refuse to work past their regular shift could face dismissal for insubordination as well as the threat of being reported to the State board of nursing for patient abandonment.

Certainly it only stands to reason that an exhausted nurse is more likely to commit a medical error than a nurse who is not required to work a 16- to 20-hour shift.

Unfortunately, nurses are placed in a unique situation when confronted by demands for overtime. We are ethically bound to refuse to engage in behavior that we know could harm our patients. At the same time, we face the loss of our license, our careers and our livelihoods when charged with patient abandonment. Without legislation, nurses will continue to confront this dilemma.

I applaud you, Chairman Durbin, for your efforts to develop legislation to ban the use of mandatory overtime.

In addition, we support legislative initiatives that provide nurses the ability to speak out about quality of care problems without fear of retaliation. This issue is addressed by a provision in the bipartisan patient protection act which we strongly support.

Looking even further into the future, one thing is certain. The current nursing shortage is nothing in comparison to the projected systemic shortage that will become a reality in the next 10 to 20 years. Current vacancies are compounded by an increased number of retirement-age nurses, a shrinking pool of new nurses, and the impending health care needs of the baby boom generation. These demographic forces will soon produce an unprecedented nursing shortage. In fact, current projections estimate that the overall number of nurses per capita will fall nearly 20 percent below requirements by the year 2020.

Now is the time to address this impending public health crisis. Chairman Durbin, I understand that you are developing legislation that contains enhanced loan repayments, scholarships, career ladder programs, and public service announcements designed to attract more people into the nursing profession. The ANA and I sup-

port you in these efforts. We believe that America must take steps now to develop its internal nurse work force.

We agree with you, Chairman Durbin. We do not believe that immigration is the answer to the emerging nursing shortage. We have been down this road many times before without success.

Experience shows that the influx of foreign-trained nurses only serves to further delay debate and action on the serious workplace issues that continue to drive American nurses away from the profession. In addition, there are serious ethical questions about recruiting nurses from other countries when there is a worldwide shortage of nurses. And sadly, there are numerous disturbing examples of the exploitation of foreign-trained nurses. Let us not make this mistake again. We should not look overseas when the real problem is the fact that the United States health care system has failed to maintain a work environment that is conducive to safe, quality nursing practice and that retains experienced American nurses in patient care.

I also want to comment on the issue of too much paperwork and nurse dissatisfaction. While we are open to discussing streamlining paperwork, this is not the primary reason why nurses are leaving the bedside.

In summary, it is critical that this Subcommittee understand that no effort to address the nursing shortage will be a success unless we first fix the serious problems in the work environment. Until we address issues such as inappropriate staffing and mandatory overtime, health care providers across the Nation will continue to experience worsening staffing shortages. Conversely, efforts to attract young people into nursing will be fruitless unless we first fix the problems that are driving experienced nurses away from the profession.

We look forward to working with you and our partners in the health care community to develop an environment that is conducive to high-quality nursing care. Efforts in this direction will have a positive impact on health care services for all Americans.

Thank you for the opportunity to provide this testimony, and I would be happy to answer any questions that you might have.

Senator DURBIN. Thank you very much.

Gary Mecklenburg, from Northwestern in Chicago and the American Hospital Association.

TESTIMONY OF GARY A. MECKLENBURG,[1] PRESIDENT AND CHIEF EXECUTIVE OFFICER, NORTHWESTERN MEMORIAL HOSPITAL, CHICAGO, ILLINOIS, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. MECKLENBURG. Thank you, Mr. Chairman.

I am Gary Mecklenburg, CEO of Northwestern Memorial Hospital in Chicago. I am here today as Chairman of the American Hospital Association, representing the AHA's nearly 5,000 hospital and health system members. We appreciate this opportunity to testify on both the immediate and long-term shortage of nurses.

Northwestern Memorial is a nationally-known teaching hospital affiliated with Northwestern University's Medical School. We em-

[1] The prepared statement of Mr. Mecklenburg appears in the Appendix in page 115.

ploy more than 5,000 caregivers, including 1,100 registered nurses, and we have 1,200 physicians on our medical staff.

Northwestern Memorial is growing rapidly, and that growth presents many challenges. However, the single greatest challenge today and in the future is the recruitment and retention of high-quality staff to serve our growing number of patients. A recent survey of AHA members revealed that hospitals have close to 168,000 open positions; 126,000 of those positions, or 75 percent, are for registered nurses.

Several factors contribute to this shortage. First, sicker patients have resulted in an increasing demand for nurses. Second, there is a shrinking supply of experienced nurses due to an aging workforce. And finally, a diminishing enrollment in nursing schools has resulted in a dearth of younger nurses to replace retirees.

At the same time, the number of patients in need of hospital care is increasing. Seventy-eight million baby boomers are approaching retirement age and Medicare, but they already are experiencing a need for more health care. Due to medical advances, we are diagnosing and treating cancer, heart disease, orthopedic conditions at an earlier age. The resulting demand for health care may soon exceed our capacity to provide it. In fact, some hospitals are being forced to reduce the number of inpatient beds available, postpone or cancel elective surgeries, or tell ambulances to bypass their overflowing emergency departments.

But these are not acceptable solutions; they are merely short-term responses. Hospitals are taking actions to cope with caregiver shortages. Northwestern Memorial, like other health care facilities around the country, employs a variety of strategies to attract and retain nurses, including flexible hours, enhanced compensation and benefit strategies, onsite child care, and programs to attract youth to health careers.

Innovative programs aimed at ensuring a current and future supply of staff come at a significant cost. Many of these expenses are not recognized as costs by the Medicare program or other payers, making it difficult to be creative in finding solutions.

The AHA recently convened a Commission on Workforce for Hospitals and Health Systems. This diverse group of stakeholders includes hospital administrators, nurses, academics, as well as business and organized labor leaders. The Commission will develop joint solutions to address worker shortages and release its final recommendations next spring.

While the hospitals of the AHA are taking steps to tackle the shortage of caregivers, there are actions that Congress can take to help alleviate this problem.

The American Hospital Association supports the following bipartisan legislation:

The Nurse Reinvestment Act, introduced by Senators Kerry, Jeffords, and Hutchison establishes a national nursing services corps and supports individuals wishing to advance in or enter nursing careers.

The American Hospital Preservation Act, introduced by Senators Bayh and Hutchison, provides a full inflationary payment update for fiscal years 2002 and 2003. This would help hospitals provide fair and reasonable wage increases and to pay for the work incen-

tives hospitals must use to attract and retain qualified staff. I would note that in the past 17 years of the Medicare Program, it has provided a full inflationary update only three times.

The Area Wage and Base Payment Improvement Act, introduced by Senators Hutchinson and Cleland, recognizes the increased competition for caregivers by providing a floor on the Medicare wage index to help improve workforce compensation.

Mr. Chairman, this Nation faces a critical shortage of women and men in health care careers. Collectively, we must take action before the crisis worsens, and the first steps toward a solution are for all stakeholders to enter into a discourse and for the Federal Government to restore remaining Medicare and Medicaid reductions, provide greater support to rural hospitals, and establish new nursing education initiatives. Together, we can develop solutions that protect the future of health care for the Nation.

Thank you very much.

Senator DURBIN. Thank you.

I now call on Carol Anne Bragg for her testimony.

TESTIMONY OF CAROL ANNE BRAGG, RN,[1] PRESIDENT, PROFESSIONAL STAFF NURSES ASSOCIATION, ON BEHALF OF SERVICE EMPLOYEES INTERNATIONAL UNION, AFL–CIO

Ms. BRAGG. Thank you, Senator Durbin, for allowing me this opportunity to speak on behalf of the Service Employees International Union on the current nursing crisis in this country.

I am a full-time registered nurse working in a cardiac unit, a member of SEIU's Nurse Alliance, and President of my Local 1998, Professional Staff Nurses Association, in Maryland. Today I am speaking on behalf of the 1.4 million members of SEIU, more than 710,000 of whom work in the home health industry and more than 110,000 of whom are nurses. I speak also as someone who is engaged in addressing the nursing crisis on a Statewide level. Last fall, I was appointed by the Governor to serve on the Commission on Crisis in Nursing created by the Maryland General Assembly to investigate and find ways to deal with this urgent issue.

Today, nurses in hospitals and related facilities are caring for more and sicker patients than we did a decade ago. The result is that hospitals are truly having increased difficulties filling vacancies for RN's. The hospital industry cites difficulty in filling vacancies to point to a nationwide nursing shortage, but a closer look at the data suggests that the real problem is that there is a shortage of nurses who are willing to work in hospitals under the current working conditions.

We view this situation as a staffing crisis rather than nursing shortage. It is systemic understaffing brought on by the restructuring of the industry under managed care that has led to dramatically deteriorating working conditions and increased concern about the quality of care which causes nurses to leave hospitals. Inadequate, unsafe assignments has given rise to increased numbers of medical errors. As you said in your opening statement, the Institute of Medicine found that 44,000 to 98,000 Americans die every

[1] The prepared statement of Ms. Bragg with an attachment appears in the Appendix in page 129.

year in hospitals due to medical errors. While the IOM report exposed a national crisis, it did not explore one of the primary causes for the crisis, which is understaffing.

SEIU recently completed a national survey reported in this document on the shortage of care. We find that the majority of nurses identified understaffing as one of the leading causes of medical errors.

In my State of Maryland, the nursing crisis and the deteriorating conditions has compromised quality of care for the people in our communities. According to the Maryland Hospital Association, "over half the hospitals throughout Maryland report that they have had to close beds, delay or cancel surgeries, disrupt scheduled procedures, and reroute ambulances to other facilities for emergency patient care." The MHA says that it is increasingly common for patients arriving in an emergency department "to be held there until adequate staffing becomes available on a patient unit." Your loved ones deserve better, and so do mine.

A particularly devastating side effect of the understaffing crisis is the abuse of mandatory overtime by many health care employers. Nurses are often mandated to work extra hours, which can mean back-to-back 8-hour shifts, or more hours on top of a 12-hour shift, to fill the gaps in staffing. Of course, this threatens patient safety. There is no way an exhausted and overworked nurse is as alert and accurate as a well-rested nurse coming on fresh for her shift.

Mandatory overtime also places an incredible stress on family life, particularly when last-minute changes have to be made to find child care or care for elderly parents.

According to our survey, nurses in acute care hospitals work an average of an additional 8½ weeks of overtime in a year. Nurses are not only being increasingly required to work excessive amounts of mandatory overtime, but are also required to routinely "float" or be reassigned to units where they lack expertise and training. Nurses are being stretched to the limit, experiencing high levels of stress, chronic fatigue, and work-related injuries.

These intolerable work practices lead to further burnout and undermine a nurse's sense of professionalism and are driving nurses from our hospitals, because we were never trained to provide inadequate or poor care.

According to the SEIU survey, only 55 percent of acute care nurses plan to stay in hospitals until they retire, and only 43 percent of nurses under age 35 plan to stay at the hospital until they retire. But 68 percent of nurses say they would be more likely to stay at their facilities if staffing levels in their facilities were adequate.

These statistics show a little discussed fact about the "shortage." In reality, the current supply of nurses far exceeds the demand. According to the Health Resources and Services Administration survey, there are approximately 500,000 nurses who have licenses but are not practicing in the field, and the proportion of nurses employed in hospitals has decreased substantially and consistently, from 68 percent in 1988 to 59 percent in the year 2000.

There is a brief window of opportunity and a fine line between the staffing crisis and the nursing shortage. Deteriorating staffing

and working conditions have led many nurses to leave the profession altogether, and fewer young people are entering it. The nursing school enrollment has declined in each of the last 6 years, and as a result, the average age of RN's working has increased to the age of 45. As these trends continue, there will likely be a severe nursing shortage in the future.

I have focused my remarks principally on the hospital, since that is where the nursing crisis is most severe. There is, however, a related and equally serious problem in nursing homes. While RN's make up a small proportion of the nursing home work force and are largely in managerial positions, most of the staff in nursing homes are certified nursing assistants, L.V.N.s or LPN's. SEIU members include more than 120,000 nursing home employees, a vast majority of whom are C.N.A.s and a large number of whom are LPN's.

Similar to administrators in the hospital industry, nursing home owners have argued that they are facing a shortage of nurses and nursing aides. For this reason, they have asked for increased Medicare and Medicaid reimbursement and have resisted setting the minimum staffing standards. But like most hospitals, the real problem is not finding people to work in nursing homes; it is keeping them there.

The turnover rate for direct care workers in nursing homes is nearly 100 percent, causing a revolving door of caregivers which renders continuity of care impossible. Workers are leading due to heavy work load; they simply do not have enough time to care for the number of residents they are assigned to, which leads to stress, guilt, and burnout. Moreover, low wages, lack of health care insurance, and high injury rates make nursing home work unsustainable for many workers.

Nurses across the country are sounding the alarm because staffing levels are too low to provide the quality of care for the needs of their patients. In many States where we have unions, we have turned to the bargaining table to change our working conditions in order to ensure safe staffing and better patient care.

Eliminating mandatory overtime, establishing safe staffing standards, and improving recruitment and retention by increasing pay have been primary issues of contract negotiations from coast to coast.

At my hospital, we have worked very hard to ensure that the past practice of not requiring mandatory overtime is followed, and I can tell you that is very much an incentive for nurses to stay.

Earlier this year, SEIU nurses at Aliquippa Community Hospital became the first in their State to win an agreement in their contract eliminating mandatory overtime, and their CEO, Fred Hyde, recently joined the nurses in pressing for a State law in Pennsylvania to protect patients and nurses from mandatory overtime, calling it "involuntary servitude."

Increasingly, SEIU, along with other unions and the American Nurses Association, have introduced legislation at the State level to establish staffing standards, ban mandatory overtime, provide whistleblower protection for nurses when they speak out on understaffing that jeopardizes good care, and provide for involvement of direct care nurses in the development of staffing policies.

On the Federal level, legislation has been introduced that is designed to attract new people into the nursing profession by making it easier to access education and training resources. While we applaud these efforts, this will not address the fundamental problems facing our profession and our patients. Forcing more overtime, or simply relying on nurse recruitment programs will not solve the problem, either. Likewise, easing immigration rules to attract more foreign nurses or expanding the number of visas allowed for nurses and nursing home workers will only push more caregivers through the revolving door of our Nation's hospitals and nursing homes.

All these measures will only treat the symptoms, but will not cure the disease. Unless and until we address the understaffing and poor working and patient care conditions that plague our nurses, we will never resolve this shortage.

Fundamentally, the solution to the nursing crisis lies in the establishment of safe staffing standards in our hospitals. Specifically, we must set enforceable minimum staffing standards linked to the acuity of patients, quality of care, skill of the staff, and the skill mix to ensure that in our hospitals, emergency rooms and outpatient facilities, patients receive the care they deserve.

We must make sure that the minimum levels do not become the ceilings. We must make safe staffing a requirement for all hospitals receiving Federal taxpayer dollars. We must make sure the Federal Government provides adequate oversight of our hospitals and that the industry's self-monitoring system under the Joint Commission on Accreditation of Healthcare Organizations be reformed. We must also protect the rights of patients and the rights of health care workers who blow the whistle on staffing problems that jeopardize quality of care without fear of losing their jobs.

This problem did not happen overnight, and it is not going to go away overnight. The first step we can take today to stop the hemorrhaging by starting a concerted effort to ban mandatory overtime. Limiting forced overtime will ease the impact of the shrinking supply of nurses by encouraging more nurses to stay in the profession. It will protect countless patients in the same way that limits on mandatory overtime is there for train engineers, air traffic controllers, truck drivers, and other occupations where public safety is at risk.

At the same time, we cannot lose sight of the fact that the system needs help. We must find a way to set meaningful standards for staffing in the health care industry. Understaffing in our hospitals is a serious problem. It is a problem that will only be solved through the joint efforts of public officials like you, nurses, and hospital administrators.

Mr. Chairman, we look forward to working with you on this critical issue, and I am certainly happy to answer any of your questions.

Senator DURBIN. Thank you very much for your testimony.

In introducing my former colleague, Congresswoman Lynn Martin, I forgot a very important part of her resume. She served as Secretary of Labor under President Bush, and she certainly has the background to address this issue.

Welcome, Lynn.

TESTIMONY OF HON. LYNN MARTIN,[1] CHAIR, PANEL ON THE FUTURE OF THE HEALTH CARE LABOR FORCE IN A GRAYING SOCIETY, ACCOMPANIED BY MARY JO SNYDER, DIRECTOR, THE NURSING INSTITUTE, UNIVERSITY OF ILLINOIS AT CHICAGO, COLLEGE OF NURSING

Ms. MARTIN. Thank you very much, Mr. Chairman, and representatives of the other Members of your Subcommittee.

The name of the panel that I chaired—not necessarily with knowledge at the beginning, that is for sure—was "The Future of the Health Care Labor Force"—in all of its permutations—"in a Graying Society." You will hear also from Mary Jo Snyder, who is Director of The Nursing Institute and was also a member of this panel.

Panel members represented public institutions, academia, think tanks, private businesses, organized labor, and professional groups. It crossed racial, gender, and political lines. We have released our report and recommendations, so this is a serendipitous time, I think, to come before this Subcommittee for what is an extraordinarily necessary look at the problem across the health care continuum.

I think it is a wake-up call. That crisis will strike with full force by 2010, and it will continue for many years thereafter. America will not have enough health care workers, particularly nursing care workers, to care for the people who will need it most—every senior citizen.

The health care labor shortage is not a short-term, temporary decline in the supply of nursing care providers. Instead, America, like the rest of the world, is facing a systemic change in the population of those being served and in the population of caregiving professionals.

How concerned should we be? Well, consider this. Between 2000 and 2030, the ratio of potential caregivers to people most likely to need care will decrease by 40 percent.

The usual American solutions of money and technology will not be enough; although they are part of the answer, they do not provide the living human beings who are needed to care for other real human beings.

In the past, we have had caregiving shortages. Today, we use some of the same solutions—flextime, higher wages, bonuses, immigration—all to increase in the short term the number of health care workers.

But for the future, we are not just facing a temporary shortage. We are facing a systemic change, not just in the population of those being served, but in the professions themselves.

The underlying problem has two dimensions—demographic change and an insufficient supply of professional nurses, nurse aides, and other health care workers in the work force. The forces of demographic change are inescapable. We face a future in which there will be many more older people in the population, some of whom are sitting here right now; and at the same time, relatively fewer younger people, both family members and professionals, to care for them.

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[1] The prepared statement of Ms. Martin appears in the Appendix in page 142.

Between the years 2010 and 2030, the proportion of the United States population aged 65 or older will increase from approximately 13 percent to 20 percent. That means 30 million people. And the number of people aged 85 or older will increase by over 4 million.

At the same time, the United States will experience a more than 6 percent decline in the proportion of people aged 18 to 64—the work force and the family members who have traditionally cared for elderly members of our society.

These demographic changes will occur, moreover, within a labor market in which the pool of potential health care employees will be in high demand by other service sector employers. You have heard talk about hospitals. This is a concentrated look at specifically the full range of services that people over the age of 65 will need.

Worse yet, many of the nursing care occupations today are neither attractive nor financially competitive. You have seen the report issued by the University of Pennsylvania School of Nursing. They surveyed 44,000 nursing professionals, and a shocking 40 percent said they intend to leave the nursing profession for a different career within 1 year.

Let me turn to the implications and the effects of these trends. Approximately 20 percent of all informal caregivers employed while giving such care gave work, either temporarily or permanently. These are people who work outside the health care setting, this informal network of people who care, temporarily or full-time, for aunts, mothers, and fathers.

Seven percent of informal caregivers went from full-time to part-time work.

Thirty-three percent of full-time employees and 37 percent of part-time employees have lost time from work due to these informal caregiving responsibilities.

In other words, the effect on the rest of the economy as these numbers increase is going to be real and negative. If our country fails to build the required professional caregiver infrastructure, the costs will come home to roost in other ways. One way or another, we will have to care for our growing elderly population. And because it is women who provide most of the informal care, it will be women who will have to scale back or even quit their jobs to take care of aging parents and relatives.

We have a list of recommendations from the panel, some for the private sector, some for the public sector, and some a combination. It is a reform agenda.

It notes that more money by itself will not totally solve the problem, but that no labor shortage has ever been solved without a market-based set of economic reasons. In other words, money still counts.

We recommend for the private sector that they have more attractive wage and benefit packages; that they make the work environment more desirable; and that they use best management practices across a spectrum of health care facilities. We believe there has to be ongoing training and continuing education for all nursing care providers, with a focus on team-oriented education.

For the public sector, we think there should be a Federal commission established to investigate economic incentives targeted to workers in geriatric nursing occupations. I can only say that with

all the difficulties, there is still a TV show called "Emergency Room" where we can see doctors and nurses and nursing care professionals in an exciting work environment. There is never going to be that successful a show titled, "Nursing Home." And yet more of us are going to need those services.

We want to see a public-private panel established to examine education and training requirements for all nursing care professions that would assist the State and employers in professionalizing all nursing care occupations.

We want to see changes in Medicare rules and regulations so that all entry-level nursing education and training programs include training in geriatrics. We are finding that so few of them do, it is actually shocking.

We want appropriate Federal agencies to require guidelines of the States so that standardized entry criteria may be developed for training.

And, as you have found out today, there is still not enough data. We want Federal data collection agencies to be required to provide more recent data so that you and your colleagues can make appropriate decisions.

We want to see partnerships that can identify the most successful recruitment and retention strategies. We want to focus more on independent and informal caregivers and the economic consequences of such caregiving.

In conclusion, Mr. Chairman, we have a challenge before us. We need to start now, because change will take time, and we cannot afford delay. In the end, I believe that America will respond to this crisis. The profession of nursing can be enhanced and respected.

America today cares for its elderly. I am confident that we will find the solutions to make sure we do it for the future.

Thank you very much for having us and for beginning the dialogue.

Senator DURBIN. Thank you very much. Ms. Snyder.

Ms. SNYDER. Actually, Senator, I will defer my comments at this time. Secretary Martin did a wonderful job, and our written testimony is part of it.

Senator DURBIN. Thank you very much. Mr. Cox.

TESTIMONY OF J. DAVID COX, RN,[1] VICE PRESIDENT, NATIONAL VETERANS AFFAIRS COUNCIL, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

Mr. COX. Chairman Durbin, Ranking Member Voinovich, and Members of the Subcommittee, I am J. David Cox. I have worked as a registered nurse at the Salisbury, North Carolina W.G. Bill Hefner VA Medical Center for 17 years.

Being a nurse at the VA and being an American Federation of Government Employees union activist are my life's work. On behalf of the 135,000 caregivers our union represents in the VA, I applaud you for holding this hearing on the issue of nursing shortages.

Thank you for giving AFGE the opportunity to tell you about the causes and harmful effects of understaffing at VA medical centers.

[1] The prepared statement of Mr. Cox appears in the Appendix in page 152.

How bad is the nursing shortage at the VA? Since 1995, the VA has cut RN staff by 10 percent, its LPN's by 13 percent, and its nursing assistants by a whopping 30 percent.

The combination punch of these staffing cuts means one in six nurses is no longer taking care of America's veterans.

These staffing cuts hurt patient safety and quality of care. The constant stresses to the system created by understaffing are creating serious fractures in the health care system. For example, nursing assistants at the VA help patients with activities of daily living. They help veterans eat, bathe, take a walk, and, yes, go to the toilet.

The shortage of nursing assistants at the VA condemns patients to the indignity, frustration, and anger associated with waiting and waiting and waiting for someone to come and help them.

Because the VA does not have enough nursing assistants, by necessity LPN's and RN's must take on increased work loads and help veterans with these basic nursing activities. Nurses on wards are already understaffed, must juggle their extra duties.

While RN's and LPN's are spread so thin and must perform more basic nursing functions, they are not able to keep an eye on their patients who need adequate monitoring.

Research shows that registered nurse staffing levels were the most important factor in predicting the success rates of saving patients who have cardiac arrest or go into shock while in the hospital. Unfortunately, this dire situation is in large part due to the VA's reorganization and budget. It is not wholly due to a tight labor market.

VA's response to its unsafe staffing levels has been to force mandatory overtime on already overwhelmed nurses to work the next shift day after day.

AFGE locals in Danville, Illinois and Cleveland, Ohio and across the country have told me alarming stories about nurses working 16-hour days with impossible patient work loads, trying to care for too many acutely ill patients with too few staff.

To top it off, nurse pay has been stagnant.

These deteriorating conditions are driving more nurses to leave the VA and the nursing profession. These difficult working conditions are not just symptoms of staff shortages. Forcing nurses to work two shifts in a row is a prescription for medical errors and nurse burnout. Mandatory overtime aggravates the problem and is driving more nurses to leave the VA and the nursing profession.

The overall increase in the VA's overtime costs suggests that the VA is using mandatory overtime to fill shifts on a routine basis. In the past 3 years, VA's cost for overtime for nurses has nearly doubled.

Stopping mandatory overtime is an immediate step that would both improve working conditions for nurses and improve patient safety.

Like other Federal employees, VA nursing staff are paid less than their counterparts in the private sector. Private hospitals typically pay staff premium pay to work on weekends. This premium is not for overtime but for a regular shift. Current law on Federal employee pay prohibits the VA from paying its nursing assistants Saturday premium pay.

If VA is to compete for and retain high-quality nursing staff, it must pay Saturday premium pay for nursing assistants.

Mr. Chairman, I need to tell you that many people who enter the nursing profession nowadays enter it through the door of a nursing assistant. I, myself, started as a food service worker and went to nursing assistant to an LPN to an RN, because somebody reached out a hand and encouraged me to go to school because there were loans, because there was an employer who stepped forward and cared, and I have been able every 2 weeks to contribute back on a regular basis to the Federal and State Governments that reached out that helping hand to me.

I encourage you to continue looking at how we can encourage people to enter whatever door is necessary to become part of the nursing profession and to be able to care for yourself and many of our other friends in this room as we continue to grow older each day, and we need nursing care.

Thank you for caring about the nursing shortage at the VA and about America's veterans. I would be happy to answer any questions, sir.

Senator DURBIN. Thank you very much, and thanks to the entire panel.

Mr. Mecklenburg, it seems like all roads lead back to us—first, the Federal Government and its level of reimbursement to the institutions that provide health care; our antiquated civil service rules; perhaps our insensitivity to funding at the Veterans Administration; and loans and scholarships—things that we can do here on Capitol Hill.

And certainly, a lot of roads lead back to the administrators of hospitals in terms of how their hospitals are managed and how they treat the people who work there. I think we have heard in the course of these two panels a lot of questions raised about mandatory overtime, and I would like to visit that first if I might.

Can you give me an indication—are there hospitals that just categorically do not have mandatory overtime, that just do not impose that as a policy on their employees?

Mr. MECKLENBURG. Well, let me say that what we have heard today is that the issue of nurse staffing and mandatory overtime is a complicated issue, and the mandatory overtime issue specifically is symptomatic of the larger issue that you are exploring of nurse staffing and critical shortage of health care workers.

You heard a lot from the first panel in terms of data. We could use more data to understand this problem. So in the absence of either a uniform definition of mandatory overtime or collecting data on this, I have to tell you what I do know, and let me tell you about my own organization.

Nurse staffing is a big issue. It has always been an issue. We are a 24-hour-a-day, 7-day-a-week, 365-day-a-year organization, and staffing is an issue on every shift. And you use a lot of different techniques to get the appropriate staffing for the number and acuity of patients that one has to take care of.

We do not know every day what our needs are going to be. We do not know how many patients are going to show up in the emergency room. We do not know the acuity of patients post-operatively. So it is a very complicated process.

Our clear preference is to use full-time staff, staff who are employed, who are our employees, or permanent part-time staff. I would point out to you that that is the most economical way for us to run our organizations as well, and when we are concerned about cost, moving to overtime, moving to people on call, using very expensive private agencies that cost us double the cost of an RN, and finally, mandatory overtime as a last resort, are very expensive ways. But nevertheless, all of those techniques are ones that we have to have available to us.

In my institution, we do not use mandatory overtime very often at all; it is a rare occurrence. In my role as chairman of the American Hospital Association, part of what I am doing this year is going around the country, meeting with colleagues, and talking about current issues. And one of the hot topics for us, in part because of the light that is being shone on this issue, is to ask about their mandatory overtime practices. And quite honestly, what I hear is very similar to what we do at Northwestern Memorial, and that is that it is a technique to be used as a last resort, for all of the reasons that I just mentioned.

I think what we have to be careful of in addressing mandatory overtime—and it is not our preferred way to solve the nursing shortage; there are too many other techniques that have to be used for both the short-term and the long-term—is to recognize that we cannot not deal with the patients in the hospital at any point in time.

Consider if you will for a moment a small rural hospital in this country where a nursing unit perhaps has six or seven patients on the evening or night shift. There is only one nurse required plus support staff on the evening and night shift. The evening shift ends. The night shift nurse who is supposed to come in calls in and has a sick child or is sick himself or herself. What do you do?

The institution as well as the professional nurse are responsible for taking care of those patients. So as we look at the dimensions of this and caring for our nurses and providing a positive work environment, we need to recognize that our patients come first, and we have to assure that there is adequate and continuous staffing to deliver the quality that we also talk about in this issue.

Senator DURBIN. Have you linked any studies on medical errors with mandatory overtime?

Mr. MECKLENBURG. I am not aware of those. I have asked that question. I think your staff asked a question in advance about the Institute of Medicine report. We have had two reports, as you know, in the last 18 months. I do not know of any direct correlation in those two reports dealing with safety, dealing with medical errors and nurse staffing.

I believe there was an Institute of Medicine report in 1996 that said the evidence did not support a linkage with staffing ratios at that time.

As you heard from this morning's panel, these are things that are——

Senator DURBIN. Medical errors and staffing ratios.

Mr. MECKLENBURG. There was no evidence for mandatory staffing ratios at that time. I do not know of any link in that study on

medical errors. Maybe there is some research out there that I am not familiar with.

But you heard this morning that those studies are occurring because all of us are concerned about medical errors; all of us are concerned about nurse staffing, and we have to find the evidence to know if much of that is true or not.

Senator DURBIN. Ms. O'Sullivan, how do we balance this? Put yourself in Mr. Mecklenburg's position for a moment. You are the administrator of a hospital, and the Federal Government and your conscience tell you that you do not turn people away from the emergency room. But you are in the midst of a complicated surgery, and you complete the surgery even if it went 14 hours instead of 4 hours, and the nurse who is supposed to show up for the next shift just called in and said her car broke down 50 miles away, and she does not know if she is going to make it.

How do you deal with the overtime issue in that circumstance?

Ms. O'SULLIVAN. First of all, nurses agree that taking care of the patients is the number one priority. We agree on that.

The issue to solve that particular problem, though, does not start when the nurse called in sick or when the nurse's car broke down. I have been in nursing for almost 30 years, and I have worked numerous overtime shifts when things exactly like that have happened. In an environment where I was respected and valued for my contributions, where I was being paid adequately for my work, and where I had not been doing it day after day after day after week after week——

Senator DURBIN. I see a lot of heads nodding out there.

Ms. O'SULLIVAN [CONTINUING.] And saw very little attempt on the part of my employer to do something more about it besides require mandatory overtime.

So the solution does not start when the nurse calls in sick. The solution starts—and it is multifaceted, absolutely. Nurses are there to take care of the patients. That is the number one priority. But the best way to take care of patients also revolves around taking care of yourself and knowing that you are there and capable of taking care of those patients.

Senator Durbin, I would like to comment a moment on the medical error and staffing issue. You referred earlier to *The Chicago Tribune* headlines, which we all so enjoyed. You know that after that, Governor Ryan appointed a task force in the State, and I have been privileged to serve on that task force representing nursing. It has been an interdisciplinary task force.

The first recommendation we made to the Governor in terms of dealing with medical errors and patient safety had to do with staffing, interdisciplinary staffing, as has been referred to here by several of the speakers—pharmacists, respiratory therapists, and nurses. If we do not have that kind of staffing, it only stands to reason that errors will occur.

In all the reading I did—and believe me, there was a lot of reading for that task force work of specific studies that show medical errors related to staffing—but they do show, as many panel members today have reported, improved outcomes, less negative outcomes, with RN staffing and appropriate skill mix, staff mix.

Senator DURBIN. Let me ask you about another thing. You talked about basic respect for nurses at the institution. If I heard you correctly, if that is present, when you are asked to fill in in an emergency situation, you have a much different attitude toward that request, rather than being asked repeatedly and not respecting your own life and your own professional need.

Let me ask you about the issue of nurse injuries. This is something that I was surprised to find out as we prepared for this hearing. Nurses and nurse aides have some of the highest workplace injuries. Nurse aids suffer 13 injuries per 100 employees annually compared to the construction industry rate of 8 per 100 employees annually.

Is this a factor——

Ms. O'SULLIVAN. Yes, this is a huge factor. The nursing profession is as dangerous as the coal mining profession in terms of injuries sustained—back injuries and infections are huge issues in terms of being able to care for patients and having a profession that attracts people to it.

In my institution and among nurses that I talk with around the State, that is only aggravating the nursing shortage. We have so many nurses off work and nurse aides off work because of back injuries. When there is less staff there, whether it be nurses or assistive personnel, you try to lift a patient or move a patient or get a patient into a chair by yourself. If you do that once, you might get away with it; if you do it day after day after day, with large numbers of patients, you are going to sustain a back injury.

When you are tired, when you are overworked, you are going to sustain injuries. So nursing is a very dangerous profession.

Senator DURBIN. Ms. Bragg, did you run into that as well?

Ms. BRAGG. Senator Durbin, I had the unfortunate experience of having a patient fall on me as I attempted to get him out of a chair. He convinced me and another nurse that he could stand on his own, and we were going to transfer him out of the bed into the chair, and he fell on me. It did not bother me at that moment, but about 2 hours later, I was walking down the hall and found myself lying on the floor, because my disc had come totally out-of-joint, and I could hardly move.

It is very serious in terms that we have hospitals still using unsafe needles; we suffer recurrence of needle-stick injuries; we have equipment that is antiquated and old and heavy. When I transfer one of my CCU patients to a test downstairs, the heart monitor that I have to carry weighs 40 pounds. Well, I get to carry that in one hand while I am pushing the stretcher with a 200- to 300-pound gentleman on it with the other hand.

You go home at night, and the heating pad becomes your best friend. We should not have to do that. The answer to the question is that there is no ancillary support to help us in hospitals' attempts to cut corners and to put people on the line who can do the job. A nursing assistant cannot do my job, so we cut them and their roles, and that leaves me in a CCU with no ancillary support to even help me move these patients.

Senator DURBIN. Mr. Cox, what about the Veterans Administration?

Mr. COX. Twenty percent of the VA's workers' comp claims are for back injuries, most of which occur when trying to lift, move, and transport patients by themselves when there is not another person to call.

Mr. Chairman, if I could also comment on the overtime issue. A nurse calling in sick this afternoon and making that coverage because coverage has to be made is one issue. But the VA puts out a time sheet every other Friday, and on that time sheet, we know 3 weeks ahead of time—there are maybe 10 shifts—that there is no nurse available, that there is not enough coverage, and then they say, "Nurse 1, you will work 16 hours this day; Nurse 2, you will work 16 hours that day—and by the way, you do not get a day off this week because you have to work overtime to make basic coverage." It is not the unplanned; it is planned to run on overtime.

Senator DURBIN. That is an important distinction.

Let me stay with the injury issue for a moment. Mr. Mecklenburg, it is clear that this is a big problem for nurses and a big problem in hospitals, and yet the American Hospital Association came out against the ergonomics rule. Can you explain that to me?

Mr. MECKLENBURG. The American Hospital Association does support a workable ergonomics proposal. We did oppose the proposal that was before us last year that was based on manufacturing standards. The hospital environment has unique aspects to it, and we are working right now with OSHA on ergonomic standards for health care.

Hospital work is hard work. Nursing work is very hard work. If you go across hospitals in the country, regardless of an ergonomics proposal, there are lots of activities going on to improve safety in hospitals. But when we get to a regulatory piece, I think we have to be cognizant that different workplaces need some different interpretations from time to time, and that was the basis for our objections.

Senator DURBIN. I do not disagree with that at all. It clearly has to be tailormade to the workplace, but we have really reached an impasse.

Madam Secretary, if I am not mistaken, your predecessor as Secretary of Labor, Elizabeth Dole, was the first to announce the ergonomics standard or at least identify it as a problem that needed to be addressed. So as Secretary of Labor, you must have gone through your own experience with the ergonomics. Can you address the whole question of injuries and health professionals and ergonomics? It is not the real focus of the hearing, but we should address it since we have visited the injury question.

Ms. MARTIN. To concentrate if I might on the area that this particular panel looked at, you are quite correct. Although we did not concentrate on injuries—and Mary Jo may wish to comment since she directs the Nursing Institute—one of the things that is quite clear is that the physical labor required in a nursing home is stupendous. And let us again stay with the obvious. Most nurses and nurse aides are women. Many people in nursing homes cannot help at all with movement. There is almost no thanks. Some of these people never have visitors, so their only contact is this health care professionals. And when she or he does not have adequate support,

the answer is that the person receives no help, or you can have the increase in injuries.

Some of the changes that can occur are technological here. We can make some differences. But the other part of the reality is that these are human beings, and I would hope that the impasse in this area could eventually be worked out in an appropriate way, because you will not have people deliberately choosing careers where their chance of being hurt is increased; and as they get older, their ability to do some of these things does become a factor. This is one of those things that keeps going around.

Nurses and nurse aides are getting older. The requirement, physically, is getting tougher in nursing homes because people go at a later age, and they are more seriously ill. That is not generally the place of choice, so the narrowing of the talent pool is something, and the injury issue is real.

I would ask Mary Jo to comment.

Ms. SNYDER. Thank you.

One of the things that we think is significant in relation to injury but with this labor issue is that remember we are speaking of the entire nursing care continuum, not just to the RN The RN's dissatisfaction from our studies and issues of working conditions and reasons for leaving the field has a lot to do with their level of support, that support being at all caregiver levels.

We would ask that as we look at solutions, we look at solutions across the entire care continuum, specifically at the nurse aide and the other caregiver levels.

We did look at the issue of technology, some of that being ergonomic type of support, to support the nurses' role in this hard labor—this is a difficult piece of labor—and we do not believe that technology is really the solution here.

Senator DURBIN. Well, I think technology can play a role in making life a little easier. The Neon plant in Belvedere, which you visited and I have visited, changed the workplace and saw a dramatic decline in the number of accidents.

I would just say on this issue of ergonomics that we have been debating this for over 20 years, and the people gathered here who are in the nursing profession know that this is a serious problem and part of the stress and difficulty of being a nurse today. We have got to find a way to establish standards that make the workplace safer for these employees.

Let me ask you this, Mr. Mecklenburg. On the question of whistleblowers, this is painful for Senators and for Members of Congress; it must be painful for hospital administrators to protect, let alone reward, those who point out deficiencies in their own management. Yet if you are going to deal with things in an honest fashion, how do you think the American Hospital Association would suggest that we deal with protecting whistleblowers within hospitals who come forward and say, "Let me tell you, you are setting up an unsafe situation here for the employees of this hospital and for the patients"?

Mr. MECKLENBURG. Senator, if I could comment one last time on the technology and the previous issue of ergonomics. There are technological helps that can be there, and if I can, I would link that

with the questions you asked this morning about Medicare reimbursement, because I think they are very important.

As you know, we opened a marvelous new facility 2 years ago.

Senator DURBIN. Yes. It is beautiful.

Mr. MECKLENBURG. When we did that, we were able to buy new equipment for that facility. If you may recall, one of the features is that every patient bed has a scale built into it.

One of the stresses for nurses is when they have to remove a patient from the bed to weigh them—and for some patients, that is multiple times every day. The technology exists to put a scale in that bed and not have to move the patient. That technology is expensive.

Senator DURBIN. How expensive?

Mr. MECKLENBURG. It is very expensive. These beds cost thousands of dollars each and are far more than the simplest bed available on the marketplace. But the cost of injuries, as is implied in our conversation here, is also very high, and it makes sense for that investment.

Hospitals are struggling with technologies like the beds, but also when we talk about medical errors, the investment in information technology that helps us get at that and also simplifies the nurse and other professional work.

We have had hospital marketbasket calculations in the last 3 years of about 3 percent a year. We have gotten less than full marketbasket. The investment in this technology requires more than that.

You also asked a question about nursing salaries and what has happened to them. If I may, I would like you to know what is happening in our institution, and it gets right back to this investment question.

In the last 3 years at Northwestern Memorial, our average starting nursing salary has gone up 16.7 percent. The average starting salary is at a 22.7 percent increase, plus increases in benefits, plus an improved pension plan, plus a contribution to their 401(k). The average nursing salary at Northwestern Memorial is $50,500 a year, which is—I do not know that this data is wrong, but it is looking at all nurses who may be working in schools and so on.

For us to afford the technology for ergonomics, the information technology, and deal with the issue of increasing worker compensation, the Medicare program has got to recognize that a marketbasket based on 1992 information just does not make it anymore.

We are not making a lot of profit on Medicare. Oftentimes—we just talked about inpatient—we are losing our shirt on home care. We are losing our shirt on outpatient care. When you put all of that together, the data that MedPAC looks at is very different.

So I wanted to link those several things together if I may.

I think the issue of whistleblower is a very complicated one, and it is difficult to give you the kind of response that you want. But there is no question that the mechanisms have to be provided within the institution for people to make their criticisms, their concerns, and their suggestions well-known. I think we have adequate laws that protect workers who are fired for the wrong reasons, and I would not disagree with that whatsoever. I must tell you that I

am concerned about enhancing the whistleblower protections for the obvious reasons.

Senator DURBIN. Does anyone else involved in this want to comment on the whistleblower issue? Ms. O'Sullivan.

Ms. O'SULLIVAN. Yes, I would like to comment. We agree that there need to be systems within the facility. Nurses need to make their concerns known where they can be solved, and that is within the facility, within the organization. That requires that nurses be a part of the decisionmaking process beforehand as well as after issues get out-of-hand.

One of the problems that the crisis in staffing has caused is that there is not the time to be as involved in these decisionmaking meetings and decisionmaking times. So nurses need to be involved ahead of time. They need to first report as they go along and have issues within the system. We certainly support that.

The issue is getting fired but also retributions occurring within the work environment if nurses whistleblow outside. So those are some of the protections for sure that we are looking at.

We are not looking at enhancing the legal costs by any stretch of the imagination, but nurses need to be protected if they are reporting in their patient advocacy role concerns that they have about health care in their institutions.

Senator DURBIN. I have learned a lot this morning, and I hope everybody has derived as much or more from the hearing as I have. It has been a good experience.

We have talked a lot about retention and workplace situations. I want to close by going back to the points that were raised by Secretary Martin as well as by Mr. Cox about recruitment and how to bring people into the profession.

I recall part of your testimony, Mr. Mecklenburg about the Explorer Post at Northwestern Hospital and the fact that what you are trying to do is introduce young people and others into the opportunities in this profession. And I think for all the negatives we have talked about today, we should never overlook the positives that can come with good nursing experience. It has to be a memory that you carry for a lifetime. My family and I have been through this with great nurses and great doctors, and we will never forget it, and I think that bears repeating. But for a moment, if we could just reflect on this recruitment question—what can we do to make sure that the food worker at some hospital even considers the possibility of being an LPN or an RN? What can we do to make sure that as tough as the nursing job might be, Secretary Martin, that the idea of caring and loving and providing that professional need is there and interests a young person, and how can we reach out to bring them in?

I have some ideas in the legislation that I am working on, but if anyone would like to comment, I welcome it; and I also hope that if you think about it on your way home and want to jot me a note with some ideas, and anyone in the audience is welcome to do the same.

Would anyone like to comment on that? I think Mr. Cox really said it pretty well.

Ms. BRAGG. Senator Durbin, I would like to make one comment. I sat in a room with a think tank group, and there was an econo-

mist there. After he heard everybody's testimony, he said, "Throw money, and throw a lot at it, but if you do not fix the systems behind it, if I cannot provide good care, I am not going to go there."

When I listen to people talk about the inflated salaries—I live in the Washington metropolitan area, and if you read the newspaper want ads for nurses like I do, we are looking at tremendous amounts of money being thrown out to get nurses in, given them a bonus for a 1- or 2-year commitment, and then they are gone. I think that is why you are seeing inflated salary, because it is not coming to those of us at the bedside for our stay at the hospital. I think that the recruitment process aimed at the people in the younger generation come up behind us is critical, because they have got to follow us. But they are not going to be around for another 5 or 6 or 8 or 10 years, and in that process, we have got to be able to retain the people that we have.

In my facility, the people who have been in the hospital system between 15 and 25 years make up over 50 percent of the nursing staff. We cannot afford to lose one of those people, and at the same time, we have got to be able to bring people in. And it becomes so inherent with the scheduling practice, with our mandatory overtime issues, with the workplace issues, with the ergonomics issues, and every single one of those pieces—and you said it very eloquently—this is not a problem that has one solution, and it is not a problem to be solved easily, because every one of those pieces is going to impact the success of the other piece.

Senator DURBIN. I think Secretary Martin made a point that I want to close on. That is, we are not just dealing with the nursing shortage in the future, we are dealing with a family shortage. There will not be as many children around to care as we might have today, and there will be a lot of us who are in a position where we are going to need it.

I thank this panel very much and all who have gathered here today. We are going to take your ideas and move them forward in the legislation.

Thank you very much.

[Whereupon, at 12:37 p.m., the Subcommittee was adjourned.]

APPENDIX

Testimony of
RACHAEL WEINSTEIN, RN
DIRECTOR, CLINICAL STANDARDS GROUP
OFFICE OF CLINICAL STANDARDS AND QUALITY
CENTERS FOR MEDICARE AND MEDICAID SERVICES
on
NURSE STAFFING
before the
SENATE COMMITTEE ON GOVERNMENT AFFAIRS
SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT, RESTRUCTURING, AND THE DISTRICT OF COLUMBIA

June 27, 2001

Chairman Durbin, Senator Voinovich, distinguished Subcommittee members, thank you for inviting me to discuss the need for adequate nurse staffing levels. As a registered nurse, this issue is important to me personally, it is a priority for Administrator Scully and Secretary Thompson, and we look forward to working with you to address this growing concern.

Nurses and nurse aides play a critical role in caring for Medicare and Medicaid beneficiaries, sometimes working more than the equivalent of two eight-hour shifts in one day. Their work can be exhausting, emotionally as well as physically, and too often they perform their duties without receiving the credit they deserve.

Nursing requires great dedication, and research has shown that it is becoming more and more difficult to recruit and retain professionals to perform this difficult work. Moreover, studies continue to demonstrate that higher nurse staffing levels, especially registered nurse staffing, directly influence positive outcomes in patient care, and poor nurse staffing levels are associated with poor patient care.

We recognize the important role that nurses play in our health care system, and we value their dedication and hard work. In our role as the largest health insurer in America, we need to ensure that we pay health care providers appropriately. Numerous objective observers, including the General Accounting Office (GAO), the Health and Human Services Inspector General (IG), the Medicare Payment Advisory Commission (MedPAC) have found that Medicare payment levels

in the last few years are more than adequate to cover the costs of providing high quality care in hospitals, skilled nursing facilities (SNFs), and home health agencies.

Despite the appropriateness of Medicare's reimbursement levels, our country faces a nursing shortage. We are analyzing the situation to determine the best way to ensure that our beneficiaries continue to receive the high quality care they need, and we are committed to reducing unnecessary burden and complexity in Medicare. We are sponsoring research into nurse staffing levels in nursing homes, and we are considering ways to guarantee that nursing homes meet the appropriate staffing levels based on the results of our research. Additionally, have been working with our partners, including the Health Resources and Services Administration (HRSA), to sponsor other nurse staffing studies. These studies will help inform solutions so that there will be enough highly trained, dedicated, caring people who will continue as nurses and provide the quality health care to the millions of people who depend on them.

PROSPECTIVE PAYMENT SYSTEMS

The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, pay for the health care of almost 40 million Medicare beneficiaries. We strive to be prudent purchasers of care, paying appropriately for health services to allow physicians and providers to give high quality care to our beneficiaries. At the same time, we have a duty to the taxpayers to safeguard the Medicare trust fund. Striking this balance is an inexact science, and we work hard to get it right.

For the most part, we pay providers prospectively. This means facilities and providers receive a specific, predetermined base payment adjusted for local wages and the care needs of individual patients. We use different prospective payment systems (PPS's) for various industries to account for differences in the costs incurred by various types of providers. For example, we pay a per diem prospective payment rate to SNFs. This rate covers the costs of furnishing most covered nursing home services, including nursing services, room, board, and minor medical supplies; related costs such as therapies, drugs, and lab services; and capital costs including land, building, and equipment.

Similarly, we reimburse hospitals prospectively. For example, an inpatient hospital receives base payments reflecting the factors that influence the cost of care in inpatient hospital settings, including nurse wages. Additionally, if a hospital is recognized as serving a disproportionate share of low-income patients, or if the hospital is an approved teaching hospital, it receives additional reimbursement for each case paid through the PPS. And, if the hospital incurs large financial losses due to unusually expensive cases, it can become eligible for additional payments, protecting it from catastrophic losses due to exceptional circumstances. In these ways we pay different hospitals appropriately based on the national cost averages of the services they are providing, adjusted for circumstances that alter those costs for individual provider differences like geographic location and patient case mix.

The same is true in the home health setting. As long as beneficiaries continue to remain eligible for home health services, they may receive an unlimited number of medically necessary episodes of care. Medicare pays home health agencies for each covered 60-day episode of care. Payments cover skilled nursing and home-health aide visits, as well as covered therapy, medical social services, and supplies. We pay home health agencies at a higher rate to care for those beneficiaries with greater needs. And, as with hospitals, home health agencies receive additional payments for an individual beneficiary if the costs of the individual's care were significantly higher than the specified payment rate. Payment rates also are adjusted to reflect significant changes in a patient's condition during each Medicare-covered episode of care.

Prospective payment systems have been phased in for different provider types over the last two decades, gradually replacing systems that based reimbursement on each provider's reported costs. These prospective payment systems reimburse more accurately for services, and also offer the flexibility for providers to manage care for their patients in the most efficient and medically appropriate way. If providers perform health services for less than the prospective payment rates, the difference between the cost of the service and their payments becomes additional revenue for them, which can be used for profit or other purposes. If they continually exceed the prospective rates, they will lose money. Prospective payment systems provide the opportunity for providers to manage their practices effectively without government micromanagement.

PAYMENT RATES

While PPS's offer an important way to appropriately reimburse health care providers for services, like any other payment system they must be updated to reflect changing conditions in the marketplace, including inflation, and other factors that might raise or lower the cost of providing care. To deal with increases in the prices of goods and services that providers purchase, we update each PPS based on a market basket, or a grouping of goods and services that a health care provider, such as a hospital or a SNF, uses to care for patients. These goods and services include employee wages and benefits, professional fees, facility utilities, drugs, office supplies, and others. We weight each of these components based on the national average proportion of a provider's costs generated by that item. The market basket components are increased by a price index, an estimate of how much the cost of each item will change, called a price index. To determine the market basket update for a coming year, we multiply each component price index by its component weight. These figures for each component, taken together, make up the market basket. We use each industry's market basket to update that industry's PPS.

Market basket updates reflect changes in most nursing costs. For example, in the inpatient hospital PPS market basket, changes in nurse wages are captured in both the hospital industry and economy-wide measures of wage change. As a June 18, 2001 MedPAC memo points out, this combination of measures means that wage increases unique to the health field, like a nurse shortage, are reflected in the market basket wage increase in a way that would not be possible if only economy-wide price measures were used. Moreover, MedPAC reported that over the past decade, the actual hospital industry wage index has increased more slowly than the combination of wage measures used in the inpatient hospital market basket. This means that during that same time period, the wage component of the market basket rose about three percentage points more than hospital wages, generally giving hospitals higher payments than necessary to cover the cost of wages. We continually monitor the appropriateness of the weights and prices used to determine the market basket increases so we can accurately reflect the price increases facing providers in efficiently caring for our beneficiaries, including expectations of a tight labor market due to nurse shortages.

While the market basket reflects wages across an entire industry, we use a wage index to measure differences in the costs of labor across geographic areas. Since it can take years for providers to submit all of the necessary data to develop the wage index, we use data from 4-year old provider cost reports. This means that if wage variations across geographic areas occur due to a more recent trend, such as the nursing shortage, those geographic variations will not be reflected in the wage index data for several years. MedPAC examined this issue in its June 2001 Report to Congress, and concluded that nurse shortages appear to be occurring across most geographic areas. This means they should not impact the accuracy of the geographic-specific wage index.

Once we calculate the wage index, we use it to adjust the proportion of the national payment rate related to labor costs. Currently, our Office of the Actuary estimates that labor-related costs account for 71.1 percent of hospital costs, as determined from the hospital market basket. We intend to review this estimate when the market basket is rebased (which occurs every 4 to 5 years) as recommended by MedPAC in its June 2001 Report to Congress. Regarding nurses specifically, the Bureau of Labor Statistics estimates that nurses account for 30 percent of hospital employees. Additionally, nursing services represent approximately 30 percent of the historical cost we use to construct SNF PPS rates. We are considering reexamining our assumptions about the proportions of providers' costs that reflect resources purchased in local and national markets, as included in MedPAC's recommendation in its June 2001 Report to Congress.

Using the market basket and wage index helps to ensure that our payment levels are appropriate. For instance, the first phase of our nursing home staffing study, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Summer 2000,* indicated that PPS payments actually exceeded the staff costs of both the minimum and preferred nurse staffing minimums identified in the report. Additionally, objective observers agree that our prospective payments have been adequate to allow providers to hire and retain the medical personnel, including nurses, necessary to provide high quality care for our beneficiaries. For example, in a December 1999 report, "Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments but

Maintain Access," the GAO indicated that nursing homes continue to enjoy adequate profit margins, and that Medicare payment levels are appropriate for the services they provide. Similarly, in its March 2001 report to Congress, MedPAC noted that although hospital profit margins suffered following the Balanced Budget Act of 1997 (BBA), there are signs of significant improvement in fiscal 2000. Additionally, MedPAC found payments are on track, and said there is no compelling reason to alter the payment update already set in the law for fiscal year 2002.

It is important to note, however, that these assessments apply to industries generally. Individual providers within these industries may not share the same perspective. For example, some rural hospitals feel that payment updates do not reflect the costs they face. We are trying to address these individual cases. Under Medicare, there are four rural hospital designations that provide additional payments to rural hospitals and often relax certain Medicare restrictions for them. For instance, critical access hospitals, which are very small, limited service rural hospitals, are exempt from both the inpatient and outpatient PPS. Additionally, the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) contained numerous provisions that significantly eased the burden of the BBA cuts for rural providers. BIPA also provided a temporary two-year increase of 10 percent to home health services provided in rural areas.

In addition to rural providers, these laws benefited specific industries as a whole. They provided substantial "givebacks" to reverse BBA cuts in Medicare spending. For example, BBRA provided SNFs a 4 percent across-the-board rate increase for fiscal years 2001 and 2002, as well as a 20 percent increase for the most common nursing home services. Likewise, BIPA increased the nursing component of the SNF PPS rate by 16.6 percent. BIPA also directed the IG to study whether this payment increase has had an effect on staffing in Medicare certified SNFs.

Paying providers appropriately to ensure our beneficiaries receive high quality care is our job. We give providers the flexibility to determine how to provide this care within the appropriate funding levels. As average hospital costs increase due to the need to pay higher wages to attract nurses, Medicare payments will increase through greater payment updates. However, Medicare

payments are not earmarked for specific aspects of provider operations. It is up to the providers to decide how to best deliver care within their prospective payments. We believe that the vast majority of providers will make prudent business decisions that allow them to deliver high quality care in the most efficient way possible when they have the flexibility and the economic incentives to do so. Reflecting the appropriateness of our payment policies, MedPAC's recent report on nursing and allied health education suggested that if Congress wants to influence the number, mix, and geographic distribution of health care professionals, it should pursue targeted programs supported with general revenues rather than Medicare payment policies.

BEYOND PAYMENTS

While financial reasons may impact some providers' ability to hire and retain an adequate nursing staff, the reasons for the nurse staffing shortage run far deeper than financing. The GAO recently testified that a higher proportion of patients with more complex care needs has expanded demand for nurses with specialized training. They added that the increased use of technology has driven up the demand for a higher skill mix of registered nurses, and the expansion of care delivery settings has increased the demand for nurses generally. The GAO also suggested that job dissatisfaction, difficult working conditions, and low compensation also may contribute to the nurse shortage. In fact, studies indicate that dissatisfaction with working conditions is a major source of frustration for nurses, both domestically and in foreign countries. These studies indicate that current working conditions have led to the decline in enrollments in schools of nursing, an increase in the number of those leaving the profession, and an older nursing population remaining in active employment.

We are very concerned about the impact the nurse shortage could have on our beneficiaries. Last summer, we completed the first of two phases of research on the relationship between nurse staffing levels in nursing homes and quality of care. It represented the first time ever that a clear relationship between nursing home staffing levels and quality of care had been demonstrated in a statistically valid way, and marked a major step forward in understanding that relationship. This preliminary research represents only the first step we have taken to address staffing issues and improve nursing home quality. We have expanded our studies based on more current and comprehensive data, and we are validating our findings with individual case samples

and examining other issues that may affect quality, such as turnover rates, staff training, and management of staff resources.

Once these studies are finished, the results may help us to better ensure our beneficiaries receive quality care. Currently, our Conditions of Participation (CoPs) for home health agencies, skilled nursing facilities, and hospitals, which these facilities must meet to receive Medicare reimbursement, require that they maintain adequate nurse staffing levels. As we complete further research, the results may enable us to require more specific minimum staffing levels to guarantee quality care.

We also continue to revise the entire set of hospital CoPs, based on our 1997 proposed rule. We anticipate completing this process in early to mid-2002. Although we did not propose staffing ratios in our proposed rule, we did offer a new Human Resources CoP. In addition continuing to meet current CoPs, under the Human Resources CoP hospitals would have to:

- Ensure their staffing levels reflect the volume of patients, patient acuity, and intensity of the services provided to achieve desirable patient outcomes;
- Develop and consistently use an explicit process to determine, on an ongoing basis, the appropriate level of nursing staff, including: registered nurses, licensed practical nurses, and nursing assistants; and
- Make their staffing methodology and evidence of its use available to the public.

Additionally, in response to the Institute of Medicine report on medical errors, we committed to publishing our hospital Quality Assessment and Performance Improvement CoP as a separate final rule. Although these requirements do not relate directly to staffing, they will help support nurses in hospitals by fostering collaboration for quality improvement among all medical disciplines, including nursing.

Along with our nursing home study and CoP refinements, we are reviewing additional research to determine whether limits on the number of hours health professionals work will reduce the risk of unsafe care due to fatigue. We also have worked jointly with our partners in the Department of Health and Human Services (HHS) to further explore the impact of nurse staffing

on patient outcomes. We have a history of working closely with HRSA on a variety of issues, and they are charged with providing national leadership to ensure an adequate supply and distribution of qualified nursing professionals. Recently, we collaborated with HRSA, the Agency for Healthcare Quality and Research, and the National Institute for Nursing Research to cosponsor a study on nurse staffing and patient outcomes in hospitals. We plan to continue working closely with our partners in HHS, to ensure our beneficiaries have access to the high quality care they deserve.

CONCLUSION

Nurses play a crucial role in caring for our beneficiaries, and we are concerned that the nurse staffing shortage could have a profound impact on the care our beneficiaries receive. We must continue to be vigilant and ensure we are paying health care providers appropriately so they can hire and retain adequate levels of nurse staff, and we are fulfilling this responsibility. We must continue to make the issue of nurse staffing levels a priority. We are working closely with our HHS partners, and we want to continue to work with you and others to find ways to address this growing concern. Thank you for the opportunity to discuss this issue with you today, and I am happy to answer your questions.

Testimony of
Denise H. Geolot, PhD, RN, FAAN
Director, Division of Nursing
Bureau of Health Professions
Health Resources and Services Administration
on
Finding a Cure to Keep Nurses on the Job
before the
Subcommittee on Oversight of Government
Management, Restructuring and the District of Columbia
Senate Committee on Government Affairs

June 27, 2001

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear before you today to discuss issues related to the nursing workforce. In my statement, I will provide an overview of the characteristics of the nursing workforce based on data from our *National Sample Survey of Registered Nurses*, speak about the extent of current and projected nursing staffing levels and review what HRSA is doing to plan for future nurse staffing needs.

Characteristics of the Registered Nurse Workforce

In March 2000, the Division of Nursing, BHPr, HRSA conducted the *National Sample Survey of Registered Nurses*, the seventh in a series of surveys on the characteristics of the nursing workforce; the previous survey was completed in 1996. This survey provides the latest and most comprehensive data on the characteristics of the registered nurse workforce. The preliminary findings were released in February 2001 and the full report is to be released this summer. Preliminary findings show the following:

- There are an estimated 2,696,540 registered nurses (RNs) in the US today. The overall number of registered nurses (RNs) increased by an estimated 137,666 between 1996 and 2000. This represents a 5.4 percent increase between 1996 and 2000 and is a substantial drop from the 14.2 percent increase in the nursing workforce seen between 1992 and 1996.

- An estimated 2,115,815 (81.7 percent) of the total licensed RN population reported being employed in nursing.

- When asked about job satisfaction, 73 percent of nurses employed in nursing indicated that they were satisfied; however, only 68 percent of staff nurses working in hospital settings indicated that they were satisfied with their jobs.

- An estimated 71.6 percent of RNs in the nursing workforce reported working full-time and 28.4 percent reported working part-time in nursing.

- A breakout by highest educational preparation of RNs in 2000 revealed that 23 percent had a diploma in nursing, 34 percent had an associate degree in nursing, 33 percent had a baccalaureate degree, and 10 percent had a masters or higher degree in nursing.

- The RN population is aging. The average age of the RN is 45.2 years, up from 44.5 years in 1996. Nine percent of the nurses are under the age of 30, and 51 percent are over the age of 45.

- The average age of the employed RN is 43.3 years, up from 42.3 in 1996.

- The average age at graduation from basic nursing education programs has increased over time. Between 1995 and 2000, the average age of a graduate from a baccalaureate program was 27.5 years; from an associate degree program was 33.2 years; and from a diploma program was 30.8 years.

- An estimated 12.3 percent of the RN population reported being in one or more of the identified racial and ethnic minority groups, up from 10.3 percent in 1996. Of these RNs, 4.9 percent reported being Black/African American (non-Hispanic); 3.5 percent reported being Asian; 2.0 percent reported being Hispanic; 0.5 percent reported being American Indian/Alaska Native; 0.2 percent reported being Native Hawaiian/Pacific Islander; and 1.2 percent reported being of two or more racial backgrounds.

- Asian, Native Hawaiian/Pacific Islander, and Black/African American RNs were more likely than Hispanic and white (non-Hispanic) nurses to have at least baccalaureate preparation in nursing.

- An estimated 5.4 percent of the RN population are men, up from 4.9 percent in 1996.

- Five major employment settings for RNs were identified: hospitals (59.1 percent), community and public health settings (18.3 percent), ambulatory care settings (9.5 percent), nursing homes and extended care facilities (6.9 percent), and nursing education (2.1 percent).

- The average annual earning for RNs employed full-time was $46,782. Salaries have remained relatively flat since 1992.

- An estimated 7.3 percent of the total RN population reported being prepared as advanced practice nurses (clinical nurse specialists, nurses practitioners, nurse-midwives and nurse anesthetist); this was up from 6.3 percent in 1996.

- A breakout of advanced practice nurses revealed that an estimated 44.9 percent reported being nurse practitioners; 27.7 percent reported being clinical nurses specialists; 7.5 percent reported being both a nurse practitioner and clinical nurse

specialist; 15.2 percent reported being a nurse anesthetist; and 4.7 percent reported being a nurse-midwife.

- The New England area had the highest concentration of employed RNs in relation to the area's population with 1,075 employed RNs per 100,000 population. The Pacific area had the lowest concentration with 596 per 100,000 population. The average number of RNs employed per 100,000 population in the country is 782.

The Nursing Shortage – What We Know

There are pockets of nursing shortages throughout the country, especially for RNs with clinical expertise and specialty preparation. Some hospitals are reporting that they must close beds and divert patients to other hospitals because of nursing shortages. The American Hospital Association (AHA) survey of 715 hospitals across the country released earlier this month indicated that of the nearly 168,000 overall hospital job vacancies identified, 126,000 (75 percent) were for registered nurses.

The aging of the nursing population, declining student enrollments in nursing schools, and current working conditions may have an effect on future nursing staffing needs. The average age of the RN is 45.2 years. Enrollments in all nursing programs have declined. Enrollment data from the American Association of Colleges of Nursing reveal that baccalaureate nursing program enrollments fell 4.6 percent in fall 1999 - the fifth straight year of declining enrollments. Figures for 2000 revealed a slowing of this decline to 2.1 percent. Graduation data from the National League for Nursing indicated that there was a 13.6 percent decrease in RN graduates between 1995 and 1999. Increased workloads, low staffing levels, mandatory overtime, limited career opportunities and low pay have been identified as reasons for increased turnover of staff in many settings.

The Nursing Shortage – What the Data Show

The answer to whether there is a national nursing shortage is complex. No single direct measure exists for indicating a shortage of nurses at the national level. The Division of Nursing, BHPr, HRSA has historically used a comparison of the projected supply of nurses and the projected demand (requirements) for nurses to assess imbalances.

However, it is important to note that the national picture, based on data from the sample survey, coupled with our supply and demand forecasting models, is significant for national health workforce policy analysis, not for predicting local disruptions in workforce needs. A balance at the national macro level may mask significant workforce imbalances at the local level in various health care settings and for needed specialties.

The March 2000 *National Sample Survey of Registered Nurses* shows that the supply of RNs has continued to increase, although at a slower rate than ever reported for a four-year period since the surveys began in 1977. The Division of Nursing uses its Supply

and Requirements Forecasting Models with the sample survey data to provide projections on the nursing workforce that serve as the basis for shaping policies designed to assure an adequate workforce.

Ideally, the number of nurses available to provide services in a given setting should be in balance with the requirements for nursing services in that setting. Based on outputs from the supply projection model and the demand projection model published in the mid-1990s, the supply of and requirements for full time equivalent (FTE) RNs is expected to be roughly in balance until the year 2010 at the national level. A projected leveling off of supply and steep increases in demand over the years between 2010 and 2020 result in a widening gap between the number of nurses expected to be required and the number of nurses expected. By the year 2020, the model indicates a shortfall in the number of needed RNs. However, because of recent rapid changes in the health care system, it is difficult to make precise predictions about what the demand for nursing services will be in the future.

Preliminary estimates from the revised demand forecasting model indicate requirements for 1,892,000 FTE RNs in 2000. Comparing this estimate with the 2000 FTE supply of 1,889,244 estimated from the 2000 sample survey indicates that, at the national level, there is roughly a balance. However, this does not negate reports from other sources of current shortages in specific geographic areas, health care sectors, or types of RNs. The demand forecasting model identifies a systematic problem that will continue to increase through 2020. If these current trends continue, all health care settings, all geographic areas, and all needed specialty nurses may experience nursing supply challenges, but there may also be advances in technology that may reduce future demands. HRSA will continue to monitor nursing data to chart future nursing staffing needs.

When we look at RN to population ratios for the Nation as a whole, data from the *National Sample Survey of Registered Nurses* show that the overall ratio of employed RNs per 100,000 population has varied from 688 in 1988 to 798 in 1996 and 782 in 2000. After more than a decade of increases, the rate appears to be dropping at a time when the population is aging. Data from the 2000 sample survey show that the variation among states is considerable. The numbers range from a low of 520 employed RNs per 100,000 population in Nevada to a high of 1,675 employed RNs per 100,000 population in Washington, DC with an average of 782 for all jurisdictions.

Although we recognize that the ratio of RN to population may be useful as indicators on the national availability of nurses and how well such availability meets demand requirements ratios, the Division of Nursing, BHPr, HRSA does not advocate the use of fixed ratios. This data may be useful in identifying State trends, but it has little meaning unless related to such factors as specific population characteristics, types of services provided, patient acuity, the types of nursing specialties available, and the educational preparation of the nursing workforce.

What HRSA is doing to Address the Nursing Shortage

HRSA administers programs authorized under Title VIII of the Public Health Service Act, often referred to as the Nurse Education Act. Title VIII was instituted by the Nurse Training Act of 1964 in response to a quantitative and qualitative shortage of nurses as a key vehicle for federal support for nursing workforce development. Title VIII programs are primarily administered by the HRSA Bureau of Health Professions' Division of Nursing. Specific activities helping to mitigate the shortage of nurses include support for (1) basic and advanced nursing education programs, (2) diversity programs targeting minority and disadvantaged students, (3) scholarship, traineeships and loans, and (4) nursing workforce analysis.

The FY 2001 budget for Division of Nursing programs is $76.5 million: $59 million (77 percent) for *Advanced Education Nursing*; $4.7 million (6 percent) for *Nursing Workforce Diversity*; and $12.8 million (17 percent) for *Basic Nurse Education and Practice*. The FY 2002 budget increases funding for HRSA's nursing programs by $5 million. The *Advanced Education Nursing* program supports projects to educate nurse practitioners, clinical nurse specialists, nurse anesthetists, nurse midwives, nurse administrators, public health nurses, nurse educators and other specialty nurses for advanced practice. Funds from this program will support advanced education projects enrolling approximately 4550 students and provide traineeship support for 5800 graduate level students. The *Nursing Workforce Diversity* program provides support to projects targeting 1800 minority and disadvantaged students in elementary and secondary schools, pre-nursing programs, and nursing schools. The *Basic Nurse Education and Practice* program supports academic and continuing education projects designed to strengthen the basic nursing workforce. Funds from this program will support projects to expand enrollments in baccalaureate programs and support basic entry level career ladder programs for licensed practical nurses, innovative academic distance learning projects for rural RNs, and faculty-run nurse managed centers caring for underserved populations.

The Bureau of Health Professions' Division of Student Assistance provides $12.7 million in support to 3,600 nursing students through the Scholarships for Disadvantaged Students Program and $22 million in support for 10,000 nursing students through the revolving Nursing Student Loan Program. In addition, two nursing faculty receive support from the Faculty Loan Repayment Program.

Within the Bureau of Primary Health Care, the Nursing Education Loan Repayment Program provides $2.3 million to assist 200 registered nurses by repaying up to 80 percent of their qualified educational loans in return for their commitment to provided services at health facilities in shortage areas. In addition, the National Health Service Corp Scholarship and Loan Repayment Programs provides $6.3 million to support 94 nurse practitioners and 29 nurse-midwives providing services to people in underserved areas.

HRSA has been working with the Centers for Medicare and Medicaid Services (CMS) to examine workforce issues. We routinely comment on proposed regulations, which

include references to nursing. Currently one of our nurse consultants is serving on the regulation team on final hospital conditions of participation to address nursing issues. Recently, HRSA and CMS collaborated with the Agency for Health Research and Quality and the National Institute for Nursing Research, National Institutes of Health to produce the *Nurse Staffing and Patient Outcomes in Hospitals* study completed by the Harvard School of Public Health.

Conclusion

In conclusion, Mr. Chairman, I appreciate the opportunity to share with you the latest information on the characteristics of the nursing workforce, the status of what the data show from a national perspective, and the types of activities being undertaken at HRSA to address the needs of the nursing workforce.

I would be happy to answer any questions you may have.

DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO

25 Jun 01
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The Honorable Richard J. Durbin
Chairman, Senate Subcommittee on
Oversight of Government Management, Restructuring and the
District of Columbia
United States Senate
Washington, DC 20510

Dear Senator Durbin:

I want to thank you for the opportunity to appear before your committee to testify on behalf of the Service's three Nurse Corps Chiefs. Previous Congressional testimony on the status of our Corps is provided for your review as attachments. There are also major areas of concern from the Tri-Service Nursing Chiefs that I would like to address:

a. Approximately 50% of nurses staffing Army and Navy facilities are civil service, resulting in direct competition with the private sector, which is also suffering from extreme shortages.
b. Increased use of contract and temporary personnel is needed to fill vacancies and achieve minimum staffing levels.
c. The current civilian personnel system impedes efforts to bring new permanent staff on board in a timely manner, resulting in loss of potential new hires to civilian employers.
d. Enrollment in baccalaureate nursing programs has decreased for the past 5 years, reducing the pool of nurses from which to recruit into the services.
e. Very attractive civilian compensation packages, such as large sign-on bonuses, childcare, loan repayment, and tuition reimbursement also add to the difficulties of recruiting.
f. Frequent moves and military deployments are becoming significant detractors to extended military service.
g. Retention problems exist at the 6-12 year career point, reducing the experience level needed to safely staff units and teach new nurses.
h. Specialty shortages exist in perioperative, maternal child, psychiatric/mental health, nurse anesthetists, and critical care; these shortages result in reduced patient care capabilities and directly impact mission readiness.
i. Overall aging of the available pool of nurses has led to an increased number of nurse accessions who are over 40 years of age, leading to an older, limited-term, non-career track force.

j. Increased workload, diminishing staff and more intensive responsibilities lead to increased stress for practicing nurses.

2. Thank you for the opportunity to testify and report for on the status of the communities. For further information please feel free to contact me at (301) 295-5800 or my deputy, CAPT Virginia R. Beeson, NC, USN at (202) 762-3040.

//Electronic Signature//
Kathleen L. Martin
Rear Admiral, Nurse Corps
United States Navy
Director, Nurse Corps

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SENATE APPROPRIATIONS COMMITTEE

STATEMENT OF

REAR ADMIRAL KATHLEEN L. MARTIN, NURSE CORPS

DIRECTOR, NAVY NURSE CORPS

UNITED STATES NAVY

FEBRUARY 28, 2001

BEFORE THE

SUBCOMMITTEE ON DEFENSE

OF THE

SENATE APPROPRIATIONS COMMITTEE

ON

MEDICAL ISSUES

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
SENATE APPROPRIATIONS COMMITTEE

Good morning, Mr. Chairman and distinguished members of the Committee. I am Rear Admiral Kathleen Martin, Director of the Navy Nurse Corps and Commander of the National Naval Medical Center. It is my pleasure to be here.

Today I would like to address two major programs: TRICARE for Life and Military Health System Optimization, an effort to make the most effective use of our resources. These two programs pose special challenges for the Military Healthcare System of today and tomorrow.

The TRICARE for Life initiative provides us the opportunity to meet the healthcare needs of our beneficiaries in a way we have not been able to in the past. The opportunity of the over 65 population to enroll in TRICARE Prime will provide them with access to comprehensive care at a time when their healthcare needs are becoming more complex. For military medicine, TRICARE for Life will contribute to a robust training environment and provide the clinical competencies necessary to keep our personnel prepared to meet operational missions.

Both TRICARE for Life and Optimization pose significant hurdles. The resource shortages we face at the facility level have serious implications for our ability to meet our missions. Presently we are struggling to provide a limited benefit for our over 65 beneficiaries. Without

further resources, we will be unable to increase services to deliver the promised comprehensive benefit.

One of the principal resource issues is staffing shortfalls. A key to optimizing health care is ensuring sufficient numbers of providers and support staff to enhance productivity and access to care. We continue to be successful in making effective use of our military personnel; however, there is a need to increase the numbers of civilian support staff in order to make Optimization work. For that, there must be improved funding for the entire system and a revamping of the civilian hiring process. The current civilian personnel system impedes our efforts to bring new staff on board in a timely manner, resulting in loss of potential new hires to civilian employers. The antiquated classification system prevents us from competing with civilian employers in salary and professional status.

Compensation is an issue for military staff as well. I clearly see this as an MTF commander. Military personnel work side by side with contract staff who command salaries far exceeding those of their military counterparts. This creates additional dissatisfaction for our military members. Compensation is a powerful driver in the decision to remain on active duty or to leave the service.

Additionally, there is little elasticity left as the health care dollar is stretched to cover advances in technology, state-of-the-art equipment, spiraling pharmacy costs, continuous training requirements, and a myriad of other overhead expenses. Finally, there is a constant trade-off of tight resources for upkeep and renovation of old infrastructure. World War II era building configurations prevent us from keeping pace with the changing healthcare environment, and facilities are rapidly deteriorating due to scarce resources.

These issues confront me daily as the commander of a military medical center. In my role as Director of the Navy Nurse Corps, I see the impact system-wide. Utilization of existing resources, advancing technology and an aging population are fueling the demand for multi-skilled, well-educated nurses to meet patient care needs in an increasingly intricate healthcare system. Navy Nurse Corps officers fulfill this need through their broad scope of professional practice. Basic preparation at the baccalaureate level provides leadership skills, critical thinking ability, and case management in addition to strong clinical skills. This enables them to serve in critical positions as clinical support staff for comprehensive care delivery as well as direct care providers.

However, we are competing with the private sector for baccalaureate prepared nurses. In light of the growing nursing shortage, we must employ effective recruiting and retention tools to maintain a healthy force structure in both the active and reserve components. The Nurse Corps has implemented initiatives that assist existing recruiting and retention processes. In partnership with Navy Recruiting Command, we created a multi-step recruiting plan that seeks the best-qualified candidates for the Nurse Corps. The current nurse accession bonus is a key component of our recruiting strategy. Our recruiting success depends heavily on your continuation of the accession bonus and educational stipend programs.

Given today's competitive health care environment, that may not be enough to maintain the force structure. Currently, only nurse practitioners, midwives and nurse anesthetists receive any type of special pay. That program has been a successful retention tool thus far, but the civilian-military pay gap is rapidly widening. Further retention bonuses may be needed to retain all types of nurses as competition increases for the dwindling supply.

An important retention tool is advanced education for Nurse Corps officers, which prepares nurses to effectively lead both military and civilian personnel of different

technical and professional levels in the delivery of quality care, in any setting. Of note, over 23% of our Nurse Corps is master's prepared. The Federal Nursing Service Chiefs partner with the Graduate School of Nursing at the Uniformed Services University of Health Sciences to create a pipeline for advanced practice nurses. The nurse anesthesia and family nurse practitioner programs are becoming stronger as we support them with exceptionally talented instructors and expand the number of clinical training sites in military facilities. Innovative distance learning programs offer military and Veterans Administration nurses the opportunity to complete nurse practitioner certificate programs within their hospitals. Uniformed Services University provides superb educational opportunities for military nurses, and we look forward to future collaboration on creative educational initiatives.

In closing, the recent advent of TRICARE for Life and Optimization are welcome news to our beneficiaries, and arguably the most significant changes to our healthcare system since the creation of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program in 1966. Navy nurses, in concert with the whole Navy Medicine team, look forward to using their considerable

talents for the successful implementation of these new initiatives. But these talented people are not enough to achieve the task before us. I sincerely hope that our entire military healthcare system will be correctly supported so that we may meet our operational and peacetime missions.

As we collaborate with our colleagues in all the services to achieve high quality, cost effective care, our beneficiaries are our highest priority. I sincerely thank-you for your support and for the opportunity to address you today, I look forward to our continued association during my tenure as Director of the Navy Nurse Corps and Commander of the Flagship of Navy Medicine.

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEE ON DEFENSE

UNITED STATES SENATE

SUBJECT: FY02 Nursing Programs

STATEMENT OF: Brigadier General Barbara C. Brannon
Director of Nursing Services
Office of the Surgeon General

February 2001

NOT FOR PUBLICATION UNTIL
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UNITED STATES SENATE

Mister Chairman and distinguished members of the committee, I am Brigadier General Barbara Brannon, Director of Air Force Nursing Services and Commander of Malcolm Grow Medical Center at Andrews Air Force Base. It is an honor and privilege to represent today the 19,000 dedicated members of the active and reserve components of Air Force Nursing Services. Thank you for this opportunity to report on our achievements and challenges, and for your continued advocacy and support of our many endeavors. My comments will focus on recruiting and retention, nursing leadership and optimization, readiness, and research.

Recruiting

The national nursing shortage is having a devastating effect on staffing throughout the healthcare industry, and the Air Force Medical Service is no exception. For the third consecutive year, we are experiencing shortfalls in accessions. We were 85 nurses, or 30 percent, short of our nurse recruiting goal in FY 99. In spite of revising the goal last year from 300 to a "remotely achievable" 225, only 205 new nurses joined the Air Force in FY00 by direct commissioning. Unfortunately, current reports project an even more serious shortfall of nurses this year.

This is despite several initiatives implemented during the past year to enhance recruitment. We changed the operational definition of a "fully qualified nurse" to include those with one year of outpatient nursing, as

opposed to only accepting those with inpatient acute care experience. The Air Education and Training Command redesigned the Nurse Transition Program and we increased training capacity at our larger inpatient facilities that enabled us to recruit nurses with no experience for the first time in over three years. We also commissioned twice the number (from 12 to 23) of enlisted members who had earned their baccalaureate degree in nursing by removing the cap on that accession source. The number of ROTC scholarships doubled to 50 from the original goal of 25 set three years ago. Anticipating a severe shortage of Certified Registered Nurse Anesthetists, we instituted, for the first time ever, a loan repayment program that grants reimbursement of education costs up to $24,000. Innovative incentives like this are essential as we struggle to meet our recruiting goals in critical nursing specialties.

Other incentives designed to enhance our officer recruiting efforts have been discussed, but could not be supported last year by our sister services due to differences in our personnel management systems and our recruiting goals. One proposal was to change Department of Defense policy to reduce the minimum term of service from three years to two years. We believe this proposal would attract nurses not interested in a longer active duty commitment.

We would also like to evaluate the nurse accession bonus. It is our belief that the five thousand dollar accession bonus no longer competes favorably with the employment bonuses offered in the civilian market place. Newspaper advertisements and our recruiters tell us that some civilian hospitals offer as much as $10,000 in sign-on bonuses. We will continue to work with our sister services to find mutually acceptable legislative answers to the bonus question.

Retention

Our current end strength reflects our accession shortfalls, the final year of the Air Force Nurse Corps voluntary draw down program, and an unexpected increase in the separation of nurses after their initial active duty commitment. At the end of FY00, there were 4048 nurses on active duty, 165 nurses below our authorized endstrength. This is the first time in over a decade that we have been below endstrength.

I have directed that every nurse who voluntarily separates from the Air Force be interviewed by the Chief Nurse, or a senior Nurse Corps officer. The standardization of exit interviews will help identify the factors that are influencing our nurses to separate early from active duty military service. Trend analysis of information provided by the survey will potentially enable us to target both the timing and type of incentives needed to improve retention.

Retention of our enlisted members has also become a challenge. For example, the retention goal for first term medics is 55 percent. Last fiscal year, the medical technician retention rate was 51 percent, the lowest in seven years. Retention among career enlisted members, those with ten to fourteen years in service, was also below goal. A selective reenlistment bonus was instituted to improve the declining retention for our first termers. Little improvement has been noted, with the January 2001 reenlistment rate for first term medical technicians at only 43.9 percent.

Quality of life issues, including child care, housing, benefits, and workload, is often cited as a major factor when our people make career decisions. Continued congressional support of legislation that focuses on improving military quality of life will bolster recruiting and retention of our officer and enlisted forces.

Nursing Leadership Opportunities

The Air Force has a solid progressive leadership track, and nurses as commanders are no longer a novelty. I am very proud to be the first Nurse Corps officer selected to command an Air Force medical center. Active duty nurses now command 22 percent of our medical groups. Thirty-one Nurse Corps colonels met the most recent Medical Commander Selection Board. Forty-two percent were identified as command

candidates, and of those 13 nurses, 6 were selected for group command. Compared to the previous year, the selection rate increased 12 percent and the match rate decreased 8 percent.

Active duty nurses currently command 19 percent of our squadrons. On the last selection board, 39 nurses were identified as squadron command candidates and comprised 24 percent of all AFMS candidates. Twenty-two nurses were selected as squadron commanders and filled 25 percent of the requirements. Nurses command 32 percent of the Air Reserve medical squadrons and 13 percent of Air National Guard medical squadrons, representing a 3 percent increase for the Air Reserve and a 2 percent decrease for the Guard.

Nursing Optimization

Air Force nurses are also on the leading edge in the implementation of new health delivery models. Primary Care Optimization, and its overarching strategy of population health management, remains the focus of our peacetime health care system. Although challenges are great, we enjoyed many successes this past year. I am as excited about the role of the Health Care Integrator this year, as when I spoke of it in last year's testimony. These nurses work at the facility level as "air traffic controllers," ensuring our patients get the right care at the right time, from the right provider. Prevention and disease management are essential

ingredients of the health care integrator function. For example, the Health Care Integrator at Tyndall Air Force Base in Florida managed the follow-up care of over 800 patients seen in local civilian emergency departments. By returning these patients to the military treatment facility, the nurse ensured continuity of care and reduced costs per patient by eliminating duplication in services. As this role continues to evolve across our health system, I am optimistic that there will be even greater improvement in services and higher cost-savings.

Another success story revolves around telephone nursing practice, telehealth that is based on a philosophy committed to the goals of delivering quality, cost effective, and safe nursing care. Our nurses in our outpatient clinics reported in a recent survey that 50 to 60 percent of their duty time was spent providing telephone support to patients, assisting them in meeting their health care needs. This is equivalent to the time our civilian counterparts report that they spend in the same activities. Our nurses use the telephone to triage, educate, and coordinate care for patients.

Because of the amount of time spent on the telephone, there was a demand to standardize Air Force telephone nursing practice. We developed guidelines, training materials, and other support tools that were deployed to the field late last year. This tool kit was well received and

stimulated improvements throughout the Air Force Medical Service. In addition, we are conducting a triage demonstration project to evaluate access to care, clinical outcomes, patient and staff satisfaction, and required resources. This project is funded through the TriService Nursing Research Program. Although the demonstration is just underway, there are early lessons learned to validate that support of nurses in the triage function was much needed. I look forward to reporting our results next year.

We have also made great strides in optimizing the role of our enlisted members providing patient care services. As a result of Primary Care Optimization, our enlisted personnel have become pivotal members of the healthcare team. They are responsible for initial patient screening, identification of preventive health needs, and many aspects of patient counseling and education. Their work improves the quality of the patient visit by enhancing the efficiency of the physicians, nurse practitioners, and physician assistants.

Last year I spoke of the vast untapped potential of our enlisted force. We have made great progress in our initiative to increase the number of Licensed Practical Nurses in our skill mix. We entered a partnership with a civilian college and our first class of 23 students are now attending an accelerated program to earn a practical nurse certificate.

Much work was done this past year to develop an inpatient staffing model to correct the skill mix imbalance prevalent in our bedded facilities. The goal is to ensure the patient receives the right level of care from the appropriate nursing staff member. The model was field-tested last summer and the new standards were applied in the FY 03 manpower programming cycle.

We are now focused on developing new staffing models for our specialty services. Advanced practice nurses can play a critical role as we expand population health and condition management programs. We believe that increasing the number of advanced practice nurses in ambulatory care settings will increase access to care, improve patient satisfaction, and enhance the efficiency and effectiveness of our health care delivery.

Deployment of "TRICARE for Life" will also present another opportunity to capitalize on the talents of nursing personnel. We are delighted that we may be given the opportunity to welcome our over-age 65 retirees and their families back to our healthcare facilities. It is absolutely the right thing to do, and will also allow our people to practice the full scope of nursing, and maintain those skills critical to our medical readiness.

READINESS

We are at the nation's call and must be prepared to respond any time anywhere. We capitalize on every opportunity to sustain top clinical skills and to gain experience in a variety of settings. Two hundred Air Force medics participated in MEDFLAG 2000, a United States European Command (USEUCM) three week medical readiness exercise in Cameroon, West Africa. The 86th Aerospace Expeditionary Group, from Ramstein Air Force Base, Germany, was the lead agency of the joint team that also included medical personnel from the Army and the Navy. I made a personal visit to one village and witnessed our medics in action as they conducted a massive immunization campaign protecting over 19,000 African children from meningitis. I will always remember those parents who patiently waited in line for hours, knowing that our help could mean the difference between life and death for their children. Nursing is critical to the success of our nation's "Partnership for Peace" missions.

In Southeast Asia, our Independent Duty Medical Technicians (IDMT) supported Joint Task Force Full Accounting, a mission to search for and recover remains of Americans Missing In Action. Our IDMTs also deployed to the Federated States of Micronesia in support of civil engineering teams, and provided immunizations and routine medical care to the local

population. These contingency operations help our people gain new skills and sustain clinical competencies essential for medical readiness.

RESEARCH

The continued support of the TriService Nursing Research Program enabled us to study military nursing practice models and new technologies in the patient care environment. Nurses at Wilford Hall Medical Center in San Antonio, Texas, conducted research on wartime nursing competencies. This initiative used a web-based computer assisted training program and an innovative simulation laboratory to verify the readiness skills of over 200 clinical nurses. A key outcome of this study is the validation of the training frequency required to sustain necessary skills.

We also received a grant from the TriService Nursing Research Program that will help us deploy "Medical Team Management" throughout the Air Force Medical Service. Using the aviation crew resource management concept well-known to our flying community, a team at Eglin Air Force Base, Florida, designed a program to improve patient safety by enhancing communication and collaboration between nursing staff and other healthcare disciplines. During the past year, over 1500 Air Force medics were introduced to the elements critical to building a successful safety culture. The initiative also produced a Hospital Safety Index to

measure staff attitudes toward patient safety. Analysis of preliminary data is pending.

CLOSING REMARKS

Mister Chairman and distinguished members of the Committee, it has been a pleasure to share the most recent chapter of our Air Force Nursing story with you today. Our motto, "Global Nursing, Precision Care", reflects our commitment to our nation and our patients, in peacetime and in war. We thank you for your tremendous support of military nursing.

STATEMENT BY
BRIGADIER GENERAL WILLIAM T. BESTER
CHIEF, ARMY NURSE CORPS
ON THE ARMY NURSE CORPS

Mr. Chairman and distinguished members of the committee, I am Brigadier General William T. Bester, Assistant Surgeon General for Force Projection and Chief, Army Nurse Corps. I am both pleased and honored to testify before you today. I look upon my appointment as the 21st Chief of the Army Nurse Corps as both an honor and a privilege. The opportunity to serve with and direct some of the finest men and women in the Army Medical Department (AMEDD) is a professional reward that far surpasses anything that I could have thought possible some twenty-seven years ago when I first joined this outstanding professional nursing organization. I have an absolute commitment to serve the Army Nurse Corps with the same tenacious spirit of my predecessors.

In that same context, I stand committed to fully support The Army Surgeon General in his quest to maintain our high quality of peacetime healthcare while, at the same time, being trained, equipped and capable of supporting the medical needs of our deployed forces. In an environment of limited resources, he has charged me to be actively engaged in our corporate business plans that will allow us to generate the greatest benefit from the resources, both human and fiscal, that we have available to us.

This morning my focus will highlight three important concerns that relate to the ability of the Army Nurse Corps to serve the nation: manning, the impact of operational deployments and the importance of the congressionally sponsored Tri-Service Nursing Research Program. I would first like to begin by discussing manning.

Manning: The demand for professional nurses in America is increasing while the supply of professional nurses is declining; according to a policy statement from Tri-Council members, The American Association of Colleges of Nursing (AACN), The American Nurses Association (ANA), and The American

Organization of Nurse Executives (AONE) dated 31 January 2001. Last year, you will recall, all armed services stressed the need for continued incentives to attract and retain military members in light of the present and future nursing shortages. We greatly appreciate the Senate directing the Health Professionals Retention/Accession Incentives Study (HPRAIS), currently being conducted by the Center for Naval Analyses (CNA), that is evaluating the adequacy of special pays and bonuses for military health care professionals. We are hopeful that this study will identify the need for incentives for both our military nurse force and our Department of Army (DA) civilian nurse workforce.

The Bureau of Labor Statistics reports that Registered Nurse positions will increase 23% by 2006. According to the policy statement form the Tri-Council members, AACN, ANA, and AONE, enrollments in all basic RN preparation programs have declined each year for the last five consecutive years. According to the National League for Nursing (NLN), between 1995 and 1999, the number of programs of most types has increased in the United States 2.6 percent. Despite this overall growth, the number of students enrolled in and graduating from nursing programs has declined 13.6 percent. The clear trend is toward an increase in the number of programs occurring simultaneously with a decrease in the number of enrollments and graduations from these programs. For the fourth year in a row, Bachelor of Science in Nursing (BSN) enrollments are down 5%. Attractive, competing career options with greater compensation are luring young adults away from nursing as a career choice. To compound the shortage, the current workforce of civilian nurses is rapidly approaching retirement age. The average age of civilian RNs is 45.1 years. By 2010 it is estimated that more than 40% of the nursing workforce will be over the age of 50 and by 2015 approximately 50% of the nursing workforce will be retirement eligible.

These trends – decreased nursing school enrollments and an aging workforce - have a dramatic impact on our ability to attract and retain qualified military and civilian nurses. In the early 1990's our Corps made a commitment to use the Reserve Officers' Training Corps (ROTC) as our main source of accessions. With the nursing shortage of the last three years however, we have

seen a decline in scholarship requests and our ROTC accession numbers have decreased 50%, from a high of 228 in 1996 to a projected low of 113 for 2001. Although U.S. Army Recruiting Command (USAREC) has made up a significant part of this shortfall, direct accessions of nurses aged 40 years and over have become much more common. This creates an older, limited-term, non-career track force. This approach further shrinks our already eroding mid- and late-career captain and major ranks that supply the majority of our expert clinical specialty base. Having to recruit a greater number of working nurses means we must compete with the civilian institutions for the same critical specialties at a time when they are offering streamlined hiring practices and significant recruitment and retention bonuses. Furthermore, continued erosions in our health education and training budgets for our military nurses adversely impact our ability to provide the professional development necessary to prepare our officers for the rigors of senior leadership and advanced practice. Our junior officers look to these educational offerings as a means to advancement and a critical motivator for retention.

Our civilian ranks present a more acute dilemma. Within our current AMEDD nursing structure approximately 50% of nursing care is provided by Department of Army (DA) civilian nurses. Over the last three years our inventory has not met the level of need. The reasons are varied. Current vacancy rates for authorized positions vary by region from a high of 27% to a low of 7%. Coupled with costly 15% to 35% turnover rates and significant differences in hiring practices between the government and private sector, expeditious hiring is tenuous at best. The average processing time from application to hiring is 93 days. .

Much has been done to alleviate current and future shortages. Recruitment bonuses and specialty course guarantees continue to attract nurses to the military. The Army Nurse Corps has partnered with the Air Force utilizing Air Force nurses to temporarily fill civilian vacancies until hiring actions are completed. Army civilian and military leaders are exploring ways to streamline

civilian recruitment and hiring processes. Further action and support are needed if we are to develop a responsive hiring system.

Several key initiatives must be realized to ensure that a robust force of civilian and military nurses is available to care for our ever-increasing number of beneficiaries seeking care at our Army Medical Treatment Facilities. Achieving recruiting goals at the entry level and retention past initial and subsequent tours is of great concern. The success of recruitment bonuses proved its worth and now must be expanded to retention bonuses for officers completing their first tour. Furthermore, economic incentives are necessary to encourage military nurses to enter specialty areas and remain in practice longer than the current one-year post-training obligation. The current specialty and certification pay for our nurse practitioners, certified nurse anesthetists, and certified nurse midwives, demonstrates the success of such initiatives.

Even greater efforts must be dedicated to achieving dramatic improvements in our civilian recruitment and retention initiatives. Government hiring practices are archaic, cumbersome, and threaten human resource availability. Wages are set by law and not easily adapted to market forces. We must have the flexibility to develop and implement accession programs that meet the current critical need for the swift hiring of highly qualified candidates. Funding civilian training and incentive programs that enhance professional development, leadership, and work force productivity, such as the revision of the Army Civilian Training Education Document System and civilian tuition assistance programs, are a must. We ask this committee to support necessary changes to simplify or eliminate outmoded hiring rules and produce a modern, streamlined personnel system, one that is more responsive to our needs.

Making such changes now will enable the military treatment facilities to execute innovative business plans designed to provide for the preventive, acute, and chronic health care needs of its beneficiaries. With the passage of the 2001 National Defense Authorization Act expanding health care for a greater number of beneficiaries, the numbers of beneficiaries enrolled in our military health care facilities is expected to rise, as is the severity of illness of our patients. The

increased demand for health services, aging of the population, and the need to maintain the appropriate "mix" of patients necessary to maintain our clinical proficiency and readiness, mandate that we have sufficient nurses to provide health care services. We must act expeditiously in order to allow us to continue to adequately support this critical patient care mission.

Deployments: In an environment of persistent personnel shortages, Army Nurses continue to provide services around the world whenever and wherever they are needed. In FY 2000, 444 Army Nurse Corps Officers deployed to over 10 countries consuming 12,116 man-days not available to deliver the TRICARE benefit. For FY 2001 we are on a glidepath to exceed that amount by 23%, with 227 Army Nurses who have already deployed, consuming 6955 man-days.

Army nurses continue their expert performance in support of the worldwide missions. During the 6-month deployment of the 212th Mobile Army Surgical Hospital (MASH) to Bosnia, Army nursing personnel were responsible for daily health support to over 10,000 Kosovo Force 4 (KFOR) soldiers and emergent care for over 250,000 local nationals. These personnel provided direct care to over 339 trauma and major medical patients, including victims of motor vehicle accidents, gunshot wounds, and grenade and mine blast injuries. In the course of providing host nation medical support, the 212th MASH's medical and nursing staff provided weekly visits to the rural town of Gnjilane to instruct the local hospital staff in basic and emergency medical care. Their efforts significantly increased the host nations' ability to provide competent regional healthcare. Shortly after their arrival at Eagle Base in Bosnia, the 249th General Hospital's (Forward) nursing personnel actively collaborated in establishing a telemedicine link with four isolated base camp aid stations establishing weekly telemedicine conferences. Such conferences significantly reduced numbers of evacuated patients through prompt diagnoses and treatment and increased unit level education for division medics. Task Force Med Eagle received recognition as a Training Site for the National Registry for Emergency Medical Technicians. This site now facilitates the 91W transition training for all follow-on units. This

action has far reaching implications, ensuring that up-to-date combat medic training and enlisted professional career development continues, even when our soldiers are deployed. The 67th Combat Support Hospital was instrumental in rebuilding a local hospital and educating the local national staff, ensuring its ability to treat trauma patients. Additionally, in just 3 months, this unit volunteered countless hours to repair a badly damaged local school void of heat, electricity, water, and functional classrooms, and stock it with donated school supplies from Germany and the United States. While participating in Joint Task Force Bravo in Honduras, US military nursing personnel and Honduran military personnel conducted a comprehensive Health Project at the Honduran Department of Defense in Tegucigalpa. This activity enhanced international medical cooperation between Honduran and American armed forces through education, information sharing, and interdisciplinary collaboration.

Not only are our active duty Army Nurse Corps Officers fully engaged, but our reserve family is in full support of our deployed forces as well. In August of 2000, the 914th Combat Support Hospital from Backlick, Ohio, traveled to the southwestern valleys of Columbia, South America, for a 15-day Medical Readiness Training Exercise. During the 10 days the clinics were in operation, the staff treated over 6,400 patients. Currently the 313th Combat Support Hospital (Hospital Unit Surgical), from Springfield, Missouri, is staffing Task Force Med Falcon in Kosovo, continuing to provide quality healthcare to the approximately 10,000 NATO soldiers in the sector.

These few examples serve to highlight once again that Army Nurses possess the expert clinical skills, critical thinking abilities and dedication necessary to execute the most challenging mission in the most austere of environments, never compromising patient care.

Nursing Research: Thanks to your continued support, the TriService Nursing Research Program (TSNRP) continues to increase our understanding of the most critical issues facing the delivery of military nursing care today. One example is the staffing shortages mentioned earlier in the testimony and their current impact on our ability to deliver timely and quality nursing care. With the

aid of Triservice Nursing Research funding, Army nurse researchers are working with experts from the California Nursing Outcomes Coalition and the University of California, San Francisco, to establish an Army-wide nursing database that uses standard definitions and data extraction techniques to measure patient outcomes. The Army nursing Outcomes Database will be used in three key ways. First, participating MTFs will use the data for internal quality improvement efforts. Second, the data will provide a foundation for research and other systematic studies assessing the impact of skill mix, educational level, and other factors on indicators of health, quality and safety. Third, data will be used to make evidence-based Army health care policy decisions that affect patient safety, educational planning, health systems design, and nurse staffing.

This year I provided direction to Army nurse researchers to re-prioritize nursing research programs within the Army Medical Department. These programs will focus on the most compelling problems over which we have an ability to influence outcomes. Among these are: 1) identification of specialized clinical skill competency training and sustainment requirements; 2) deployment health challenges (nursing care requirements during current mobilization and operations other-than-war situations); 3) issues related to the nursing care of our beneficiaries in garrison; 4) identification of acute care nurse staffing requirements and their relationship to patient outcomes; 5) issues related to civilian and military nurse retention in this era of critical shortages;) and finally,6) program evaluation of our core education programs for nursing personnel. I am confident that Army Nurse researchers will continue to add to the scientific body of knowledge underlying military nursing practice.

Your support of the Triservice Nursing Research Program is fundamental to the success of military nursing research. I would like to share some brief examples of our successes. In a series of Triservice Nursing Research funded studies, two self-diagnosis kits were developed that can accurately determine the presence of vaginal or urinary tract infections in deployed female soldiers. These kits will allow self-diagnosis and treatment. Implications for military women deployed in austere environments include less time away from duty, increased

manpower availability for mission-related operations, and greater health and comfort levels.

Research not only answers questions; it frequently uncovers gaps in what we know. In a study evaluating intravenous catheter insertion by nursing personnel wearing chemical-biological protective gear, nurse researchers discovered that some personnel encountered difficulties with task completion due to claustrophobia associated with the confinement of the protective clothing. Based on this finding, further study will address this issue in an attempt to find the means to improve nurses' performance in the chem-bio environment.

The TriService Research Advisory Group, fully supported by all Federal Nursing Chiefs, has developed a strategic plan that prioritizes the most critical and relevant topics for future military nursing research. These topics include: (1) deployment health – studies that analyze factors that affect operational readiness before, during, and after deployment; (2) development and sustainment of skills – studies that address the acquisition and maintenance of key nursing competencies; (3) clinical practice outcomes management – studies that determine the most effective health care interventions across the full spectrum of care from health promotion to disease management in military populations; (4) recruitment and retention – studies that identify strategies to improve force management of military and civilian nurses within the Department of Defense (DOD); and (5) clinical resource management – studies that determine staffing models that optimize the utilization of DOD nursing personnel.

Military nurses are ever vigilant of the health care needs of those we serve. We possess a unique understanding and knowledge to provide the care required by our beneficiaries. Continued congressional support for the Triservice Nursing Research Program is essential for military nurse researchers to conduct studies to improve practice and develop policy within the DoD.

Army Nurses are a key spoke in the wheel of Army Medicine. Collaboration with our sister Corps within the Army Medical Department will insure that we capitalize on every opportunity to support The Army Surgeon General's vision of providing the highest quality of patient care predicated on

evidenced-based practice and business plans that utilize our fiscal and human resources in the most efficient and effective way possible.

Finally, I would like to express my unqualified support of the Uniformed Services University of the Health Sciences (USUHS). The Graduate School of Nursing has been instrumental in providing trained Certified Registered Nurse Anesthetists and Family Nurse Practitioners. Most importantly, USUHS has become the sole educator of our Family Nurse Practitioners, saving the Army Medical Department in excess of $300,000.00 annually in Health Education Funds. Graduates of the USUHS programs have excelled masterfully and have enjoyed a 100% pass rate on their certification exams. Our continued affiliation with USUHS is a must if we are to maintain sufficient numbers of practitioners necessary to support our primary care mission.

In a closing note, on February 2, 2001, the Army Nurse Corps celebrated 100 years of nursing service to our country. Army Nurses reflected on our illustrious past and applauded our accomplishments of service to our soldiers. Now we are poised and ready to address the challenges of the future, with the same drive, professionalism and dedication as our predecessors. We will be successful. Army Nurses remain Ready, Caring, and Proud. Thank you for this opportunity to address Army Nursing. We are grateful for your assistance in keeping the force strong for the future.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Oversight of Government Management, Restructuring and the District of Columbia, Committee on Governmental Affairs, U.S. Senate

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NURSING WORKFORCE

Multiple Factors Create Nurse Recruitment and Retention Problems

Statement of Janet Heinrich
Director, Health Care—Public Health Issues

GAO-01-912T

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss issues related to the current difficulties in the recruitment and retention of nurses and concerns about their future supply. The health and long-term care systems in the United States rely heavily on the services of nurses, the largest group of health care workers. Nursing shortages have been reported around the country, and providers and provider associations have been studying the issue. In addition, both state legislators and members of the Congress have proposed legislation to address the problem.

To assist the Congress as it considers the impact of nurse recruitment and retention issues on federally funded health programs, including Medicare and Medicaid, my remarks will focus on (1) what is known about the current supply of nurses, (2) factors contributing to current recruitment and retention difficulties, (3) and factors that will affect the supply of and demand for nurses in the future.

While comprehensive data are lacking on the nature and extent of current difficulties recruiting and retaining nurses, current evidence suggests an emerging shortage. Several factors, including nurses' decreased levels of job satisfaction, are combining to constrain the current supply of nurses. Furthermore, like the general population, the nurse workforce is aging, and the average age of a registered nurse (RN) increased from 37 years in 1983 to 42 in 1998. Additionally, enrollments in registered nursing programs have declined over the past 5 years, shrinking the pool of new workers to replace those who are leaving or retiring. The problem is expected to become more serious in the future as the aging of the population substantially increases the demand for nurses.

BACKGROUND

Registered nurses are responsible for a large portion of the health care provided in this country. RNs make up the largest group of health care providers, and are 77 percent of

the nurse workforce.[1] Historically, RNs have worked predominantly in hospitals; in 2000, 59.1 percent of RNs worked in hospitals. A smaller number of RNs work in other settings, such as ambulatory care, home health care, and nursing homes. Their responsibilities may include providing direct patient care in a hospital or home health care setting, managing and directing complex nursing care in an intensive care unit, or supervising the provision of long-term care in a nursing home. In 1999 licensed practical nurses (LPN) composed 23 percent of the nurse workforce. LPNs provide patient care under the direction of physicians and registered nurses, with 32 percent working in hospitals, 28 percent working in nursing homes, and the rest working for doctors' offices, home health agencies, residential care facilities, schools, temporary help agencies, and government agencies.

Individuals usually select one of three ways to become an RN—through a 2-year associate degree, 3-year diploma, or 4-year baccalaureate degree program. As of 2000, 40.3 percent of nurses had received their training through an associate program, while 29.6 percent and 29.3 percent had received their training in a diploma or baccalaureate degree program, respectively. LPN programs are 12 to 18 months in length and generally focus on basic nursing skills such as monitoring patient or resident condition and administering treatments and medications. Once they have completed their education, RNs and LPNs must meet the licensing requirements of their state to be allowed to practice.

The U.S. health care system has changed significantly over the past two decades, affecting the environment in which nurses provide patient care. Advances in technology and greater emphasis on cost effectiveness have led to changes in the structure, organization, and delivery of health care services. While hospitals traditionally were the primary providers of acute care, advances in technology, along with cost controls, shifted some care from traditional inpatient settings to ambulatory, community-based, nursing facility, or home health care settings. The transfer of less acute patients to nursing homes and community-based care settings created additional job opportunities

[1]Bureau of Labor Statistics Data, 1999 Occupational Employment Statistics data.

and increased demand for nurses in these settings. This change in service settings has also resulted in decreased lengths of patient stay in hospitals and a decline in the numbers of beds staffed. At the same time, the acuity of patients increased as those patients remaining in hospitals were those too medically complex to be cared for in another setting. In an additional effort to contain costs in the early 1990s, acute care facilities restructured and redesigned staffing patterns, introducing more non-RN caregivers and reducing the number of RNs on staff.

Recent studies have identified a relationship between the level of nurse staffing and the quality of patient care. A recent Health Resources and Services Administration (HRSA) study found a relationship between higher RN staffing levels and the reduction of certain negative hospital inpatient outcomes, such as urinary tract infection and pneumonia.[2] Furthermore, a Health Care Financing Administration (HCFA) report to the Congress last year found a direct relationship between nurse staffing levels in nursing homes and the quality of resident care.[3]

EVIDENCE SUGGESTS EMERGING SHORTAGES OF NURSES

Current evidence suggests emerging shortages of nurses available or willing to fill some vacant positions in hospital, nursing home, and home health settings. National data are not adequate to describe the full nature and extent of nurse workforce shortages, nor are data sufficiently sensitive or current to allow a comparison of the degree of nurse workforce shortages across states, specialties, or provider types.

The nationwide unemployment rate for RNs, which has been low for many years, has recently declined further from 1.5 percent in 1997 to 1.0 percent in 2000, the lowest level in more than a decade.[4] Rising vacancy rates reported by providers provide another

[2]Harvard School of Public Health, Vanderbilt University School of Nursing, and Abt Associates, *Nurse Staffing and Patient Outcomes in Hospitals*, contract No. 230-99-0021, HRSA (Washington, D.C.: HHS, 2001).
[3]HCFA is now known as the Centers for Medicare and Medicaid Services (CMS).
[4]*A Shortage of Registered Nurses: Is It On the Horizon or Already Here?*, 2001.

indicator of possible excess demand.[5] A survey recently conducted by the Association of Maryland Hospitals and Health Systems reported a statewide average RN vacancy rate for hospitals of 14.7 percent in 2000, up from 3.3 percent in 1997. The Association reported that the last time vacancy rates were at this level was during the late 1980s, during the last reported nurse shortage. As of a June 2001 American Hospital Association survey, 17 state hospital associations reported statewide RN vacancy rate data for 2000 or 2001, and 11 of these states reported vacancy rates of 10 percent or higher. For 2000, California reported an average RN vacancy rate of 20 percent, while in 2001 Florida and Delaware reported nearly 16 percent, and Alabama and Nevada reported an average rate of 13 percent. Other surveys indicate that the difficulty recruiting RNs appears to be affecting a variety of provider types. California reported an RN vacancy rate of 8.5 percent for all employers in 1997, with hospitals reporting a rate of 9.6 percent, nursing homes 6.9 percent, and home health care 6.4 percent. A recent survey of providers in Vermont found that nursing homes and home health care agencies had RN vacancy rates of 15.9 percent and 9.8 percent, respectively, while hospitals had an RN vacancy rate of 4.8 percent (up from 1.2 percent in 1996).

JOB DISSATISFACTION, DEMOGRAPHIC CHANGES, AND DECLINING INTEREST IN THE NURSING PROFESSION CONTRIBUTE TO RECRUITMENT AND RETENTION PROBLEMS

Job dissatisfaction is reported to be high among nurses. Nurses report unhappiness with a variety of issues, including staffing, respect and recognition, and wages, and this dissatisfaction is affecting their decision to work in nursing. Furthermore, the nurse workforce is aging and fewer new nurses are entering the profession to replace those who are retiring or leaving.

[5]Caution must be used when comparing vacancy rates from different studies. While nurse vacancy rates are typically the number of budgeted full-time RN positions that are unfilled divided by the total number of total budgeted full-time RN positions, not all studies identify the method used to calculate rates.

Nurses Report Dissatisfaction with Current Work Environment

Job dissatisfaction may play a significant role in both current and future recruitment and retention problems. A recent Federation of Nurses and Health Professionals (FNHP) survey found that half of the currently employed RNs who were surveyed had considered leaving the patient-care field for reasons other than retirement over the past 2 years.[6] Over one-fourth (28 percent) of RNs in a 1999 study by The Nursing Executive Center described themselves as somewhat or very dissatisfied with their job, and about half (51 percent) were much less satisfied with their job than they were 2 years ago. In that same survey, 32 percent of general medical/surgical RNs, who constitute the bulk of hospital RNs, indicated that they were dissatisfied with their current job. According to a survey conducted by the American Nurses Association (ANA), 54.8 percent of RNs and LPNs responding would not recommend the nursing profession as a career for their children or friends, while 23 percent would actively discourage someone close to them from entering the profession.[8] Almost half (49 percent) of current RNs surveyed in another study said that if they were younger and just starting out, they would pursue a different career, rather than becoming a registered nurse.[9]

Inadequate staffing, heavy workloads, and the use of overtime to address staffing shortages are frequently cited as key areas of job dissatisfaction among nurses. Seventy-nine percent of nurses responding to the FHNP survey said they had seen a rise in acuity of patients.[10] When adjusted to reflect the rise in acuity levels, the number of hospital employees on staff for each patient discharged, including nurses, declined by more than 13 percent between 1990 and 1999. This increases the work intensity for individual

[6]Federation of Nurses and Health Professionals, *The Nurse Shortage: Perspectives from Current Direct Care Nurses and Former Direct Care Nurses* (opinion research study conducted by Peter D. Hart Research Associates)(Washington, D.C.: 2001).
[7]*The Nurse Perspective: Drivers of Nurse Job Satisfaction and Turnover*, 2000.
[8]American Nurses Association, *Analysis of American Nurses Association Staffing Survey* (Internet survey compiled by Cornerstone Communications Group for the American Nurses Association)(Warwick, RI, 2001).
[9]*The Nurse Shortage: Perspectives From Current Direct Care Nurses and Former Direct Care Nurses*, April 2001.
[10]*The Nurse Shortage: Perspectives From Current Direct Care Nurses and Former Direct Care Nurses*, April 2001.

nurses. According to one survey, of those RNs responding who had considered leaving the patient-care field for reasons other than retirement, 56 percent indicated that they wanted a less stressful and physically demanding job and 22 percent said they were concerned about schedules and hours.[11] The same survey found that 55 percent of current RNs were either just somewhat or not satisfied by their facility's staffing levels, while 43 percent of current RNs surveyed indicated that increased staffing would do the most to improve their job. Another survey found that 36 percent of RNs in their current job more than one year were very or somewhat dissatisfied with the intensity of their work.[12] Officials of unions representing nurses told us the issues of staffing and overtime have been important for their nursing members during recent negotiations. State legislators have also indicated concern— in 2001 alone, legislation designed to limit mandatory overtime or protect nurses who refuse to work additional hours has been introduced in 10 states.

Registered nurses have also cited the lack of respect and recognition given them, along with their perceived lack of authority, as areas of dissatisfaction. In a survey conducted by The Nursing Executive Center, 48 percent of RNs surveyed who had held their current job more than one year indicated that they were very or somewhat dissatisfied with the recognition they receive, while 35 percent were dissatisfied with their level of participation in decision-making.[13] Over half (53 percent) of RNs responding to a survey from the FNHP were either just somewhat or not satisfied by the degree to which they had a voice in decisions, while 47 percent were either just somewhat or not satisfied by the support and respect they received from management.[14]

While surveys indicate that increased wages might encourage registered nurses to stay at their jobs, money is not always cited as the primary reason for job dissatisfaction. According to the FNHP survey, of those RNs responding who had considered leaving the

[11] *The Nurse Shortage: Perspectives From Current Direct Care Nurses and Former Direct Care Nurses*, April 2001.
[12] *The Nurse Perspective: Drivers of Job Satisfaction and Turnover*, 2000.
[13] *The Nurse Perspective: Drivers of Job Satisfaction and Turnover*, 2000.
[14] *The Nurse Shortage: Perspectives From Current Direct Care Nurses and Former Direct Care Nurses*, April 2001.

patient-care field for reasons other than retirement, 18 percent wanted more money, versus 56 percent who were concerned about the stress and physical demands of the job.[15] However, the same study reported that 27 percent of current RNs responding cited higher wages or better health care benefits as a way of improving their job. Another study indicated that 39 percent of RNs were dissatisfied with their total compensation, but 48 percent were dissatisfied with the level of recognition they received from their employer.[16] The American Hospital Association recently reported on a survey that found that 57 percent of responding RNs said their salaries were adequate, compared to 33.4 percent who thought their facility was adequately staffed and 29.1 percent who said that their hospital administration listened and responded to their concerns.[17]

Nurses have also expressed dissatisfaction with a decrease in the amount of support staff available to them over the past few years. Less than half the RNs responding to the recent study by the AHA agreed that their hospital provided adequate support services.[18] Nurses responding to a survey by the ANA also pointed to a decrease of needed support services. Current nurse workforce issues are part of a larger health care workforce shortage that includes a shortage of nurse aides.[19] Nurse aides support nurses and assist patients with activities of daily living such as dressing, feeding, and bathing.[20] Several state and local-level studies cite nurse aide recruitment and retention as a problem for many providers. The shortage among nurse aides may be linked to difficult work conditions as well as dissatisfaction with wages and benefits. Studies have cited low wages and few benefits as factors contributing to nurse aide turnover. Our recent analysis of national data from the Bureau of Labor Statistics indicated that, on average, nurse aides receive lower wages and fewer benefits than workers generally; this is particularly true for those working in nursing homes and home health care.[21] In 1999, the

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[15]*The Nurse Shortage: Perspectives From Current Direct Care Nurses and Former Direct Care Nurses*, April 2001.
[16]*The Nurse Perspective: Drivers of Nurse Job Satisfaction and Turnover*, 2000.
[17]American Hospital Association Trend Watch, *The Hospital Workforce Shortage: Immediate and Future*, (Washington, D.C.: AHA, 2001).
[18]*The Hospital Workforce Shortage: Immediate and Future*, 2001.
[19]*Analysis of American Nurses Association Staffing Survey*, 2001.
[20]We use the term "nurse aide" to refer to all paraprofessional nursing staff working in healthcare settings.
[21]See *Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides is a Growing Concern* (GAO-01-750T, May 17, 2001).

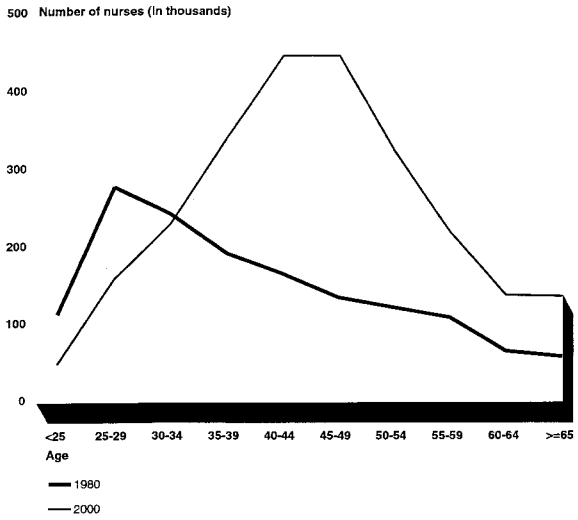
national average hourly wage for nurse aides working in nursing homes was $8.29, compared to $9.22 for service workers and $15.29 for all workers. For nurse aides working in home health care agencies, the average hourly wage was $8.67, and for nurse aides working in hospitals, $8.94. Our analysis indicated that many nurse aides have sufficiently low earnings and family incomes to qualify for public benefits such as food stamps and Medicaid.

Studies have also identified the physical demands of nurse aide work and other aspects of the workplace environment as contributing to retention problems. Nurse aide jobs are physically demanding, and have one of the highest rates of workplace injury, 13 per 100 employees in 1999, compared to the construction industry rate of 8 per 100 employees. Additional factors that affect turnover include workloads and staffing levels, respect from administrators, organizational recognition, and participation in decision-making — all very similar to areas of dissatisfaction identified by nurses.

The Nurse Workforce Is Aging

While job dissatisfaction is a primary reason cited for nurse retention problems, demographic changes are also a contributing factor. As shown in figure 1, there has been a dramatic shift upward in the age distribution of registered nurses in the past 10 years. The average age of the RN population in 2000 was 45, almost 1 year older than the average in 1996. Over half (52 percent) of all RNs were reported to be under the age of 40 in 1980; by 2000 fewer than 1 in 3 were younger than 40.

Figure 1: Age Distribution of the Registered Nurse Population, 1980 and 2000



Source: HRSA, The Registered Nurse Population: National Sample Survey of Registered Nurses, March 2000.

Fewer People Have Chosen to Enter the Nursing Profession

While the current nurse population continues to age, fewer young people are choosing nursing as a profession. Over the past 25 years, career opportunities available to women have expanded significantly, and there has been a corresponding decline of interest by women in nursing as a career. A recent study reported that women graduating from high school in the 1990s were 35 percent less likely to become RNs than women who graduated in the 1970s.[22] The decline in nursing program enrollments in recent years reflects this development. According to a 1999 Nursing Executive Center Report, enrollment in diploma programs dropped 42 percent between 1993 and 1996, and

[22]Buerhaus, Peter I. et al., "Policy Responses to an Aging Registered Nurse Workforce," *Nursing Economics* Vol. 18, No. 6 (Nov.-Dec. 2000).

enrollment in associate degree programs declined 11 percent.[23] Furthermore, between 1995 and 1998, enrollment in both baccalaureate and master's programs also dropped.

In addition to the reduced number of students entering nursing programs, there is concern about a pending shortage of nurse educators. The average age of professors in nursing programs is 52 years old, and 49 years old for associate professors. The average age of new doctoral recipients in nursing is 45, compared with 34 in all fields. From 1995 to 1999, enrollments in doctoral nursing programs were relatively stagnant. Both Arkansas and California have reported that qualified applicants have been turned away from basic RN education because of a lack of institutional resources, including faculty and facilities.

Growth in the number of new RNs has slowed in recent years. The number of new RNs passing the licensing examination declined steadily from 1996 to 2000; in 2000 it was 23 percent lower than in 1996, falling from 96,679 to 74,787. Although the total number of licensed RNs increased 5.4 percent between 1996 and 2000, to a total of 2,696,540—this was the lowest increase ever reported in HRSA's periodic survey of RNs. In contrast, the highest increase in the RN population occurred between 1992 and 1996, when the total number of RNs increased by an estimated 14.2 percent, from 2,239,816 to 2,558,874.[24]

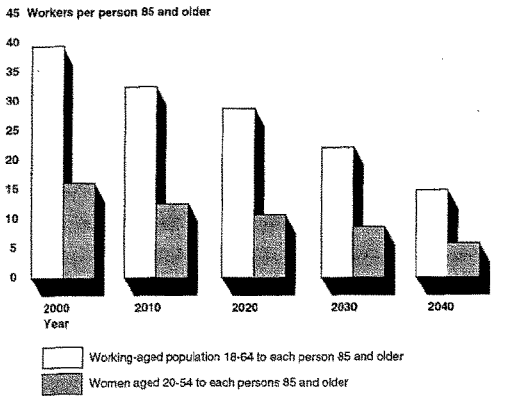
DEMAND FOR NURSES WILL CONTINUE TO GROW AS THE SUPPLY DWINDLES

A serious nurse shortage is expected in the future, as pressures are exerted on both demand and supply. The future demand for nurses is expected to increase dramatically when the baby boomers reach their 60s, 70s, and beyond. The population age 65 years and older will double from 2000 to 2030. During that same time period the number of women between 25 and 54 years of age, who have traditionally formed the core of the nursing workforce, is expected to remain relatively unchanged. This potential mismatch

[23]The Nursing Executive Center, *A Misplaced Focus: Reexamining the Recruiting/Retention Trade-Off* (Washington, D.C.: The Advisory Board Company, Feb. 11, 1999).
[24]HRSA, *The Registered Nurse Population: National Sample Survey of Registered Nurses*, Mar. 2000.

between future supply and demand for caregivers is illustrated by the change in the expected ratio of potential care providers to potential care recipients. As shown in figure 2, the ratio of the working age population, age 18 to 64, to the population over age 85 will decline from 39.5 workers for each person 85 and older in 2000, to 22.1 in 2030, and 14.8 in 2040. The ratio of women age 20 to 54 to the population age 85 and older will decline even more dramatically, from 16.1 in 2000, to 8.5 in 2030, and 5.7 in 2040.

Figure 2: Decline in Elderly Support Ratio Expected, 2000 to 2040



Source: GAO analysis of U.S. Census Bureau Projections of Total Resident Population, Middle Series, December 1999.

Unless more young people choose to go into the nursing profession, the nurse workforce will continue to age. By 2010, the average age of nurses will be 45.4, while approximately 40 percent of the workforce will be older than 50. By 2020, the total number of full-time equivalent RNs is projected to have fallen 20 percent below requirements.[35]

[35]American Organization of Nurse Executives, *Perspectives on the Nursing Shortage: A Blueprint for Action*, October 2000.

CONCLUDING OBSERVATIONS

Providers' current difficulty recruiting and retaining nurses may worsen as the demand for nurses increases with the aging of the population. Certain changes in the labor market are similar to those that occurred during past nurse shortages. However, impending demographic changes are widening the gap between the numbers of people needing care and available caregivers. Moreover, the current high levels of job dissatisfaction among nurses due to management decisions to restructure health care delivery and staffing may play a crucial role in determining the extent of future nurse shortages. Efforts undertaken to improve the areas of the workplace environment that contribute to job dissatisfaction may reduce the likelihood of nurses leaving or considering leaving the profession, and of fewer people considering entering it. More data that can describe the exact scope and nature of the current problem are needed to assist in planning and targeting corrective efforts. As providers, states, and the federal government focus on the nursing workforce, they have the opportunity to collect and analyze critical information on changes in the supply of and demand for nurses.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or Members of the Subcommittee may have.

GAO CONTACTS AND STAFF ACKNOWLEDGMENTS

For more information regarding this testimony, please contact me at (202) 512-7118 or Helene Toiv at (202) 512-7162. Eric Anderson, Connie Peebles Barrow, Emily Gamble Gardiner, and Pamela Ruffner also made key contributions to this statement.

(290091)

STATEMENT

for the

COMMITTEE ON GOVERNMENTAL AFFAIRS

Subcommittee on

OVERSIGHT of GOVERNMENT MANAGEMENT,
RESTRUCTURING, and the DISTRICT of COLUMBIA

On

ADDRESSING DIRECT CARE STAFFING SHORTAGES

Presented by

ANN O'SULLIVAN, MSN, RN

for the

AMERICAN NURSES ASSOCIATION

June 27, 2001
10:00 a.m.

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Good morning Mr. Chairman and Members of the Subcommittee, I am Ann O'Sullivan, MSN, RN, President of the Illinois Nursing Association. I am pleased to be here today representing the American Nurses Association (ANA) in support of your efforts to improve the recruitment and retention of America's registered nurses (RNs). ANA is the only full-service association representing the nation's RNs through its 54 constituent member nurse associations.

As this Committee is aware, health care institutions across the nation are experiencing a crisis in nurse staffing, and we are standing on the precipice of an unprecedented nursing shortage. The current and emerging shortage of RNs poses a real threat to the nation's health care system. RNs are the largest single group of health care professionals in the United States; we underpin the entire health care delivery system. Concerns that we have all been hearing about the current nursing shortage underscore the fact that having a sufficient number of qualified nurses is critical to the nation's health.

The emerging nursing shortage is very real and very different from any experienced in the past. Hospitals, long term care facilities and other health care providers across the nation are reporting problems filling nursing positions. Employers are having difficulty finding experienced nurses, especially in emergency departments, critical care, labor and delivery, and long term care who are willing to work in their facilities. Press reports about emergency department diversions and the cancellation of elective surgeries due to short staffing are becoming commonplace. In addition, projections show that these current shortages are just a minor indication of the systemic shortages that will soon confront our health care delivery system.

It is important to realize that the causes, and therefore the answers, for the emerging nursing shortage are complex and interrelated. It is critical to examine issues in education, health delivery systems and the work environment. ANA maintains that the reasons for the current nurse vacancy rates to the impending shortage are multifaceted. Therefore, we must approach this shortage from many fronts.

Recent Changes in Nurse Employment

Current staffing problems are inexorably tied to changes in nurse employment practices over the last decade. Just ten years ago we were emerging from the nursing shortage of the late 1980's. Nursing workforce issues had caught the attention of the highest reaches of the Reagan and Bush Administrations and the HHS Secretary's Commission on Nursing had recently released recommendations on methods to improve the work environment for nurses. Very few of these workplace initiatives were actually implemented, but health care facilities across the nation did institute aggressive recruitment campaigns and wages were increased. In fact, the Health Resources and Services Administration's (HRSA's) National Sample Survey of Registered Nurses shows that the average real annual salary of all RNs employed full-time rose 33 percent between 1980 and 1992 (in constant 1984 dollars). At the same time, RN employment in hospitals grew by a steady rate of 2-3 percent annually through the 1980's and early 90's. By the early 1990's reports of nurses shortages had significantly diminished.

However, in the mid-1990's the picture changed. At this time, managed care began to exert downward pressure on provider margins. In addition, the impact of the change in Medicare reimbursement to prospective payment was taking hold. Providers eagerly sought out and implemented programs designed to reduce expenditures. New models of health care delivery were implemented, and highly-trained, experienced - and therefore higher paid - personnel were eliminated or redeployed. As RNs typically represent the largest single expenditure for hospitals (averaging 20 percent of the budget) we

were some of the first to feel the pinch. Lesser-skilled, lower-salaried assistive staff were hired as replacements, and RN salaries decreased in both actual and real terms.

Analysis of census data shows that between 1994 and 1997 RN wages across all employment settings dropped by an average of 1.5 percent per year (in constant 1997 dollars). Between 1993 and 1997, the average wage of an RN employed in a hospital dropped by roughly a dollar an hour (in real terms). RN employment in the hospital sector reversed to the negative, dropping most precipitously in areas of the country that experienced high managed care saturation. Many providers eliminated positions for nursing middle managers and executive level staff. Hospital employment for unlicenced aides, however, increased by an average of 4.5 percent a year between 1994 and 1997.

The overall impact of the changes in the 1990s was to increase pressure on staff nurses who were required to oversee unlicenced aides while caring for a larger number of sicker patients. The elimination of management positions shortened the career ladder and decreased the support, advocacy and resources necessary to ensure that nurses could provide optimum care. At the same time employment security was uncertain and wages were being cut.

The Current Employment Situation

Not surprisingly, the changes in the RN employment environment in the last decade have precipitated a downturn in the number of people working in the nursing profession, and growing discontent among those who remain. As the image of professional nursing has changed from a field that offered many opportunities and high job security to one that holds great uncertainty, low starting wages and difficult working conditions, students have shied away from nursing programs. The number of students entering nursing school has dropped consistently and dramatically through the mid-to-late 1990's (the General Accounting Office reports a 20 percent decline in baccalaureate enrollments, a 11 percent decline in associate degree programs, and a 42 percent decline in diploma programs).

A recent ANA survey of nurses revealed that nearly 55 percent of the nurses surveyed would not recommend the nursing profession as a career for their children or friends. In fact, 23 percent of the respondents indicated that they would actively discourage someone close to them from entering the nursing profession. I know as a nurse educator, nurses often ask my students, "Why on earth do you want to become a nurse and get into this mess? It's not worth it. You can't give patients the care they need--there's just not enough staff to do it right."

A large multi-national survey recently conducted by the University of Pennsylvania's Center for Health Outcomes and Policy Research shows that America's nurses are particularly dissatisfied with their jobs. More than 40 percent of nurses in American hospitals reported being dissatisfied with their jobs, as compared to 15 percent of all workers. In addition, this report shows that 43 percent of American nurses score higher than expected on measures of job burnout. ANA statistics show that nurses typically burn out and leave hospital bedside nursing after just four years of employment.

Years of discontent have led us to a situation in which an alarming number of our experienced RNs have chosen to leave the profession. The 2000 National Sample Survey of Registered Nurses shows that a large number of nurses (500,000 nurses - more than 18 percent of the nurse workforce) who have active licenses are not working in nursing. In Illinois alone, the numbers of licensed RNs who are no longer working in nursing increased by 8% in the years between 1996 and 2000. Clearly, something in the practice setting is driving these nurses away from their chosen profession.

The Environment of Care

In an effort to ascertain the cause of nurse discontent, ANA recently conducted an on-line survey of nurses across the nation. Nearly 7,300 nurses took the opportunity to express their opinions about their working conditions. These nurses report that over the last two years they have experienced increased patient loads, increased floating between departments, decreased support services and increasing demands for mandatory overtime. These studies reveal that the recent changes in RN employment have negatively impacted patient care, the work environment for nurses, the perception of nursing as a career, and the staffing flexibility needed to address temporary staffing shortages.

The American Hospital Association reports that there are 126,000 openings for RNs in hospitals across the nation. We have all been hearing about the difficulties that they are having finding nurses to take these positions. I often hear from staff nurses in Illinois who tell me that the reason for these vacancies is dissatisfaction with the work environment. The numbers of nurses with active licenses who are no longer working in nursing bolsters my belief that there is not a current shortfall in the number of nurses, *per se*. Rather, there is a shortage of positions that these RNs find attractive. Nurses are, understandably, reluctant to accept positions in which they will face inappropriate staffing, be confronted by mandatory overtime, inappropriately rushed through patient care activities, and face retaliation if they report unsafe practices.

Solutions

ANA is supporting an integrated state and federal legislative campaign to address the many components of the current and impending nursing shortage. Following are key federal initiatives we hope this Committee will consider.

Adequate Staffing

The safety and quality of care provided in the nation's health care facilities is directly related to the number and mix of direct care nursing staff. More than a decade of research shows that nurse staffing levels and skill mix make a difference in the outcomes of patients. Studies show that when there are more nurses, there are lower mortality rates, shorter lengths of stay, better care plans, lower costs, and fewer complications. In fact, four HHS agencies - the Health Resources and Services Administration, Health Care Financing Administration, Agency for Healthcare Research and Quality, and the National Institute of Nursing Research of the National Institutes of Health - recently sponsored a study on this very topic. The resulting report, released on April 20, 2001, found strong and consistent evidence that increased RN staffing is directly related to decreases in the incidence of urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, and decreased hospital length of stay.

In addition to the important relationship between nurse staffing and patient care, several studies have shown that one of the primary factors for the increasing nurse turnover rate is dissatisfaction with workload/staffing. ANA's recent survey states that 75 percent of nurses surveyed feel that the quality of nursing care at the facility in which they work has declined over the past two years. Out of nearly 7,300 respondents, over 5,000 nurses cited inadequate staffing as a major contributing factor to the decline in quality of care. More than half of the respondents believed that the time they have available for patient care has decreased.

The University of Pennsylvania research shows that 70-80% of more than 43,000 registered nurses surveyed in five countries reported that there are not enough RNs in hospitals to provide high quality care. Only 33 percent of the American nurses surveyed believed that hospital staffing is sufficient to "get work done." This survey reflects similar findings from a national survey taken by the Henry J. Kaiser Family Foundation (1999) that found that 69 percent of nurses reported that inadequate nurse staffing levels were a great concern. The public at large should be alarmed that more than 40 percent of the nurses who responded to the ANA survey stated that they would not feel comfortable having a family member cared for in the facility in which they work.

Adequate staffing levels allow nurses the time that they need to make patient assessments, complete nursing tasks, respond to health care emergencies, and provide the level of care that these patients deserve. It also increases nurse satisfaction and reduces turnover. For these reasons, ANA supports efforts to require acute care facilities to implement and use a valid and reliable staffing plan based on patient acuity as a condition of participation in the Medicare and Medicaid programs. In addition, we support your efforts to enact upwardly adjustable, minimum nurse to patient staff ratios in skilled nursing facilities. In addition, we support the active implementation of the expert-panel based methodology for nurse staffing and resource management in our Veteran's Affairs Medical Centers.

Mandatory Overtime

Nurses across the nation are also expressing concerns about the dramatic increase in the use of mandatory overtime as a staffing tool. We hear that overtime is the most common method facilities are using to cover staffing insufficiencies. Employers may insist that a nurse work an extra shift (or more) or face dismissal for insubordination, as well as being reported to the state board of nursing for patient abandonment. Our concerns about the use of mandatory overtime are directly related to patient safety.

We know that sleep loss influences several aspects of performance, leading to slowed reaction time, failure to respond when appropriate, false responses, slowed thinking, and diminished memory. In fact, 1997 research by Dawson and Reid at the University of Australia showed that work performance is more likely to be impaired by moderate fatigue than by alcohol consumption. Their research shows that significant safety risks are posed by workers staying awake for long periods. It only stands to reason that an exhausted nurse is more likely to commit a medical error than a nurse who is not being required to work a 16 to 20 hour shift.

Nurses are placed in a unique situation when confronted by demands for overtime. Ethical nursing practice prohibits nurses from engaging in behavior that they know could harm patients. At the same time, RNs face the loss of their license - their careers and livelihoods - when charged with patient abandonment. Absent legislation, nurses will continue to confront this dilemma. For this reason, ANA supports legislative initiatives to ban the use of mandatory overtime through Medicare and Medicaid conditions of participation.

I applaud you, Chairman Durbin, for your efforts to develop legislation to ban the use of mandatory overtime through the Medicare Program. ANA endorses this effort because problems arising from mandatory overtime harm patients, nurses and the nursing profession. We also encourage you to work with the Bush Administration to assure that similar overtime protections are enacted for nurses who work in government facilities that are not covered by Medicare law (e.g., VA Medical Centers, the Department of Defense, the Indian Health Service, and prisons).

Whistleblower Protections

In addition, nurses must be able to speak out about quality-of-care problems without fear of retaliation or loss of their jobs. Patient advocacy is the heart of nurse's professional commitment. In turn, patients depend on nurses to ensure that they receive proper care. Patients must be assured that nurses and other health care professionals, acting within the scope of their expertise, will be able to speak for them without fear of retaliation.

Whistleblowing by nurses usually results from concern about issues that jeopardize the health or safety of patients, or occupational safety and health violations that place the employee at risk. Although they are responsible for patient care and well-being, nurses often are powerless when another health care provider performs unethical or life-threatening practices. There have been a number of legal cases involving nurses who have "blown the whistle" on their employers.

Current whistleblowing laws remain a patchwork of incomplete coverage. For example, the False Claims Act contains a whistleblower provision that applies only in cases of fraud of Federal funds. The Emergency Treatment and Labor Act (EMTALA) includes protection for patient advocacy, but only for personnel working in the emergency department of a hospital. The Whistleblower Protection Act of 1989 only applies to federal employees (e.g., VA nurses). This confusing, incomplete coverage leaves many nurses in fear of reprisal. This lack of protection prevents many nurses from taking the risk of trying to protect public health and safety. Reprisal has included dismissal, harassment, and blacklisting. This patient advocacy issue is addressed by a provision in the Bipartisan Patient Protection Act (S. 283, H.R. 526), which ANA strongly supports.

The Emerging Nurse Shortage

Today's staffing shortage is compounded by the lack of young people entering the nursing profession, the rapid aging of the RN workforce, and the impending health care needs of the baby boom generation. As new opportunities have opened up for young women and new stresses have been added to the profession of nursing, fewer people have opted to choose nursing as a career. New admissions into nursing schools have dropped dramatically and consistently for the past six years.

The lack of young people entering nursing has resulted in a steady increase in the average age of the working nurse. Today, the average working RN is over 43 years old. The national average is projected to continue to increase before peaking at age 45.5 in 2010. At that time, large numbers of nurses are expected to retire and the total number of nurses in America will begin a steady decline. At the same time, the need for complex nursing services will only increase. America's demand for nursing care is expected to balloon over the next 20 years due to the aging of the population, advances in technology and various economic and policy factors. In fact, the Bureau of Labor Statistics ranks the occupation of nursing as having the seventh highest projected job growth in the United States.

The increasing demand for nursing services, coupled with the imminent retirement of today's aging nurse, will soon create a systemic nursing shortage. A recent study published in the *Journal of the American Medical Association* estimates that the overall number of nurses per capita will begin to decline in 2007, and that by 2020 the number of nurses will fall nearly 20 percent below requirements.

Now is the time to address this impending public health crisis. ANA strongly supports both the Nurse Reinvestment Act (S. 706, H.R. 1436) and the Nursing Employment and Education Development Act

(S. 721) as both take important steps in alleviating the growing shortage of nurses. Chairman Durbin, I understand that you are working on legislation that contains many similar education initiatives. The ANA and I support you in these efforts because these programs will help boost nursing school enrollments and will encourage existing nurses to go back to school to increase their levels of education. The combination of scholarships, loan repayments and innovative recruitment techniques contained in these bills are much needed. ANA wholeheartedly agrees with you that the solution to the nursing shortage lies in the further development of our nation's existing nurse population and the cultivation of our youth into this very worthwhile profession.

Immigration

The ANA and I have deep concerns about the use of immigration as a means to address the emerging nursing shortage. As you are well aware, Chairman Durbin, immigration is the standard "answer" proposed by employers who have difficulty attracting American nurses to work in their facilities. We have been down this road many times before without success. There are a number of problems with increasing the immigration of foreign-trained nurses, following are just a few issues:

- The influx of foreign-trained nurses only serves to further delay debate and action on the serious workplace issues that continue to drive American nurses away from the profession. As I mentioned earlier, a Presidential task force called to investigate the last major nursing shortage developed a list of recommendations. These 16 recommendations, released in December, 1988, are still very relevant today - they include issues such as the need to adopt innovative nurse staffing patterns, the need to collect better data about the economic contribution that nurses make to employing organizations, the need for nurse participation in the governance and administration of health care facilities, and the need for increased scholarships and loan repayment programs for nursing students. Perhaps if these recommendations were implemented we would not be here today. Certainly, we will be here in the future if they are ignored.

- There are serious ethical questions about recruiting nurses from other countries when there is a world-wide shortage of nurses. The removal of foreign-trained nurses from areas such as South Africa, India, and the Caribbean deprives their home countries of highly trained health care practitioners upon whose skills and talents their countries heavily rely.

- In addition, immigrant nurses are too often exploited because employers know that fears of retaliation will keep them from speaking up. There are numerous, disturbing examples from our experience with the expired H-1A nurse visa. In fact, several cases came from Illinois. The INS Chicago District issued a $1.29 million fine against FHC Enterprises, Inc. for 645 immigration document violations. FHC, Inc. fraudulently obtained 225 H-1A visas which were used to employ Filipino nurses as lower-paid nurse aides ($6.50 per hour) instead of as registered nurses ($12.50 per hour). The Catholic Archdiocese of Chicago agreed to pay $50,000 in fines and $384,700 in back wages to 99 Filipino nurses who were underpaid. In Kansas, 66 Filipino nurses were awarded $2.1 million to settle a discrimination case in which the Filipino nurses were not paid the same wage rate as U.S.-born registered nurses at the same facility. These are just a few of the cases that have come to light over the last decade.

Conclusion

ANA maintains the current nursing shortage will remain and likely worsen if changes in the workplace are not immediately addressed. The profession of nursing will be unable to compete with the myriad of other career opportunities available in today's economy unless we improve working conditions. Registered nurses, hospital administrators, other health care providers, health system planners, and consumers must come together in a meaningful way to create a system that supports quality patient care and all health care providers. We must begin by improving the environment for nursing.

ANA looks forward to working with you and our industry partners to make the current health care environment conducive to high quality nursing care. Improvements in the environment of nursing care, combined with aggressive and innovative recruitment efforts will help avert the impending nursing shortage. The resulting stable nursing workforce will support better health care for all Americans.

AHA
Advancing Health in America

Testimony of the
American Hospital Association
before the United States Senate
Subcommittee on Oversight of Government Management,
Restructuring and the District of Columbia
Government Affairs Committee

"Finding a Cure to Keep Nurses on the Job: The Federal Government's Role in Retaining Nurses for Delivery of Federally Funded Health Care Services"

June 27, 2001

Mr. Chairman, I am Gary Mecklenburg, president and CEO of Northwestern Memorial Healthcare in Chicago. I also serve as the chairman of the American Hospital Association's (AHA) Board of Trustees, and am here today on behalf of the AHA's nearly 5,000 hospital, health system, network and other health care provider members. We are pleased to testify on an issue of great concern to the health care community and the general public: the immediate and long-term shortage of nurses.

Though Northwestern Memorial Hospital's history dates back to the mid-1860s, the Northwestern of today was created in 1972 when two leading Chicago hospitals, Wesley Memorial and Passavant Hospital, consolidated their services. Today, Northwestern Memorial is the primary teaching hospital for the Northwestern University Medical School and enjoys a national reputation as a strong, well-managed organization. The hospital is staffed by more than 5,000 caregivers, which includes more than 1,100 registered nurses (RNs). In addition, we have 1,200 physicians in 30 medical and surgical specialties on staff – all are dedicated to the organization's "Patients First" mission.

In 2000, Northwestern Memorial provided care for more than 304,000 outpatients and admitted more than 35,000 patients. The hospital has a diverse patient population in its urban locale, serving patients with many ethnic and socioeconomic backgrounds. We are an organization that is growing rapidly, and the single greatest challenge to us today and in the future is the recruitment and retention of high quality staff across many disciplines to serve our growing number of patients.

BACKGROUND

Mr. Chairman, health care is at a critical juncture. Along with choking regulation and decreased reimbursement, a shortage of qualified workers greatly affects the ability of those serving in the field to care for the nation's women, men and children. If nurses, physicians, respiratory therapists, medical technologists and scores of others who take care of our nation's ill and injured are not available, our mission will be threatened.

This crisis affects every aspect of health care delivery, from direct patient care given by a nurse or respiratory therapist to prescriptions filled by a pharmacist and home health care visits from a nurse assistant. The most visible shortage, though, is a lack of nurses needed to provide critical bedside care.

The current environment differs from shortages in previous years, which were largely a function of fluctuations in the economy. Now, we face a shortage due to several factors: an increasing demand for nurses; the supply of experienced nurses is shrinking due to an aging workforce; and a dearth of younger nurses to replace those who retire. According to Peter Buerhaus et al.

(Implications of an Aging Registered Nurse Workforce, JAMA, June 2000), the number of registered nurses under the age of 30 dropped by 41 percent from 1983 to 1998. The National Sample Survey of Registered Nurses for 2000 reported that the RN population under 30 has reached a new low of 9 percent of the total RN population. After 2010. the demand for health care and nursing services is expected to increase while the supply of nurses will continue to decline. Buerhaus and colleagues state that the average age of nurses remaining in the workforce after 2010 will increase from 45 today to 50. Without an influx of young people into the profession and an increasing demand for nurses will lead to an even greater shortage in the near future.

Overall enrollment in basic RN programs declined by over 50,000, or 22 percent, since 1993. Further eroding the supply of new nurses is the explosion in career opportunities for women, who make up about 95 percent of the nursing workforce. This phenomenon alone has greatly contributed to the decline in the number of college-bound women entering the nursing field. Less than 2 percent of college freshman indicate nursing as a likely major. In addition, many nursing programs have had to cut back because of faculty shortages (the average age of nursing school professors is 52), lack of clinical training sites and insufficient classroom space.

At the same time, 78 million baby boomers are approaching retirement age and their demand for health care resources is increasing. Due to medical advances, we are diagnosing and treating cancer, heart disease and orthopedic conditions at an earlier age. Thus, our hospitals are already experiencing the impact of this generation of Americans, long before they are eligible for Medicare. Demand for health care may soon exceed our capacity to provide it.

The public's demand for the highest quality patient care at the lowest possible cost has come face-to-face with the tightest labor market in the past 30 years. A recent survey of AHA members revealed that hospitals have up to 168,00 open positions – 126,000 of those positions, or 75 percent, are for registered nurses. Vacancy rates among hospital staff are:

- 21% for pharmacists
- 18% for radiological technicians
- 12% for laboratory technicians
- 11% for registered nurses

Today's staffing shortages are affecting access to care. Some hospitals are being forced to reduce the number of inpatient beds available, postpone or cancel elective surgeries, and tell ambulances to bypass their overflowing emergency departments.

WORKFORCE CONDITIONS

While most nurses work in hospitals, we've seen a growing demand for nurses in alternative health care settings, such as clinics, managed care and home health; and we are competing with private companies such as HMOs and pharmaceutical suppliers that are hiring more nurses. Meanwhile, hospital patients are older, sicker and require a greater intensity of care from nurses and other personnel. Further, nurses, and everyone involved in health care delivery, are also spending an increasing amount of time on paperwork, which takes valuable time away from patient care. Most women and men were attracted to nursing because they wanted to care for people. The current regulatory environment buries dedicated employees in bureaucratic paperwork.

Today's nurses are frustrated with their work environment, especially when they spend as much time on paperwork as patient care. A recent study by PricewaterhouseCoopers found that every

hour of care in the emergency department requires one hour of paperwork. Every hour of care for surgery and acute inpatient care requires 36 minutes of paperwork and every hour of home health care requires 48 minutes of paperwork. Northwestern Memorial Hospital recently hosted a meeting with HHS Secretary Tommy Thompson to show him firsthand the burden of paperwork and suggest possible solutions. We look forward to the results of his commitment to eliminate some of these problems in the near future.

We all need to recognize that health care workers are a valuable national asset. New work arrangements require a broader perspective on employee relations. Compensation strategies need to be reviewed and evaluated, but competitive compensation is a serious challenge to hospitals with revenues limited by inadequate payments determined by Medicare, Medicaid and private insurers.

Developing innovative work arrangements is challenging. Health care is not like the manufacturing industry, with a predictable production schedule. We never know who or how many patients will walk through our door on any given day or night, or even at what time during the day or night. We do not know how sick they will be or what type of service will be required. We have no control over flu outbreaks, highway accidents or the scores of other health conditions that we attend to on a daily basis.

Because we also have no way of predicting when personal illness or family emergencies may render a staff member unable to work, hospitals need a great deal of flexibility in staffing arrangements to deal with changing circumstances.

Hospitals cannot turn patients away, so each hospital uses a variety of techniques to ensure adequate staffing for patient care. These may include:

- Requesting nurses or other staff to work voluntary overtime
- Contacting staff who are paid to be "on call"
- Scheduling workers through a hospital's in-house staffing pool
- Contacting a for-profit staffing agency outside the hospital.

And in some cases, mandatory overtime is used. But be clear: mandatory overtime is a hospital's tool of last resort. It is expensive and the alternative would be reducing or shutting down services, which is unacceptable to us and the community. Mandatory overtime is a symptom of the severe shortage of health care workers. With the aging of the health care workforce, increased demand for services and dropping enrollments at nursing schools, the workforce shortage in hospitals could easily reach crisis proportions.

RECRUITMENT AND RETENTION STRATEGIES

To overcome this shortage, hospitals must employ innovative recruitment and retention strategies. Along with other health care facilities around the country, we are looking at a variety of options to retain our current nursing staff and attract new nurses. Hospital administrators report using a number of incentives to minimize their current shortages. These include flexible hours; bonuses; child care assistance - either on-site or with a stipend; relocation bonuses or assistance; pay differentials for weekend and holiday hours; more attractive benefits packages; transportation assistance; housing allowances or subsidies; and a salaries that are competitive with increases in the local market. With programs like these, hospitals are striving to create a favorable workplace environment.

At Northwestern Memorial, our retention and recruitment efforts are multifaceted because there is no one solution to the problem. We focus on flexible staffing options, professional career development opportunities, compensation/benefits strategies, building relationships with nursing schools, and developing methods to simplify work and improve the quality of the work-life balance.

Recognizing that 64 percent of our staff has children under the age of 12, Northwestern Memorial provides on-site childcare for working parents. The childcare center accepts infants through toddlers with school holiday care and summer camp for children up to the age of 12. We cover almost half of the center's costs, and tuition assistance is available based on an employee's income.

Employees have the option of choosing to work compressed work schedules or flexible hours to accommodate family and personal needs. In addition, Northwestern Memorial offers tuition reimbursement to encourage career advancement. We conduct weekly employee surveys to stay abreast of staff morale.

In our system, we place less attention on hiring bonuses, and instead emphasize employee referral bonuses. This rewards current employees for recruiting others to the organization and has been very successful.

Perhaps our most critical challenge of nurse retention is reducing nurses' workload so they can dedicate maximum time to interacting with patients. Today's admission, care and discharge of

patients is rapid, most occurring during peak work hours for the staff nurse. While there is always an element of unpredictability of when patients arrive for hospital care, we are striving for the right balance of staff to support the workload.

While Northwestern Memorial and other hospitals are employing strategies such as these to retain current health care workers, we also are examining how to attract the next generation of nurses, therapists and other caregivers. Many hospitals support advanced training and education for staff aspiring to a more fulfilling health care career as a nurse or other caregiver. Some have set up partnerships with local nursing schools and community colleges. And still others are reaching out to their communities and enlisting the help of retired military personnel and other professionals who may have finished their first careers.

For the past five years, Northwestern Memorial has been active partner in the Medical Explorers Program. This dynamic program offers young men and women information about and experience in health careers through seminars, workshops, projects, tours and summer jobs. I'm proud to say that last year our program was selected as "Explorer Post of the Year." Currently, three former Medical Explorers are working at Northwestern Memorial, and many others are in college or other health profession training programs.

In addition to the Explorer program, Northwestern Memorial has other internship and youth programs to attract high-caliber students, provide financial assistance and encourage students to remain with us upon graduation.

For Northwestern Memorial and other hospitals, innovative programs aimed at encouraging individuals to enter or advance in the health care profession, and ensuring that we are the "employers of choice" by offering employees incentives, both monetary and otherwise, comes at a significant cost. These expenses, not recognized by the Medicare program, are essential to hospitals' future.

AHA WORKFORCE COMMISSION

If we do not have the women and men devoted to providing care, our ability to provide health care services for an aging population will be severely affected. That is why the AHA convened the Commission on Workforce for Hospitals and Health Systems. It is charged with identifying strategies to increase recruitment, retention and development of experienced caregivers and support staff as well as making hospitals and health systems "employers of choice." Because this issue has many stakeholders, the AHA has brought together a diverse group that includes hospital administrators, caregivers, academics, business leaders, organized labor and many others. (For a complete list of the 27 commissions, refer to Attachment A.)

Earlier this month, the Commission held its first in a series of face-to-face meetings. Discussions focused on a variety of issues, including the number of people entering the workforce and issues of human resource management, work design and environment and cultural diversity. Commissioners also addressed worker loyalty and root causes of dissatisfaction, as well as potential strategies to improve this situation. The meeting was a good start toward developing the bold solutions necessary to solve this problem.

The Commission's work will culminate in a report to be released at the AHA's April 2002 Annual Meeting – a blueprint of solutions that will also be shared outside the health care field with government leaders and a variety of professional groups including educators, labor and technology leaders.

SOLUTIONS

A shortage of qualified health care workers is a problem that cannot be solved by any one group alone. And it cannot be solved solely by the federal government, although there are actions Congress can take to help address the problem. It demands a multi-tiered, collaborative approach among all affected parties to develop short and long-term effective strategies and solutions to meet the health care needs of the future.

Earlier, I discussed the steps hospitals and the AHA are taking to tackle this problem. Several workforce proposals before Congress are critical to our efforts.

Strategies for Increasing the Supply of Nurses. To address the workforce shortage, we need a mix of initiatives to increase the health care workforce and enhance the flexibility in educational preparation and clinical practice. Congress should consider two initiatives to expand the supply of nurses:

- The Nurse Reinvestment Act (S. 706), introduced by Sens. John Kerry (D-MA), Jim Jeffords (I-VT) and Kay Bailey Hutchison (R-TX) establishes a national nursing service corps to provide scholarships to nurses who commit to serving in a health facility that has a critical shortage of nurses. S. 706 also provides direct support to individuals wishing to advance or enter the nursing profession.

- The Nurse Employment and Education Development Act (S. 721), introduced by Sens. Tim Hutchinson (R-AR) and Barbara Mikulski (D-MD), provides grants to develop recruitment and retention strategies, and scholarships and loans to encourage nurses to pursue graduate degrees for teaching.

Increase Payment Adjustments to Attract Caregivers. Over the past few years, especially in the wake of the Balanced Budget Act's (BBA) deep Medicare and Medicaid payment cuts, hospitals have been forced to reduce or even eliminate critical patient services. Enactment of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act (BBRA) and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) helped return some funds to hospitals, but most of the cuts have not been restored. Hospitals still face skyrocketing costs for labor, which accounts for more than 70 percent of hospital budgets.

Adequate government funding is essential to helping hospitals attract and retain experienced personnel. Since overall hospital margins have been reduced due to the BBA cuts and rising costs, funds to increase wages have been limited. Congress should enact several proposals that would afford hospitals the opportunity and flexibility to address rising labor costs:

- The American Hospital Preservation Act of 2001 (S. 839), introduced by Sens. Evan Bayh (D-IN) and Kay Bailey Hutchison (R-TX), provides a full inflationary payment (market basket) update for FY 2002 and 2003. The market basket, Medicare's measure of inflation, is intended to measure the annual growth in prices faced by hospitals in delivering care to Medicare beneficiaries. Rising labor costs dictate that the market basket update keeps pace

with these increases. With the Medicare program not even providing a full inflationary increase to hospitals, we cannot deal with the reality of providing fair and reasonable wage increases. S. 839 also acknowledges the higher costs teaching hospitals incur to provide adequate learning experiences and faculty support to medical students by maintaining the indirect medical education adjustment at 6.5 percent for FY 2003 and beyond.

- The Area Wage and Base Payment Improvement Act (S. 885), introduced by Sens. Tim Hutchinson (R-AR) and Max Cleland (D-GA), recognizes that the severe shortage of caregivers, especially nurses, has driven wages higher, increased competition for these workers, and created an increasingly "national" market for hospital labor. S. 885 establishes a "floor" on the Medicare wage index to help improve workforce compensation. It also creates a national standardized rate for the Medicare inpatient base payment by eliminating the difference in payments between large urban hospitals and other hospitals located in rural and smaller metropolitan areas.

CONCLUSION

Mr. Chairman, we have a critical shortage of women and men serving in health care. Before it becomes a greater crisis, we must work together toward solutions that allow us to continue our mission of providing high quality and compassionate care to all Americans.

The first steps toward a solution are to enter into a discourse so that all stakeholders can find the best way to respond to this growing problem, and for the federal government to restore remaining Medicare and Medicaid reductions, provide greater support to rural hospitals, and establish new and innovative nursing education initiatives. Together, we can develop solutions that protect the future of health care for the nation. Thank you, Mr. Chairman.

Attachment A

The AHA Commission on Workforce for Hospitals and Health Systems

Chairman
Peter W. Butler, president and CEO, Methodist Health Care System (Houston)

Other Commissioners
Rumay Alexander, RN, EdD, senior vice president of clinical/professional practices, Tennessee Hospital Association (Nashville, Tennessee)

Jacquelyn M. Belcher, JD, president, Georgia Perimeter College (Decatur, Georgia)

Maureen Bisognano, RN, executive vice president and chief operating officer, Institute for Healthcare Improvement (Boston)

Leo P. Brideau, president, Strong Health Regional Network (Rochester, New York)

Sandra Bennett Bruce, president and CEO, Saint Alphonsus Regional Medical Center (Boise, Idaho)

Stephen W. Daeschner, PhD, superintendent, Jefferson County Public Schools (Louisville, Kentucky)

Karen Davis, PhD, president, The Commonwealth Fund (New York City)

Laura Easton, RN, vice president for nursing, Caldwell Memorial Hospital (Lenoir, North Carolina)

Antonio Flores, PhD, president, Hispanic Association of Colleges and Universities (San Antonio, Texas)

Mary E. Foley, RN, president, American Nurses Association (Washington)

John C. Gavras, president, Dallas-Fort Worth Hospital Council (Irving, Texas)

Raymond Grady, president of hospitals & clinics, Evanston Northwestern Healthcare (Evanston, Illinois)

Joyce Grove Hein, chief executive officer, Phelps Memorial Health Center (Holdrege, Nebraska)

Troy Hutson, RN, JD, director of legal and clinical policy, Washington State Hospital Association (Seattle)

Anita Langford, vice president of continuing care, Johns Hopkins Bayview Medical Center (Baltimore)

Karen L. Miller, RN, PhD, dean, University of Kansas School of Allied Health and Nursing (Kansas City, Kansas)

Jack A. Newman, Jr., executive vice president, Cerner Corporation (Kansas City, Missouri)

Robert J. Parsons, PhD, chairman, Romney Institute of Public Management, Marriott School, Brigham Young University and trustee, Intermountain Health Care (Provo, Utah)

Limaris Perez, student, Pennsylvania State University (State College, Pennsylvania)

Randolph B. Reinhold, MD, chairman, Department of Surgery, Hospital of St. Raphael (New Haven, Connecticut)

Robert G. Riney, corporate vice president of human resources, Henry Ford Health System (Detroit)

Fran Roberts, RN, PhD, vice president for professional services, Arizona Hospital and Healthcare Association (Phoenix)

Bruce J. Rueben, president, Minnesota Hospital and Healthcare Partnership (St. Paul, Minnesota)

Edward S. Salsberg, director, Center for Health Workforce Studies at the School of Public Health, University of Albany at the State University of New York (Rensselaer, New York)

Andrew L. Stern, president, Service Employees International Union (Washington)

Sara J. White, director of pharmacy services, Stanford Hospital and Clinics (Stanford, CA)

Ex-Officio
Dick Davidson, president, American Hospital Association (Washington)

Gary A. Mecklenburg, chairman, American Hospital Association and president and CEO, Northwestern Memorial HealthCare (Chicago)

Sr. Mary Roch Rocklage, chair-elect, American Hospital Association and chairperson of the board, Sisters of Mercy Health System (St. Louis)

Testimony of Carol Bragg, RN, for the Service Employees International Union Before the Senate Subcommittee on Oversight of Government Management, Restructuring and the District of Columbia of the Senate Governmental Affairs Committee On Nursing Shortages in Federally-funded Programs

June 27, 2001

Thank you Senator Durbin for allowing me to testify at this hearing on behalf of the Service Employees International Union on the current nursing crisis in this country.

My name is Carol Bragg. I am registered nurse (RN), a member of SEIU's Nurse Alliance and President of SEIU Local 1998, the Professional Staff Nurses Association in Maryland. Today I am speaking on behalf of the 1.4 million members of SEIU, more than 710,000 of whom work in the health care industry, more than 110,000 of whom are nurses, and more than 120,000 of whom work in nursing homes. I also speak as someone who is engaged in addressing the nursing crisis on a statewide level. Last Fall I was appointed by the Governor to serve on the Commission on the Crisis in Nursing created by the Maryland General Assembly to investigate and find ways to address this urgent issue.

As the largest and fastest-growing union of nurses in the country, SEIU is committed to achieving access to quality health care for all who live and work in America – and quality jobs for all who dedicate their lives to caring for others. Last month, our Nurse Alliance released *The Shortage of Care*, a report that is helping to redefine thinking about the nation's nursing shortage. This report on the nursing crisis is based on the views of nurses in acute care facilities collected as part of a nationwide survey conducted by an independent polling firm.

Conventional wisdom about the shortage has held that it's a recent crisis driven by demographic shifts in a traditionally female profession. But the fact is that this is the third nurse shortage I have experienced in my career, and the roots of this crisis go much deeper than the changing roles and attitudes of women in our society.

With the rise of managed care in the 1980s, long before a nursing shortage began to emerge, hospital administrators moved to cut costs by cutting staff. Across the country, the industry reduced staffing levels to the point where nurses — increasingly unable to provide our patients with the care we were trained to give — began to leave hospitals for more rewarding and less physically and emotionally taxing jobs.

Nurses in hospitals and related facilities are caring for more patients today than we did a decade ago. And because of restrictions on hospital admissions and lengths of stay imposed by managed care, the patients in hospitals are more acutely ill and in need of greater care.

The result is that hospitals are having increasing difficulties filling vacancies for RNs. This is confirmed by a our survey, where:

- nurses reported that on average it took nearly 11 weeks (10.77) to fill a nursing vacancy in their unit, and

- 52 percent of the nurses believed that it takes longer to fill vacancies today than three years ago.

The crisis in my own state parallels these national trends. According to a recent survey by the Maryland Hospital Association, the RN vacancy rate was 14.7 percent in 2000, up from 3.3 percent in 1997. This figure was higher than at any time in the last 11 years that surveys have been conducted. Last year it took on average nearly ten weeks – 68.8 days – to fill a RN position, up from four weeks just in 1995.

In Maryland, RN turnover rates jumped to 15.7 percent in 2000, from 8.3 percent in 1996, the highest at any time in the last 11 years. This doesn't just show nurses' job dissatisfaction; it signals a real problem for patients. When staff is less experienced and stable, it is more likely that patient care will suffer.

The hospital industry cites many of these statistics to point to a nationwide "nursing shortage." But a closer look at the data suggests that the real problem is *a shortage of nurses willing to work in hospitals under current working conditions*. We view the situation as a *staffing crisis* rather than a nursing shortage; systemic understaffing brought on by the restructuring of the industry under managed care has led to dramatically deteriorating working conditions and increasing concern about the quality of patient care which is causing nurses to leave hospitals. This is confirmed in a survey of health care human resource managers conducted by the William M. Mercer consulting company[1] who found three important factors affecting turnover:

- "dissatisfaction with the job itself, working conditions, the relationship with the supervisor, or career opportunities;"
- "workload and staffing," noting that "a reduction in RN resources has increased the job demands of those remaining in the workforce."
- "better pay."

They warn that employers concerned about turnover "should examine their own practices and work environment..."

It cannot be stressed enough that when our nursing profession is in crisis, our nation's health care system is in crisis.

Inadequate staffing has given rise to increased numbers of medical errors. In 1999, the Institute of Medicine found that between 44,000 and 98,000 Americans die every year in hospitals due to medical errors; more people die of medical errors than from motor vehicle accidents, breast cancer, or AIDS. While the IOM report exposed a national crisis, it did not explore one of the primary causes of it: understaffing. However this issue was comprehensively assessed by a research team from the Harvard School of Public Health led by Professor Jack Needleman, which found that higher RN staffing was associated with a 3 to 12 percent reduction in the rates of patient outcomes sensitive to nursing[2] – in particular urinary track infections, pneumonia, length of stay, upper gastrointestinal bleeding, and shock.

A majority of nurses in our SEIU survey identified understaffing as the cause of medical errors. And the situation, they say, is not improving.

- 54 percent of nurses say that half or more of the errors they report are the direct result of inadequate staffing.
- Despite the growing attention focused on medical errors, most nurses say the rate of incidents has remained unchanged over the last year – while fully 30 percent of nurses say the errors have actually increased.

We also should keep in mind that there are many more medical errors that go unreported for fear of retaliation. Most health care workers who blow the whistle on short staffing and poor patient care have no legal protections against retaliation. Federal whistleblower laws are narrow in coverage and do not apply specifically to the health care industry. That is why we are fighting so hard for a Patients' Bill of Rights that includes whistleblower protection.

In my state of Maryland, the staffing crisis and the deteriorating conditions it has created have compromised quality care for people in our communities. According to the Maryland Hospital Association,[3] "over half the hospitals throughout Maryland report they have had to close beds, delay and cancel surgeries, disrupt scheduled procedures, and 'reroute' ambulances to other facilities for emergency patient care." The MHA says that it is increasingly common for patients arriving in an emergency department "to be held there until adequate staffing becomes available on a patient unit."

In Baltimore, Johns Hopkins Hospital has closed as many as 10 of the 44 beds in its neurology and neurosciences area, because it doesn't have the nurses to safely staff them. Heidi Zhang, a nurse at Hopkins for 13 years says that "People have come in for elective surgeries and been sent home. I've never seen anything like this."[4]

A particularly devastating side effect of the understaffing crisis is the abuse of mandatory overtime by many health care employers. Nurses are often mandated to work extra hours, which can mean back-to-back eight-hour shifts or four extra hours on top of a 12-hour shift to fill gaps in staffing. Of course this threatens patient safety. There is no way an exhausted, overworked nurse is as alert and accurate as a well-rested nurse working a regular shift. Mandatory overtime also places an incredible stress on family life, particularly when last minute changes have to be made to find child care or care for elderly parents.

Mary Hesse-McBride is a nurse and an SEIU member who used to work in the cardiac intensive care unit at the University Hospital in Madison, Wisconsin. Too many overtime hours drove her out of intensive care – where the nursing shortage is particularly acute – to the outpatient unit. She would often say "I would go to work and I would never know if I was leaving."

Mary Hesse-McBride is not alone. According to our survey, nurses in acute care hospitals work an additional 8.5 weeks of overtime on average every year. Nurses are not only being increasingly required to work excessive amounts of mandatory overtime, but also routinely are required to "float" or be reassigned to units where they lack the experience and training. Nurses are being stretched to the limit, experiencing high levels of stress, chronic fatigue, and work-related injuries. These intolerable work practices lead to further "burnout" and undermine nurses' sense of professionalism and are driving nurses from hospitals.

According to the SEIU survey:

- Only 55 percent of acute care nurses plan to stay in hospitals until they retire.
- And only 43 percent of nurses under 35 plan to stay in hospitals until retirement.
- But 68 percent of nurses say they would be more likely to stay in acute care if staffing levels in their facilities were adequate.

These statistics show a little-discussed fact about today's "shortage." In reality, the current supply of nurses far exceeds demand. According to a recent Health Resources and Services Administration (HRSA) survey on RNs, there are approximately 500,000 nurses who have licenses but are not practicing in the nursing field. The proportion of RNs employed in hospitals has decreased substantially and consistently from 68 percent in 1988 to 59 percent in 2000.

Deteriorating staffing and working conditions have led many nurses to leave the profession altogether, and fewer young people are entering it: nursing school enrollment has declined in each of the last six years. As a result, the average age of working RNs has increased 7.8 years since 1983 to 45.2. And as these trends continue, there is likely to be a severe nursing shortage in the future. By 2020, we expect that there will be a shortage of 400,000 nurses, when the majority of the baby boomers will be seeking care.

Nurses wish to remain in hospital work, and would do so if staffing and working conditions improve. If these conditions are not improved, nurses' flight from hospital care will intensify and in the near future we will face a true shortage. The fact that younger nurses are even less likely to stay in acute care than their older colleagues is a warning sign.

I have focused my remarks principally on hospitals, since that is where the nurse crisis is most severe. There is, however, a related and equally serious problem in nursing homes. While RNs make up a small proportion of the nursing home workforce, and are largely in managerial positions, most of the staff in nursing homes are certified nurse assistants (CNAs) and, to a lesser extent, licensed practical nurses (LPNs) or licensed vocational nurses (LVNs).

SEIU members include more than 120,000 nursing home employees, the vast majority of whom are CNAs and a large number of whom are LPNs/LVNs. Similar to administrators in the hospital industry, nursing home owners have argued that they are facing a shortage of nurses and nurse aides. For this reason they have asked for increased Medicare and Medicaid reimbursement and have resisted the setting of minimum staffing standards.

But just like in hospitals, the real problem isn't finding people to work in nursing homes, it is keeping them there. Turnover rates for direct care workers in nursing homes are nearly 100 percent, creating a revolving door of caregivers, which renders continuity of care impossible. Workers are leaving due to heavy workloads: They simply do not have enough time to care for the number of residents they are assigned to, which leads to stress, guilt, and burn-out. Moreover, low wages, lack of health insurance coverage, and high injury rates also make nursing home work unsustainable for many workers.

Just like nurses, more and more people who have become certified to work as nurse aides are leaving the profession. For example, the state of Iowa reported last year that there were between 50 and 60 thousand names on the CNA registry but only 23 to 24 thousand were actively working in nursing homes.

Now that we have outlined the crisis that exists in our hospitals and nursing homes, we can discuss what is being done to change these conditions and what can Congress do to stop the nursing profession from bleeding to death.

Nurses across America are sounding the alarm: staffing levels are too low to provide the quality of care their patients need. In many states nurses who are in unions have turned to the bargaining table to change their working conditions in order to ensure safer staffing and better patient care. Eliminating mandatory overtime, establishing safe staffing standards, and improving recruitment and retention by increasing pay have been the primary issues in nurse contract negotiations from coast to coast. One has only to look at the number of strikes occurring among nurses in 1999 (21) and 2000 (10), and those so far in 2001 (7) to see that nurses are increasingly determined to resolve the problems they face in hospitals today.

I am proud to report that many members of SEIU's Nurse Alliance have been able to negotiate limits – if not outright prohibitions – on mandatory overtime. At my hospital, our union has ensured that our hospital's past practice of not requiring mandatory overtime is followed. And I can tell you that it is an incentive for many nurses to stay on at our hospital. Earlier this year, SEIU nurses at Aliquippa Community Hospital became the first in their state to win an agreement in their contract eliminating mandatory overtime. Their hospital CEO, Fred Hyde, recently joined nurses in pressing for a state law in Pennsylvania to protect patients and nurses from mandatory overtime, calling it "involuntary servitude."

SEIU nurses at Kaiser Permanente, the League of Voluntary Hospitals in New York, and many other hospitals have negotiated contracts with breakthrough agreements that give bedside nurses a voice in setting staffing levels through labor-management committees. But while we have made some progress, this issue is too big and too important to the health of our profession, our hospitals, and our communities to address hospital by hospital and contract by contract.

Increasingly, SEIU along with other unions and the American Nurses Association have introduced legislation on the state level to establish safe staffing standards, ban mandatory overtime, provide whistleblower protection for nurses when they speak out on understaffing that jeopardizes good patient care, and provide for involvement of direct care nurses in the development of staffing policies.

California was the first state in 1999 to pass legislation to require fixed minimum staff-to-patient ratios in hospitals. The regulation that will spell out the specific statewide standards is expected to take effect next year. There is also safe staffing legislation being considered in New Jersey, New York, Oregon, and Pennsylvania. Legislation was introduced in Illinois with the support of the SEIU Nurse Alliance and the Campaign for Better Health Care. The model bill calls for hospitals and other facilities to: meet minimum staffing requirements set by the legislature, submit annual staffing plans that include a system for determining staffing levels based on acuity

(severity of illness or injury), maintain daily staffing records, prohibit mandatory overtime, set maximum hours for nurses, protect whistleblowers, publicly disclose mandated and actual staffing levels, and provide access to unannounced inspections.

Other states are also considering laws prohibiting or restricting mandatory overtime for nurses. Maine has just passed legislation banning mandatory overtime. Mandatory overtime legislation has been introduced in Maryland, New Jersey, New York, Rhode Island, Washington, and West Virginia, and may soon be introduced in Connecticut, Massachusetts, Pennsylvania, and Wisconsin. In West Virginia, the SEIU Nurse Alliance successfully introduced legislation that would provide whistleblower protection for nurses who report staffing problems. Similar legislation has passed in the state of Washington.

On the Federal level, legislation has been introduced designed to attract new people into the nursing profession by making it easier to access educational and training resources. While we applaud these efforts, this will not address the fundamental problems facing our profession and our patients. America's hospitals are in a state of emergency. And it's one that will only grow worse as the nursing shortage grows more severe. Forcing more mandatory overtime or simply relying on new nurse recruitment programs won't solve the problem either. Likewise, easing immigration rules to attract more foreign or expanding the number of visas allowed for nurses and nursing home workers will only push more caregivers through the revolving doors of our nation's hospitals and nursing homes. I know the area of immigration is of interest to the chairman of this subcommittee. I have attached for the record a copy of Congressional testimony given by one of my SEIU nurse colleagues that explores this issue in greater depth. All of these measures will only treat the symptoms, not cure the disease. Unless and until we address the understaffing and poor working and patient care conditions that plague nurses, we will never solve the shortage.

In nursing homes, we need staffing standards that will change the culture of care in nursing homes to one of which ends the assembly line and instead truly values residents and their lives. And we need adequate reimbursement with built in accountability to ensure that taxpayer dollars are spent on resident care instead of profits. We support many of the recommendations proposed by the National Citizens Coalition for Nursing Home Reform.

Fundamentally, the solution to the nursing crisis lies in the establishment of safe staffing standards in our hospitals.

- We must set enforceable minimum staffing standards linked to the acuity of patients, skill of the staff, and skill mix to ensure good quality care in hospitals, emergency rooms and outpatient facilities. But we must make sure that such minimums do not become the maximums.
- We must make safe staffing a requirement for all hospitals receiving federal taxpayer dollars.
- We must make sure the federal government provides adequate oversight of our hospitals, and that the industry's self-monitoring system under the Joint Commission on the Accreditation of Healthcare Organizations be reformed.
- And we must protect the rights of patients and the rights of health care workers who blow the whistle on staffing problems that jeopardize the quality of care.

To be sure, it will take time to enact and implement staffing standards. The understaffing problem didn't develop overnight, and neither will the solution.

But there is a step we can take today, immediately, to stop the hemorrhaging – and that's to put a ban on mandatory overtime. Limiting forced overtime will easing the impact of the shrinking supply of nurses by encouraging more nurses to stay in the profession. And it will protect countless patients in the same way that limits on mandatory overtime for train engineers, air traffic controllers, truck drivers, and other occupations where public safety is at risk.

At the same time, we cannot lose sight of the fact that the system needs a fix. We must find ways to set meaningful standards for staffing in the health care industry. Understaffing in our nation's hospitals is a serious problem. It's a problem that will only be solved through the joint efforts of public officials, nurses, and hospital administrators. And it's a problem that must be solved if we are to guarantee quality care for patients – and keep skilled nurses in our hospitals.

SEIU, along with other unions representing health care workers and the ANA, are working with Senator Ted Kennedy and Senator John Kerry to introduce legislation that would ban mandatory overtime. Additionally, we endorse the legislation that Senator Durbin will introduce that seeks to address the shortage in health care facilities through recruitment and educational programs, a ban on mandatory overtime, expansion of the definition of health shortage area, and financial incentives for nursing homes to adopt higher staffing ratios.

We look forward to working with you on this critical issue and I would be happy to answer any questions.

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[1] William M. Mercer, Inc. "Attracting and Retaining Registered Nurses – Survey Results." December 2000.
[2] Jack Needleman, Peter I. Buerhaus, Soeren Mattke, Maureen Stewart, Katya Zelevinsky, "Nurse Staffing And Patient Outcomes In Hospitals." Final Report, US Department of Health and Human Services, Health Resources and Services Administration, Contract No. 230-99-0021, February 28, 2001
[3] "Maryland Facing a Shortage of Nurses," *Health Matters*, **The Association of Maryland Hospitals and Health Systems, Fall 2000.**
[4] "Nursing staffs shrink; quality, availability of medical care suffer," *The Baltimore Sun*, March 19, 2000.

Testimony of Diane Sosne, RN
Service Employees International Union, AFL-CIO
Co-Chair, SEIU Nurse Alliance
Before the Senate Judiciary Committee, Subcommittee on Immigration
Hearing on Rural and Urban Health Care Needs
Tuesday, May 22, 2001
2:00 p.m., SD-226

Thank you Senator Brownback and Senator Kennedy for allowing me to testify at this hearing on behalf of the Service Employees International Union.

My name is Diane Sosne, and I am registered nurse (RN) and co-chair of SEIU's Nurse Alliance. Today I am speaking on behalf of the over 1.4 million members of the SEIU, 110,000 who are nurses and 120,000 nursing home workers in our health care division. SEIU is committed to achieving access to quality health care for all who live and work in America – and quality jobs for all who dedicate their lives to caring for others.

We are a nation of immigrants that has benefited from the talent and expertise of immigrants in every occupation. Today countless nurses, doctors, and other health care givers who have come from other countries are working in the United States. SEIU has embraced these dedicated workers. They are making our union stronger through their diversity and energy, and they have joined our movement for quality patient care.

We are proud of our SEIU immigrant members working in home healthcare, nursing homes and hospitals. We are very aware of the staffing crisis, because our members are working in health facilities with too few staff, and too many patients with increasingly complex and chronic health conditions. SEIU is uniquely qualified to be a partner in the health care staffing dialog as the largest health care union. SEIU's Committee for Interns and Residents (CIR) members are doctors working in inner city hospitals, many of whom are in this country through the H1-B visa program. Other SEIU members are health caregivers in some of the toughest public hospitals in New York, New Jersey, Washington D.C. and Los Angeles.

Hospitals today are expecting too few nurses to care for far too many patients. That reality was confirmed by a recent national poll of acute care RNs commissioned by the SEIU Nurse Alliance. In that survey, more than one third of all nurses surveyed said that patients on their units experience missed or delayed medication or treatments at least once a week – usually as a result of inadequate staffing.

If the problem were just too few nurses in this country, easing immigration might make sense. But, since the root cause of the nursing shortage isn't lack of nurses. Working conditions such as short staffing are driving existing staff away from the profession. Immigration is a bandaid to cover the real problem. Unsafe working conditions diminish quality care for patients and make it unsafe for nurses to practice. The risk of making fatal mistakes and putting licenses on the line is causing nurses to

leave the profession in record numbers. In fact, nurses who come to this country on visas will be facing the same unsafe, poor work environments that are driving tens of thousands of American nurses out of hospitals.

The proportion of the nation's registered nurses working in hospitals declined from 68 percent in 1988 to 59 percent in 2000, as a result of industry and occupation restructuring.

The same problems exist in nursing homes where nine in 10 homes lack staffing that is needed to provide high quality care, according to the Health Care Financing Administration (HCFA). The problem is not a nurse aide shortage but a retention crisis that has led to a revolving door workforce. Heavy workload, high risk of injury from lifting and bathing patients, and low wages have combined to create 100 percent turnover among nursing home caregivers each year on average. By the year 2020, when the U.S. baby boomer generation will be in greatest need of care, and a shortage of 400,000 nurses in the United States is projected.

We do not oppose Immigration as one approach to solving the nursing shortage. But, the priority in our health care system should be to attract and retain health care-givers. Today, only 55 percent of acute care nurses plan to stay in hospitals until they retire. And yet, fully 68 percent say they would be more likely to stay in hospitals if staffing levels in their facilities were adequate.

SEIU believes we can reduce our staffing shortage by increasing funding and financial support for nurse and nurse aide education, recruitment and retention by increasing wages and improving working conditions. These kinds of initiatives should be implemented first before turning to immigration as the solution.

We can attract more American workers to the profession by removing barriers and expanding the pool of potential health caregivers. We need to change the complexion of nursing, we need to recruit more men, and improve the racial and ethnic diversity. Finally, more emphasis should be placed on welfare-to-work programs. Former welfare recipients could be encouraged to choose healthcare as profession if Congress would define post-secondary education programs as a qualified work activity.

However, we acknowledge that new caregiver recruitment and education programs alone won't solve the problem. They will only treat the symptoms, not cure the disease. Unless we address the poor working and quality patient care conditions plaguing our caregivers today, the best we can hope for is a revolving door – with nurses and nurse aides leaving hospitals and nursing homes as fast as they enter.

But I'm certain that all of our members – regardless of where they come from – would agree that trying to solve the current nursing crisis by bringing in more health caregivers from around the world is a short-sighted response. Regardless of nationality, the working conditions are driving health care givers away from these jobs. We should not exploit immigrant workers because conditions in this country may be

better than from where they came. Neither American nor foreign-born workers should be subjected to these working conditions.

First of all, the nursing shortage is a worldwide phenomenon. As a member of the global community, our nation should not draw trained nurses away from poor countries that need them even more desperately than we do.

Nor should we selectively adapt our immigration policies to cater to the needs of one particular industry. What we really need is broad reforms of our immigration laws. It's no secret that an estimated 9 million undocumented workers reside in the United States today. But lesser known is the fact that because of the way our current laws work, many of those people are actually working outside of their chosen professions -- including health care professions. The time has come for our nation to take a hard look at how best to protect the rights and enhance the quality of life for everyone who lives and works in the United States. SEIU as a member of the AFL-CIO is calling on Congress to allow undocumented workers already in this country to be able to legalize, (a copy of AFL-CIO resolution is attached to this testimony).

Rather than seeking stopgap measures to ease the crunch in the short term, we need to fix the system for the long term. Fundamentally, the only real and lasting solution to the growing nursing shortage lies in the establishment of safe staffing standards in our hospitals and nursing homes.

We must make safe staffing a requirement for all hospitals receiving federal taxpayer dollars. We must make sure the federal government is providing adequate oversight of our hospitals. We must protect the rights of patients and the rights of health care workers who blow the whistle on problems with patient care. We must take action immediately to stop the hemorrhaging – by banning mandatory overtime for nurses, just as we do for train engineers, air traffic controllers, truck drivers, and other occupations where public safety is at risk.

Perhaps most of all, we must make sure that workers have a voice in the decisions that affect their professions, their jobs, and their livelihoods. We must involve nurses in the process of designing solutions to the staffing crisis. Any employment based immigration program must involve workers -- not just employers.

Understaffing in our nation's hospitals is a serious problem. It's a problem that will only be solved through the joint efforts of public officials, nurses, and hospital administrators. And it's a problem that must solved if we are to guarantee quality care for patients -- and keep skilled nurses in our hospitals.

SEIU, is committed to the following principles:

- The creation or expansion of temporary or permanent visa programs for health care professionals must be evaluated in light of a comprehensive analysis of the

projected needs of the health care industry and the adequacy of measures to train and retain American nurses.

- Immigrant health caregivers should meet existing licensing and certification requirements.

- Immigrant workers should be allowed to stay in this country under any visa program. We should not seek immigrant workers from around the world with the expectation of using them to solve our workforce problem temporarily, and then sending them home. It should be the worker's choice to stay.

- Where established labor/management relationships exist, unions must have a direct role in the labor certification process – such as a joint labor/management visa application process.

- Immigrant workers must be guaranteed all labor protections, including whistleblower protections for both patient quality care and labor rights.

- SEIU is concerned that the health care industry is seeking a quick fix by asking for renewal of the H1-A visa program, which was widely abused by temporary agencies and nursing homes.

- SEIU also opposes efforts by industry to relax the H1-B or expand H1-C requirements so that more RN's and health caregivers workers in general can be made eligible.

- SEIU supports legalization of undocumented workers currently living and working in this county. It is time for undocumented workers already working paying taxes and living in the U.S. to come out of the shadows and work legally without fear. Many are already working in home health care industry, nursing homes and hospitals. Many other undocumented workers could work in these professions because of their foreign training but are not allowed to work because of their undocumented status.

We look forward to working with this committee to crafting a comprehensive solution to the shortage of health care professionals facing this country. Thank you again for allowing me to testify.

# # #

Attachments:

AFL-CIO Resolution 2/16/2000

February 16, 2000
New Orleans, LA
Immigration

The AFL-CIO proudly stands on the side of immigrant workers. Throughout the history of this country, immigrants have played an important role in building our nation and its democratic institutions. New arrivals from every continent have contributed their energy, talent, and commitment to making the United States richer and stronger. Likewise, the American union movement has been enriched by the contributions and courage of immigrant workers. Newly arriving workers continue to make indispensable contributions to the strength and growth of our unions. These efforts have created new unions and strengthened and revived others, benefitting all workers, immigrant and native-born alike. It is increasingly clear that if the United States is to have an immigration system that really works, it must be simultaneously orderly, responsible and fair. The policies of both the AFL-CIO and our country must reflect those goals.

The United States is a nation of laws. This means that the federal government has the sovereign authority and constitutional responsibility to set and enforce limits on immigration. It also means that our government has the obligation to enact and enforce laws in ways that respect due process and civil liberties, safeguard public health and safety, and protect the rights and opportunities of workers.

The AFL-CIO believes the current system of immigration enforcement in the United States is broken and needs to be fixed. Our starting points are simple:

- Undocumented workers and their families make enormous contributions to their communities and workplaces and should be provided permanent legal status through a new amnesty program.
- Regulated legal immigration is better than unregulated illegal immigration.
- Immigrant workers should have full workplace rights in order to protect their own interests as well as the labor rights of all American workers.
- Labor and business should work together to design cooperative mechanisms that allow law-abiding employers to satisfy legitimate needs for new workers in a timely manner without compromising the rights and opportunities of workers already here.
- Labor and business should cooperate to undertake expanded efforts to educate and train American workers in order to upgrade their skill levels in ways that enhance our shared economic prosperity.
- Criminal penalties should be established to punish employers who recruit undocumented workers from abroad for the purpose of exploiting workers for economic gain.

Current efforts to improve immigration enforcement, while failing to stop the flow of undocumented people into the United States, have resulted in a system that causes discrimination and leaves unpunished unscrupulous employers who exploit undocumented workers, thus denying labor rights for *all* workers.

The combination of a poorly constructed and ineffectively enforced system that results in penalties for only a few of the employers who violate immigration laws has had especially detrimental impacts on efforts to organize and adequately represent workers. Unscrupulous employers have systematically used the I-9 process in their efforts to retaliate against workers who seek to join unions, improve their working conditions, and otherwise assert their rights.

Therefore, the AFL-CIO calls for replacing the current I-9 system as a tool of workplace immigration enforcement. We should substitute a system of immigration enforcement strategies that focuses on the criminalization of employer behavior, targeting those employers who recruit undocumented workers from abroad, either directly or indirectly. It should be supplemented with strong penalties against employers who abuse workers' immigration status to suppress their rights and labor protections. The federal government should aggressively investigate, and criminally prosecute, those employers who knowingly exploit a worker's undocumented status in order to prevent enforcement of workplace protection laws.

We strongly believe employer sanctions, as a nationwide policy applied to all workplaces, has failed and should be eliminated. It should be replaced with an alternative policy to reduce undocumented immigration and prevent employer abuse. Any new policy must meet the following principles: 1) it must seek to prevent employer discrimination against people who look or sound foreign; 2) it must allow workers to pursue legal remedies, including supporting a union, regardless of immigration status; and 3) it must avoid unfairly targeting immigrant workers of a particular nationality.

There is a long tradition in the United States of protecting those who risk their financial and physical well-being to come forward to report violations of laws that were enacted for the public good. Courageous undocumented workers who come forward to assert their rights should not be faced with deportation as a result of their actions. The recent situation at the Holiday Inn Express in Minneapolis highlights the perversity of the current situation. Therefore, the

AFL-CIO calls for the enactment of whistleblower protections providing protected immigration status for undocumented workers who report violations of worker protection laws or cooperate with federal agencies during investigations of employment, labor and discrimination violations. Such workers should be accorded full remedies, including reinstatement and back pay. Further, undocumented workers who exercise their rights to organize and bargain collectively should also be provided protected immigration status.

Millions of hard-working people who make enormous contributions to their communities and workplace are denied basic human rights because of their undocumented status. Many of these men and women are the parents of children who are birthright U.S. citizens. The AFL-CIO supports a new amnesty program that would allow these members of local communities to adjust their status to permanent resident and become eligible for naturalization. The AFL-CIO also calls on the Immigration and Naturalization Service to address the shameful delays facing those seeking to adjust their status as a result of the Immigration Reform and Control Act.

Immediate steps should include legalization for three distinct groups of established residents: 1) approximately half-a-million Salvadorans, Guatemalans, Hondurans, and Haitians, who fled civil war and civil strife during the 1980s and early 1990s and were unfairly denied refugee status, and have lived under various forms of temporary legal status; 2) approximately 350,000 long-resident immigrants who were unfairly denied legalization due to illegal behavior by the INS during the amnesty program enacted in the late 1980s; and 3) approximately 10,000 Liberians who fled their homeland's brutal civil war and have lived in the United States for years under temporary legal status.

Guestworker programs too often are used to discriminate against U.S. workers, depress wages and distort labor markets. For these reasons, the AFL-CIO has long been troubled by the operation of such programs. The proliferation of guestworker programs has resulted in the creation of a class of easily exploited workers, who find themselves in a situation very similar to that faced by undocumented workers. The AFL-CIO renews our call for the halt to the expansion of guestworker programs. Moreover, these programs should be reformed to include more rigorous labor market tests and the involvement of labor unions in the labor certification process. All temporary guestworkers should be afforded the same workplace protections available to all workers.

The rights and dignity of all workers can best be ensured when immigrant and non-immigrant workers are fully informed about the contributions of immigrants to our society and our unions, and about the rights of immigrants under current labor, discrimination, naturalization and other laws. Labor unions have led the way in developing model programs that should be widely emulated. The AFL-CIO therefore supports the creation of education programs and centers to educate workers about immigration issues and to assist workers in exercising their rights.

Far too many workers lack access to training programs. Like all other workers, new immigrants want to improve their lives and those of their families by participating in job training. The AFL-CIO supports the expansion of job training programs to better serve immigrant populations. These programs are essential to the ability of immigrants to seize opportunities to compete in the new economy.

Immigrant workers make enormous contributions to our economy and society, and deserve the basic safety net protections that all other workers enjoy. The AFL-CIO continues to support the full restoration of benefits that were unfairly taken away through Federal legislation in 1996, causing tremendous harm to immigrant families.

Testimony of

The Honorable Lynn Martin, Chair

The Future of the Health Care Labor Force in a Graying Society

Mary Jo Snyder, Director, The Nursing Institute

University of Illinois at Chicago, College of Nursing

Submitted to The U. S. Senate

Subcommittee on Oversight of Government Management, Restructuring

and the District of Columbia

The Honorable Richard J. Durbin, Chairman

June 27th, 2001

Mr. Chairman, Members of the Subcommittee, on behalf of the Labor Panel and the Nursing Institute at the University of Illinois, I thank you for this opportunity to testify. I am joined by Mary Jo Snyder, Director of the Nursing Institute and a panel member.

As you may know, I've had the privilege of chairing a panel that looked at this subject over the past year. Panel members represented public institutions, academia, think tanks, private businesses, organized labor, and professional groups. It crossed racial, gender, and political lines. We released our report and recommendations just a few weeks ago.

We are here today, Mr. Chairman, to deliver a wake-up call. America will face a health care crisis that will strike with full force by 2010, and continue for many years thereafter. America will not have enough health care workers, particularly nursing care workers, to care for the people who will need it most: every senior citizen.

The health care labor shortage on American's horizon is not a short-term, temporary decline in the supply of nursing care providers. Instead, America, like much of the rest of the world, is facing a systemic change in the population of those being served and in the population of care giving professionals themselves. America and its health care labor force are aging, and there will not be enough people to fill the nursing care jobs at the very moment that the need for such providers will dramatically increase.

Who will care for our elderly in need of assistance with everyday living? Who will care for those in the nursing homes? Who will care for those still living alone who need some help to stay independent? In other words, who will care for our mothers, fathers, grandmothers, grandfathers, sisters, spouses, and friends? We must even ask the selfish question: Who will take care of me?

The answer to these questions is terrifying because the answer may be: no one. Millions of Americans will face the frightening prospect that, along with a welcome rise in longevity, there will be a staggering decline and shortage of registered nurses, LPNs and Nurse Aides in our workforce.

How concerned should we all be about this? Consider the following: Between 2000 and 2030, the ratio of potential caregivers to the people most likely to need care will decrease by approximately 40 percent.

The usual American solutions of money and technology will not be enough. Though they are part of the answer, they do not provide the living human beings needed to care for other real human beings. They will not provide the person who will change your bed, give you medicine, bathe and dress you – there will be no one to provide the touch, the smile, the intellect to care for you in a way so you do not just endure, but can enjoy your later years.

In the past, the United States has had care-giving shortages for which different answers were found. Today those same solutions are being called upon: flex time, higher wages, bonuses, immigration – all to increase the number of health care workers.

But, for the future, we are not just facing a temporary shortage; we are facing a systemic change not just in the populations of those being served, but also in the care giving professions themselves.

First of all, what constitutes a health care professional is evolving. Years ago we could talk about nurses and be done. Today we have RNs, LPNs, nurses' aides, home health care aides, personal assistants and other health care professionals who are all an important part of the health care system.

What we do not have is an increasing number of people choosing these professions. Even those who do choose health care are not choosing to care for the elderly. At every level of care, the number of health care givers is decreasing relative to the number of those aging. Young people are increasingly turned off to this area of health care.

The underlying problem has two dimensions – demographic change and an insufficient supply of professional nurses and nurse' aides in the workforce. The forces of demographic change are inescapable. We face a future in which there will be many

more older people in the population and at the same time relatively fewer younger people, both family members and professionals to care for them.

Between the years 2010 and 2030, the proportion of the U.S. population aged 65 or older will increase from approximately 13% to 20%. This represents an increase of about 30 million people over the age of 65. And, the number of people aged 85 or older will increase by more than four million.

At the same time, by 2030, the United States will experience more than a 6% decline in the proportion of people aged 18-64 – the family members and the workforce that have traditionally cared for elderly members of our society.

These demographic changes alone will create a genuine crisis unless the numbers of people in the nursing profession grow in proportion to the rising elderly population. Yet these demographic changes will occur within a labor market in which the pool of potential health care employees will be in high demand by other service sector employers.

Worse yet, many of the nursing care occupations today are neither attractive nor financially competitive. You may have seen the report issued recently by the University of Pennsylvania School of Nursing. They surveyed 44,000 nursing professionals and a shocking 40% said they intend to leave the nursing profession for a different career within one year.

A national survey, prepared by the Federation of Nurses and Health Professionals, (700 current nurses and 207 former nurses) found that one in five nurses plans to leave the profession within five years because of unsatisfactory working conditions. Of the nurses who said they plan to leave, 75 percent said they could be persuaded to stay if improvements were made, including better staffing levels, more flexible schedules, and higher salaries. More than half said they are leaving because their jobs are too stressful and physically demanding. Mandatory overtime, irregular hours and worsening working conditions were among other complaints. And 68 percent of the current nurses polled said morale is low.

The Pennsylvania report, much like the findings of the Nursing Institute Panel, cites several key dissatisfactions – most notably low pay, patient overload and poor working conditions. Now let me turn to implications and effects of these trends

The Impact

Consider the following:

- In 1997, 25 percent of workers provided informal care to a person 65 or older
- Approximately 20 percent of all informal caregivers employed while providing such care gave up work, either temporarily or permanently.
- Seven percent of informal caregivers went from full-time to part-time work or took a less demanding job.

- Thirty-three percent of full-time employees and 37 percent of part-time employees have lost time from work due to informal caregiving responsibilities.

In macro terms, the demand for informal caregiving is likely to have an increasingly negative effect on the overall economy, especially as the proportion of people 18 to 64 decreases relative to the elderly population. This increasing demand will translate into additional lost hours of paid work, lost wages, and lower productivity. These losses will affect individuals and their families, directly impacting their standard of living. And employers will also feel the impact as they struggle with tightened labor markets and competing demands for the time and energy of employees.

In other words, if our country fails to build the required professional caretaker infrastructure, then the costs will come home to roost in other ways. One way or another, we will have to care for our growing elderly population. And because it is women who provide most of the informal care, it will be women who will have to scale back or even quit their jobs to take care of aging parents and relatives.

Recommendations

Our panel, Mr. Chairman, wrestled with all these concerns. In the end, we suggested that public policy must focus on four wide-ranging objectives. We must:

1. Increase wages and benefits to more successfully recruit and retain nursing care providers;

2. Create a more professional and desirable work environment for all nursing care providers;
3. Ensure adequate training and education of all nursing care providers; and
4. Provide relevant data and research support related to health care labor issues.

Our report suggests a reform agenda for the private and public sectors, both separately and in partnership. It notes that "more money, by itself, will not solve projected labor shortages, but no labor shortage has ever been solved without a market-based set of economic incentives." We focused on the private sector, the pubic sector, and on public/private partnerships. We offered a comprehensive set of recommendations:

For The Private Sector, We Recommend:

1. Create more attractive wage and benefit packages and design these packages to reward occupational longevity.
2. Make the work environment more desirable through the development and implementation of management models of shared workplace governance and reduced administrative and bureaucratic responsibility for direct care providers and,
3. Provide on-going training and continuing education to all nursing care providers, with a focus on team-oriented education.

For the Public Sector, We Recommend:

1. Establishing a federal commission to investigate economic incentives targeted to workers in geriatric nursing occupations.
2. A national public/private panel be established to examine education and training requirements for all nursing care occupations. This would assist the state and employers in professionalizing all nursing care occupations.
3. Medicare rules and regulations be amended so that all entry-level nursing education and training programs include training in geriatrics.
4. Appropriate federal agencies be required to issue guidelines to the states so that standardized entry criteria may be developed for training and education programs at all levels of nursing care and,
5. Federal data collection agencies be required to provide more recent data on health care occupations and health care utilization.

In the area of Public/Private Partnerships, we point out –

The federal government and private foundations have a long history of public/private partnerships. They once again need to form such a partnership supporting research and demonstration projects that:

- Identify the most successful recruitment and retention strategies for nursing care providers, especially those providing geriatric care; and
- Focus on informal caregivers and the economic consequences of informal caregiving, including its impact on work and family life.

In conclusion, Mr. Chairman, it is clear we have a real challenge before us. We need to start now, because change will take time and we can't afford delay. In the end, I believe America will respond to this crisis as we have so well in the past. The profession of nursing will be enhanced and respected. America today cares for its elderly. I am confident that as different generations consider this issue, that is the one constant we can count upon.

Thank you, Mr. Chairman. My colleague, Mary Jo Snyder, and I would be pleased to answer any questions.

Congressional Testimony

STATEMENT

OF

J. DAVID COX, RN
VICE PRESIDENT, NATIONAL VA COUNCIL
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE

THE SUBCOMMITTE ON OVERSIGHT OF GOVERNMENT MANAGEMENT,
RESTRUCTURING AND THE DISTRICT OF COLUMBIA
SENATE GOVERNMENTAL AFFAIRS COMMITTEE

REGARDING

NURSING SHORTAGES IN FEDERALLY-FUNDED PROGRAMS

JUNE 27, 2001

Chairman Durbin and Ranking Member Voinovich: my name is J. David Cox. I am a Registered Nurse from the Salisbury, North Carolina, VA Medical Center. I am pleased to be here today representing the American Federation of Government Employees, AFL-CIO (AFGE). I am the 1st Vice President of AFGE's National VA Council. AFGE is the largest federal employee union and we represent some 135,000 employees in the Department of Veterans Affairs.

I applaud you for holding this hearing to examine the issue of nursing shortages in federally funded programs. AFGE greatly appreciates this opportunity to discuss with you the causes and effects of the current staffing shortages at the Department of Veterans Affairs.

The DVA is a significant and unique federally funded health care system

The DVA health care system is the largest integrated health care system in our country. The DVA operates 163 hospitals, more than 800 ambulatory care and community-based outpatient clinics, 135 nursing homes, 43 domiciliaries and 73 comprehensive home-care programs. In 2000, more than 3.8 million people received care in DVA health care facilities. The DVA is used annually by approximately 75 percent of all disabled and low-income veterans. DVA is the safety net for homeless veterans, low income veterans and veterans with mental illness. DVA's budget in FY 2001 for health care was $21 billion.

In addition to providing quality medical care to our nation's veterans, DVA-conducted research has yielded major scientific and clinical breakthroughs. For example, DVA researchers developed the cardiac pacemaker, developed a vaccine for hepatitis, pioneered the theory that led to the development of the CAT scan (computerized axial tomography) for diagnosis, and developed the MRI scan (magnetic resonance imagery) for diagnosis. DVA's role in training health care professionals is also significant. More than half of the physicians practicing in the United States have had part of their professional education in the DVA health care system. DVA facilities are affiliated with 107 medical schools, 55 dental schools and more than 1,200 other schools across the country, including hundreds of nursing schools.

The veterans health care system is a unique federally funded health care system that is vital to our nation's interests. This system is cracking under the strain of the current nursing shortages. Congressional action would help DVA respond appropriately to the current situation and congressional action would help ameliorate the shortage on the horizon.

DVA Is Currently Experiencing Nursing Shortages

For DVA hospital staff there is no need for an extensive discussion on whether and to what extent nursing shortages are on the horizon. They experience the shortages on their ward everyday. For hands-on caregivers, the existence and effects of the nursing shortages at the DVA are readily apparent.

From 1995 to 1999, DVA was unable to replace a third of the 15,851 RNs who left DVA. From September 1995 to September 2000, DVA cut Registered Nurses (RNs) by 10 percent, Licensed Practical Nurses (LPNs) by 13 percent and Nursing Assistants (NAs) by 30 percent.

Unfortunately, these staffing cuts are not wholly due to a tight labor market. These reductions are in large part due to DVA's reorganizations and budgetary constraints. In other words, the nursing shortages at the DVA are largely self-inflicted. The problem of the shortages has worsened because DVA top management too often ignores the effects of these shortages.

The Nursing Shortage at the DVA is Likely to Get Worse

This Subcommittee has held hearings on the how the aging of the federal workforce will have enormous impact on all federal agencies. The problem of an aging nursing staff at the DVA is compounded because DVA's patient population is also aging faster than the general population. DVA patients are already older, sicker and poorer than the non-DVA patient population treated in the private sector. Although the overall veteran population will decrease in the coming decades, the demand on the DVA for the most labor intensive medical care for elderly veterans with chronic and multiple illnesses, and disabling conditions will increase.

The increase in demand will occur when DVA's workforce is approaching retirement at a faster rate then the nursing workforce in the private sector. According to the American Hospital Association, the average age of nurses providing inpatient care is 45; in the DVA the average age for a full time RN is 48. Within four years 35% of DVA's RNs will be eligible to retire. At the same time, 29% of the LPNs and 34% of the NAs will be eligible to retire. DVA will not be able to provide care for the most vulnerable veterans -- the poor, elderly and disabled -- when they are most in need of DVA's care, unless we act expeditiously.

The Current Nursing Shortage Is Affecting Access to Care, Patient Safety and Quality of Care

These staffing reductions undermine DVA's ability to provide safe and high quality health care. These shortages impact veterans' access to care. When DVA does not have RNs to staff its wards, the DVA must turn away patients, many who have no health insurance. Veterans are being denied access to care at the DVA and veterans are being diverted to private sector hospitals at what we presume is a great expense to DVA facilities because DVA lacks sufficient numbers of nurses. In addition, veterans have had to wait longer and longer for a medical appointment because there is a shortage of physicians, nurses and medical support personnel.

When veterans do have access to inpatient care at VA hospitals the quality and safety of the care they receive is compromised by the current staffing shortages.

The 1998 study "Nurse Staffing Levels And Adverse Events Following Surgery In U. S. Hospitals" (Kovner and Gergen) showed that patients who have surgery done in hospitals with fewer registered nurses per patient than other hospitals run a higher risk of developing avoidable complications following their operations. The study found hospitals that provided one more hour of nursing care per patient day than the average nursing care hours per patient day had almost 10 percent fewer patients with urinary tract infections and 8 percent fewer patients with pneumonia. One estimate is that an additional one hour per day of nursing care is about a seventeen percent increase in nurse staffing levels.

A 1995 study, "Comparing the Contributions of Groups of Predictors: Which Outcomes Vary with Hospital Rather than Patient Characteristics" (Silber, Rosenbaum and Ross) found that RN-to-bed ratio was the most important factor in predicting the differences among hospitals' success rates in saving patients who experienced serious adverse events. Silber's research found that RN staffing levels were even more significant than the board certification of physicians in rescuing a patient because nurses are the ones who first recognize a complication and call the physician.

Studies have shown that even slight increases in nurse-to-patient ratios reduce the likelihood of patient falls in nursing homes. For the elderly a single fall may have significant medical consequences.

This February the Department of Health and Human Services released a study on "Nurse Staffing and Patient Outcomes in Hospitals" that found facilities with more RNs on staff had a 3 to 12 percent reduction in rates of unfavorable outcomes for patients, like urinary tract infections, pneumonia, and shock/cardiac arrest. The study also showed that a reduced rate of unfavorable outcomes for patients subsequently lowered hospital costs.

Working Conditions that are Sending Nurses out the Door at the DVA and Driving People Away from Nursing

We are concerned that DVA, to the extent it has acknowledged the impending staffing shortages, regards the problem as solely one of inadequate supply of nurses which should be addressed through efforts to encourage greater enrollment in nursing programs. Of course, it is important to understand and address the supply of nurses but we must also acknowledge and improve the alarming working conditions in DVA hospitals that are forcing nurses out the door and jeopardizing patient safety.

From Cleveland, Ohio to Albuquerque, New Mexico, from Togus, Maine to Danville, Illinois, I have heard nurse after nurse express grave concerns about how the working conditions at the DVA deteriorated. Impossible patient work loads, handling too many acute care patients with too few staff, being mandated to work excessive levels of overtime, unsafe working conditions, stagnant pay, and the lack of opportunity to be involved in important staffing decisions are driving more nurses to leave the DVA.

These worsening working conditions are symptomatic of short staffing and, simultaneously, exacerbate nursing shortages because they are the cause for many nurses leaving hospitals. Unless these working conditions are improved, efforts to increase nursing school enrollments will be corroded because nursing students will quickly learn that working in a DVA hospital is not desirable and pursue jobs in other settings.

When DVA fails to create favorable working conditions by treating its staff with respect and dignity it sends a profound message to not only its workforce but to candidates for employment and potential nursing students. Moreover, the way that DVA management treats its workforce ultimately redounds to DVA's genuine desire and capability to honor veterans with compassionate and high quality care.

The Use of Mandatory Overtime Is Risky and Short-sighted

DVA's primary responses to its nursing shortage have resulted in placing nurses in increasingly difficult and untenable working conditions. Because AFGE's nurse members are first and foremost patient advocates, they are very concerned that excessive mandatory overtime is damaging to patient care. AFGE Local officers representing nurses at the Danville, Illinois, DVA Medical Center have told us how nursing assistants, LPNs and RNs have been mandated to work 16 hour shifts day-after-day to the point that they burst into tears.

Working RNs 16 hours or more a day takes a toll on patient care. The cumulative impact of DVA's use of mandatory overtime is that RNs and other nursing staff are overworked, overwhelmed, and fatigued from working too many hours day after day. Under these working conditions RNs are more likely to make medical errors. Even when medical errors are avoided, patients still suffer. Weary and worn out nurses may not be as observant of the subtle changes in a patient's condition that signal a medical problem. Overwhelmed and overtired nurses may also lack the keen level of concentration and emotional stamina necessary to deliver high quality and compassionate care. Medications, basic care, and critical medical interventions are delayed, forgotten or mixed up because staff is spread too thin and exhausted.

The DVA does not have a nationwide policy on mandatory overtime, nor does DVA take disciplinary actions against Medical Directors or nurse managers who rely upon mandatory overtime excessively in lieu of adequate staffing. Only the patient and the RN suffer the consequences when a bleary-eyed RN makes a medical error at the end of two consecutive tours of duty. AFGE regards DVA's failure to hold management accountable for excessive overtime as a disturbing indication of DVA's lack of commitment to patient safety and in becoming the employer of choice.

DVA does not keep nationwide statistics on the pervasiveness of the use of mandatory overtime. The overall increase in DVA's overtime costs, however, does validate the anecdotal comments our union has gathered from DVA nurses across the nation – that

mandatory overtime is used regularly to fill work shifts. Since FY 1997, DVA has nearly doubled its costs for overtime, from $31.5 million in FY 1997 to $57.6 million in FY 2000.

DVA's use of excessive overtime ignores the reality of what is required to deliver high quality care. Nurses are the quality and safety monitors of health care. They are responsible for providing the first warning and swift intervention for those too vulnerable and sick to help themselves. When nurses are exhausted from working 16 or more hours a day, day-after-day, how can we expect them to recognize an impending or actual complication and mobilize intervention from physicians and other staff to save a patient's life?

The DVA should not be allowed to use mandatory overtime as a routine method of filling shifts instead of an emergency response to urgent circumstances. It is not an acceptable substitute for adequate nurse staffing levels. The use of mandatory overtime is a short-sighted response to inadequate staffing because it worsens the problem, places patients at risk and puts extraordinary burdens on direct patient care staff.

For public safety, airline crews, air traffic controllers, train operators and truckers have limits on the maximum hours they can work. Isn't it time that we set similar public safety protections for patients and the workers who care for them?

AFGE recognizes that many approaches to the nursing shortage must occur to address a problem that has been years in the making. But giving nurses the ability to refuse to work overtime is necessary to improve quality care and protecting patients at the DVA. Stopping mandatory overtime is an immediate step that would improve the working conditions of nurses at the DVA.

Improving Pay

Like other federal employees, DVA nurses are paid less than their counterparts in the private sector. If DVA wants to be the employer of choice, the salaries it pays nursing staff must improve.

LPNs and Nursing Assistants

LPNs and Nursing Assistants understand that they must work on weekends because medical care for veterans is a round-the-clock, seven-day-a-week operation, even though it is time away from their families. On behalf of these caregivers, AFGE, however, must object to the current law on weekend pay. It is unfair, arbitrary, and unnecessarily complex.

The law treats Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Nursing Assistants (NAs) differently when it comes to premium pay for working on the weekends. RNs are guaranteed a premium for working a regular shift on Saturday or Sunday. This premium is not for overtime but for a regular shift.

LPNs and NAs are guaranteed only Sunday premium pay. Saturday premium pay is at the option of the Medical Director. This is because in the 1980's Congress created a category of employees considered "hybrid employees". For hybrid employees their pay can follow, but is not required to follow, Title 38 rules. Medical Directors have a significant amount of discretion concerning the pay for hybrid employees, and frequently this discretion is not used to proactively retain LPNs. For example, Medical Directors at DVA facilities in Marion, IL, Cleveland, OH, Cincinnati, OH, Jackson, MS, Biloxi, MS, Anchorage, AK, Memphis, TN, Mountain Home, TN, Poplar Bluff, MO, and Wilmington, DE, have all denied LPNs Saturday premium pay despite a current shortage of LPNs.

For Title 5 employees, like nursing assistants, food service workers, and housekeeping staff, the law prohibits them from being paid premium pay for working a regular shift on Saturdays. For these workers the law only provides them with Sunday premium pay. Nursing Assistants in the DVA can be required to work every Saturday as a regular shift, as is the case for many Nursing Assistants in the West Haven, CT, DVA medical center. It is wrong and unfair not to pay these Title 5 employees Saturday premium pay.

AFGE asks this committee to press for a change in the law to ensure Saturday premium pay for all Title 5 employees and Title 5-Title 38 hybrid employees at the DVA who are required to work on Saturday.

RNs

Between 1994 and 1997 the wage growth for nurses fell by 1.5% annually, according to a 1999 Buerhaus and Staiger study. For many DVA nurses their real earning power has fallen even farther because for many years Medical Directors had the authority to deny them a pay increase. Thanks to the enactment of the Veterans Benefits and Health Care Improvement Act of 2000, DVA RNs are now guaranteed the annual General Schedule (GS) nationwide increase. This change in the law was desperately needed to ensure that RNs standard of living does not drop further and to help keep DVA RN pay competitive with the private sector.

RNs at the DVA, however, are not guaranteed any locality pay increase. DVA Medical Directors retain the authority to grant or deny RN the GS locality pay increase. **AFGE urges that the legislation to address the nursing shortages include correcting the continuing inequities in the nurse locality pay system.**

As with other federal employees who have reached the upper steps of their pay grade, DVA nurses who are on "pay retention" do not even receive the full GS nationwide pay increase. In order for DVA nurses to maintain a decent standard of living and for DVA to become an employer of choice, locality pay and full pay raises for nurses on pay retention must be addressed.

DVA is in a powerful position to increase the number of qualified nurse candidates

Given the current nursing shortage, the expected retirement of nearly a third of DVA's nursing workforce and DVA's significant role in training health care professionals, DVA stands in a unique position to encourage workers to join the nursing profession. DVA has a pool of qualified staff who with proper encouragement and support would become RNs, LPNs or NAs. AFGE strongly believes that DVA would benefit from a revitalized upward mobility program for current staff to encourage them to go into the field of nursing and other health care professions on the verge of shortages, such as pharmacy and social work. An upward mobility program could also enhance the diversity of DVA's RN staff.

A sound federally funded upward mobility education program involves:

- Requiring each DVA facility to recruit and fund a minimum number of scholarships for current staff to become RNs, LPNs, or NAs.
- Linking the overall scholarship limit to increases in education cost inflation;
- Reduce the scholarship requirement for continuous employment from 2 years to 1 year, provided that more senior employees receive preference when funds are limited;
- Making the scholarship and debt reduction programs permanent;
- Ensuring that DVA employees who attend school full time receive salary replacement pay.

AFGE would also urge the Committee to direct the DVA to work with nursing schools and colleges to provide classes at the DVA facility either in person or through teleconference to facilitate greater participation in the scholarship program.

The Crisis in Staffing Affects Other Professions

Although the nursing shortage has been most visible, other professions are on the verge of a crisis of similar proportions. Unfilled pharmacists positions are rapidly growing, at the same time the demand for pharmacists is increasing and enrollment in pharmacy schools is decreasing. DVA is particularly vulnerable to this emerging shortage because nearly a third of DVA's pharmacists are 50 years or older and moving towards retirement.

DVA's inability to recruit pharmacists prompted AFGE to support legislation in the 106th Congress to raise the ceiling on the amount of pay DVA could provide pharmacists under special pay rates. Although this legislation was enacted we remain concerned that DVA is not hiring enough additional pharmacists. DVA's failure to increase its pharmacists and pharmaceutical staff will mean that incumbents will be forced to work longer hours, have less time to counsel patients, and have a greater potential for fatigue-related errors. These undesirable working conditions will then lead to earlier

retirements, more pharmacists leaving the DVA and DVA becoming a less desirable workplace for pharmacists.

As with the nursing shortage, we must heed the warning signs in the current working conditions for pharmacists while we address supply issues.

In sum, AFGE recognizes that many approaches to the nursing shortage must occur to resolve a problem that has been years in the making. But addressing these adverse working conditions at DVA is a necessary and prudent course to improve quality of care and protect patients at the DVA.

Thank you.

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