Approved 3-15-89
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./~~p.m.~~ on February 28, 19 89 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Legislative Research
Norman Furse, Revisors Office
Clarene Wilms, Committee Secretary

Conferees appearing before the committee:

Richard G. Gannon, Executive Secretary, Kansas Board of Healing Arts
Dick Hummel, Executive Vice President, Kansas Health Care Association
Garry Swords, Chairman, Governmental Affairs Committee, Kansas Health Care Asociation
Monte Coffman, Vice-President, Top Management Services
Diana Johnson, R.N., Providence Place, Kansas City
Sally Gates, Administrator, Regency Health Care Center, Olathe
Elizabeth C. Dayani, Corporate Administrator, American Nursing Resources
Terri Roberts, Executive Director, Kansas State Nurses Association
Dr. Lois Scibetta, Executive Administrator, Kansas State Board of Nursing
Amy Heithoff, Director, Favorite Nurses
Linda Lubensky, Executive Director, Kansas Home Care Association
Ben Coates, Director of Policy, Social Rehabilitation Services
Marilyn Bradt, Kansans for Improvement of Nursing Homes
Dr. Walter Powers, President, Creative Care, Wichita
Linda Baker, Branch Manager, Quality Care, Written Testimony

The chairman placed the minutes for February 20,21,22, 23 and 24 for approval or correction. Senator Hayden, moved, with a second from Senator Anderson, to approve the minutes for February 20, 21, 22, 23 and 24 as presented. The motion carried.

Senator Hayden introduced his pages, Richard Frederick, Cory Riedl, and Cody Fisher from Lakin, Kansas.

Richard Gannon, Executive Director, Board of Healing Arts, appeared in support of SB-287 stating that this bill seeks to create a new authority to process and issue temporary educational licensure to physicians wishing to come to this state in order to obtain specialized training from accredited state institutions or their authorized affiliates. The present procedures for application are extensive and therefore, discouraging. Senate Bill 287 would streamline the process but retain the basic safeguards necessary to ensure the state will not lay itself open for possible future fraud or abuse. (Attachment 1)

Dick Hummel, Kansas Health Care Association, introduced Garry Swords.

Garry Swords, Kansas Health Care Association, appeared in support of SB 184 stating that the proliferation of pool agencies are having adverse affect on quality care and quality of life for residents since pool personnel are in and out of the facility for short term periods. He further expressed concern about their sky-rocketing effect on health care expenditures due to the fact that pool personnel often cost two or three times more than regular employees. (Attachment 2)

Monte Coffman, T.M.S., Inc., appeared in support of SB-184 stating their organizations were caring for frailer, sicker residents with fewer and fewer nurses available to work. Stricter enforcement of regulatory standards and inadequate Medicaid reimbursement rates mean less purchasing

power to hire professionals whose work is harder and more stressful than ever before. (Attachment 3)

Diana Johnson, Providence Place, appeared in support of SB-184 stating she has been a co-worker of agency employees and have also contracted agency employees as a manager. Ms. Johnson stated that her organization cannot maintain competitive wages for their own employees without charging the expense back to the private-pay patients. She further stated their own new employees are required to undergo an orientation program concerning specific facility policies and procedures as well as life and safety codes. Comments were made concerning difficulties encountered with nursing pool help. (Attachment 4)

Sally Gates, Regency Health Care Center appeared in support of SB-184. Ms. Gates stated that the shortage of necessary nursing personnel is clearly evident throughout the long term care industry and these organizations are constantly struggling with high turnovers, which in turn results in use of nursing pool services. She further stated her experience with nursing pools has been mostly negative. Poor job performance, failure to appear for work, appearance of employees when they weren't requested, and lack of adherance to care home policies by agency personnel all combine to present a negative image. Pool labor is also quite expensive. (Attachment 5)

Elizabeth Dayani, American Nursing Resources, Inc., appeared in opposition to SB-184 stating, in her opinion, that this bill would create more problems than it would solve. The need for nursing care at all levels and in all settings has increased dramatically while the pool of available workers is shrinking. Ms. Dayani stated that this bill would interfere with demand and supply and would limit free enterprise and deals with only one segment of the health care system - the nursing homes. It was further stated that this bill could cause nurses to go to work in other states. (Attachment 6)

Terri Roberts, KSNA, spoke in opposition to SB-184 stating their organization has supported efforts to control health care costs but they also support the principal that employees wages and benefits in any work setting should be governed by the forces of the market place. It was further stated that temporary nursing pools provide a much needed service to health care facilities in Kansas and across the country. Ms. Roberts testimony also included a statement from the Kansas State Nurses' Association and the American Nurses' Association stating fee restrictions on nurse staffing agencies which affect nurses' compensation will, in the long run, delay the resolution of the nursing shortage. (Attachment 7)

Dr. Lois Scibetta, State Board of Nursing, appeared in opposition to SB-184 stating that the Long Range Planning Committee of the Board of Nursing reviewed this bill and the opposition to it was unanimous. It was further stated that concern was expressed about the regulation of nursing pools because the Board issues individual licenses, not licenses to "groups" or "pools." (Attachment 8)

Amy Heithoff, Director of Favorite Nurses appeared stating opposition to SB-184. Ms. Heithoff stated this bill would affect the profession's ability to recruit and retain the required number of nurses to meet demands. The agencies provide control and flexibility in scheduling hours, days and shifts of work which exhibit themselves in job satisfaction and nurse retention in the profession. (Attachment 9)

Linda Lubensky, Kansas Home Care Association, appeared in opposition to SB-184 stating her organization was greatly concerned that this bill attempts to use quality assurance as a vehicle to initiate rate setting for the singular benefit of the adult care home industry. It was further stated that "Nursing Pools" have become a part of our system. They provide an important option to the health professional and paraprofessional in offering higher salaries, flexibility, and greater

control over work schedules. This keeps workers in their fields and provides benefits to healthcare consumers. (Attachment-10)

Ben Coates, SRS presented testimony from Secretary Winston Barton, Social and Rehabilitation Services, stating this bill would require SRS to establish maximum rates and would put SRS in the position of establishing rates for a group that they do not purchase services from. It would change the fundamental role of SRS, thrusting them into a level of governmental control usually reserved for those services that are granted a monopoly such as public utilities. It was further stated that should the legislature decide to regulate nursing pools that SRS not be involved in the process as they prefer to continue their role as a purchaser of servides instead of a regulator. (Attachment-11)

Marilyn Bradt, KINH, appeared concerning SB-184 stating sympathy with circumstances which gave rise to the bill. She further stated KINH would support the concept of registering or otherwise establishing the responsibility of nursing pools to provide qualified temporary help but oppose limitation of the rates paid to nursing pool personnel. (Attachment 12)

Dr. Walter L. Powers, Creative Care, appeared in opposition to SB-184 stating he appeared on behalf of not only his company but the Kansas Association of Supplemental Health Care Providers. Dr. Powers stated he felt uniquely qualified to speak on this issue since he is a co-owner of Creative Care Corporation, a nursing pool and also president of Eagle Health Care Corporation, a professional management company, located in Wichita which operates nursing homes in Kansas as well as other states. He further stated it was evident that the real intent of this bill was to regulate wages that supplementary nursing personnel could earn as every other provision in the bill was a duplication of existing regulations or practices. Dr. Powers further stated it was the conviction of the KASHCP membership that governmental regulation of rates to nursing homes would drive full-time nursing personnel out of nursing homes, force nursing pools out of an unprofitable market, worsen the already intolerable nursing shortage in nursing homes and will postpone action by the legislature on the real issue facing all health care providers...the low level of reimbursement from Medicaid and Medicare systems. (Attachment 13)

Written testimony was submitted by Linda Baker, Quality Care. Ms. Baker was also representing two other branches, Kimberly Services of Leawood, Ks and Kimberly Quality Care of Wichita. Ms. Baker stated opposition to SB-184 stating that the groups she represented felt this bill would add a redundant layer of regulation to the health care system. They also opposed this bill because it would prohibit them from collecting liquidated damages. (Attachment 14)

The meeting adjourned at 11:03 a.m. and will convene March 1, 1989, room 526-S, at 10:00 a.m.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE February 28, 1989

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Nancy L. Tucker, 2804 E. Central, Wichita 67214	Nursefinders of Wichita.
Barbara Sharpe 9375 W. 75 Overland Park	Nursefinders of K.C.
Tim Yonally, 10039 Mastin O.P. Ks.	KASHCP
Alvin Hall 4146 SW 6 Apt 123 Topeka, KS	L.P.N working for Agency
Janette Nanglich Topeka	Kansas Psychological Assn.
Eileen McGeachy RN, 777 N Silverspring, Wichita 67212	Kimberly Quality Care of Wichita
Teresa Marling 4931 E Morris Wichita 67218	Kimberly Quality Care Wichita
Lynda Franklin RR1 Box 118 Basehor KS 66007	Medical Personnel Pool of Topeka
Nyel E. Shoemaker 5012 SE 10th Topeka 66607	LPN - Agency Nurse
Kathryn L Cashman 338 Golden Ave 66607	Creative Care Agency
Marsha Tregellas 3440 Brendan	Creative Care - Topeka
Barbara Shoup 1840 S Water Wichita	Creative Care - Wichita
Dr. George Goebel - Topeka	AARP Task Force Chr.
Sandra Patterson 2210 40.75th St Prairie Village KS	Medical Personnel Pool.
Judy Stehley 805 Wildcat Ridge Manhattan KS. 66502	Medical Personnel Pool
Don R. Stehley 805 Wildcat Ridge "	" " "
Linda Montgomery Rt 1 Silver Lake	Alma Manor Nursing Home
Linda Baker 2902 W 72 Terr PV KS 66208	Quality Care Nurses
Martha L. Hegarty P.O. Box 279 Easton, Ks 66020	Easton Manor Inc. KHCA

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE February 28, 1989

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
DIANA JOHNSON Olathe, Ks	KHCA
Vicki Allen Topeka, Ks.	KHCA
Sally Gates Olathe Ks	KHCA
Linda Karlin Olathe KS	KCHCA
Mike O'Dea Kansas City Ks	KAFP
Lewis Allen Topeka	KHCA
Mary Trowbridge Kansas City Ks	KHCA
Elizabeth Rowe K C Ks	KHCA
Judy L. Foster Topeka	KHCA
Amy Veithoff RN Kansas City,	Favorite Nurses
Libby Dargani Overland Park KS	American Nursing Resources
C. Kuth	FAVORITE NURSES
Marilyn Bradt Lawrence	KINH
Walter L. Powers Wichita	Creative Care Corp.
Terri Roberts Topeka	Kansas State Nurses' Association
Linda Lubensky Lawrence	KS Home Care Assoc.
Gary Sowards	K.H.C.A.
Rick Hummel	KHCA - Ks Health Care Assn.
Monty Coffman	Top Management Services, Inc

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE February 28, 1989

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
John E. Cahill, 10460 W. 110th Ter., Overland Park, KS	Amega, Inc.
Ann Harvey 120 N. West St. Wichita KS	Osteo Health Care
John Grace KS	Assoc Homes for Aging
JACK GUMB SRS	TOPEKA.
Richard Morrissey	KDHE
Debra Walter 7015 College Blvd. OP, KS	Kimberly Nurses
Margaret Clark 16605 W 147th Olathe, Ks.	Staff Builders
Carol L. Allen PO. Box 19166013 Burlingame, Ks.	Staff Bldrs Ns Agency OV AK KS.

Office of
RICHARD G. GANNON, EXECUTIVE DIRECTOR
CHARLENE K. ABBOTT, ADMINISTRATIVE ASSISTANT
LAWRENCE T. BUENING, JR., GENERAL COUNSEL
JOSEPH M. FURJANIC, DISCIPLINARY COUNSEL

State of Kansas

Landon State Office Building
900 S.W. JACKSON, SUITE 553
TOPEKA, KS 66612-1256
(913) 296-7413

Board of Healing Arts

TO: Senate Committee on Public Health and Welfare

FROM: Richard G. Gannon, Executive Director

DATE: February 28, 1989

RE: Senate Bill No. 287

Mr. Chairman and members of the Committee, thank you very much for the opportunity to appear before you and submit testimony on behalf of this bill. As you are aware, this bill was requested by the State Board of Healing Arts to be introduced as a committee bill through your committee.

This bill seeks the creation of new authority to process and issue temporary educational licensure to physicians wishing to come to this State in order to obtain specialized training from accredited state institutions or their authorized affiliates.

For many years Kansas medical institutions have pioneered or participated in new methodologies of health care. As this leadership has become recognized nationwide, increasing numbers of physicians from across the country have sought training here. When the volume of such physicians was relatively small, the requirement for their completion of the comprehensive medical license application posed few problems or delays.

It has now become clear that a more expedited review process is needed -- possibly one which mirrors the approach used in temporary licensing of Visiting Professors. In the Visiting Professor example, physicians from other states are invited to Kansas to train our health care professionals (ie imported expertise). The reverse of this is achieved under SB 287, that being Kansas health care professionals providing training to physicians from other states.

SB 287 would facilitate the sharing of Kansas medical expertise.

Using present procedures of application, visiting physicians must undergo the extensive application process for full licensure, much the same as a physician who wishes to obtain licensure for a private practice, not an education for a few days or weeks. The

SPHW
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Attachment 1

Board requires the individual to submit copies of diploma and transcripts and also for their medical school to complete a section of the application that requires the school seal. The physician must also have all states in which he has ever held a license, currently or not, complete a verification form to the Board. If an individual has been licensed in several states this can take six to eight weeks to complete. This has, as a result, sometimes discouraged physicians from coming to Kansas for training experiences. When this occurs, they choose to go to other states with application processes more favorable to achieve their goals.

As indicated above, SB 287 offers a method of streamlining the application process, while retaining the basic safeguards necessary to ensure that the state will not lay itself open for possible future fraud or abuse.

Under SB 287, physicians seeking temporary licensure for educational purposes would be experienced in the related fields or procedures within which they seek further training. They would also be a practicing physician in good standing and must be capable of securing coverage under the state's stabilization fund program.

All applicants must make application based upon their desire to participate in an approved continuing medical education program offered by the University of Kansas School of Medicine or one of its authorized affiliate sites/institutions. Further, the Board itself will continue to review such applications, affording this new process continued oversight and monitoring.

This type of training would allow Kansas to increasingly become recognized as an innovative, progressive state relative to state of the art health care, thus attracting high quality physicians for training.

Approval of SB 287 will encourage new opportunities in health care for the State of Kansas.

Thank you very much for the opportunity to appear before you today. If you have any questions, I would be happy to respond.

RGG/pd

KHCA

Member of ahca

Kansas Health Care Association
221 SOUTHWEST 33rd STREET
TOPEKA, KANSAS 66611 • 913-267-6003

February 28, 1989

POSITION OF THE KANSAS HEALTH CARE ASSOCIATION

ON

SENATE BILL NO. 184

"Establishing registration standards and limits on fees charged to adult care homes by nursing pools."

TO: Senate Committee on Public Health and Welfare

The Kansas Health Care Association (KHCA) is a voluntary non-profit organization which represents over 200 licensed adult care homes in Kansas. Our membership includes both proprietary and non-profit nursing homes located in both urban and rural areas of the state.

We suggested the introduction of S.B. 184, which places standards of practice upon nursing pools and limits the fees they may charge to nursing homes. With growing alarm we've witnessed the proliferation of pool agencies, the adverse affect they have upon quality care and quality of life for our residents, and their sky-rocketing effect on health care expenditure.

BACKGROUND:

The severe shortage of nursing personnel, nurses and nurses aides, is forcing nursing homes to increasingly turn to nurse staffing agencies, commonly known as "nursing pools" to meet their basic staffing requirements. Until recently pools played a relatively minor but useful role in assisting nursing homes and other providers in meeting their short-term staffing needs.

In Kansas the dependency by nursing homes for pool labor is growing, from 10% in 1985 to 27% in 1987. This means that to varying degrees over 100 nursing homes have used contract labor to staff facilities.

This is creating two problems. First, quality of care is being compromised. Pool personnel, generally dispassionate to the care and concerns of the facility, do not provide the continuity of care essential to our residents' well being. They are in-and-out of the facility, there for the short term. Other conferees will elaborate on this.

S.P&W
2-28-89
Attachment 2

Second, the agencies are driving up health care costs. Pool personnel often cost two-three times more than regular employees. This is financially draining to the provider and private-pay residents, and is indirectly increasing Medicaid expenditures. For example, one non-profit nursing home in the Olathe area spent $10,000.00 on pool personnel in 1986; in 1988 expenses were $195,000.00. Being 50% Medicaid occupancy, you see what the ramifications are. Other conferees will share their cost experiences with you.

Section 8 of the bill would permit the Department of SRS to set maximum fees pool agencies can charge to adult care homes participating in the Medicaid Program. This isn't unreasonable. SRS sets maximum fees for physicians, nurses, etc. Adult care homes are becoming a convenient source and conduit of Medicaid funds for nursing pools.

An argument has been raised that if nursing homes increased their staff wages they wouldn't have the pool competition. Untrue, as we raise our wages to stay competitive (within the Medicaid limits we are forced to remain under), pools raise theirs higher. The spiral continues (reference attachment).

SENATE BILL 184 CONTENT/DISCUSSION:

Sections 3-7 charge the Kansas State Board of Nursing with the responsibility of registering and regulating nursing pools. Section 4 establishes the minimum standards for registration.

These include:

- Temporary employees meet minimum licensing, education, orientation and continuing education requirements.

  COMMENT: A state health facility surveyor during a recent facility inspection discovered that a pool nurse didn't have a valid Kansas license. The facility was held accountable.

- Pools can't require their employees to recruit new employees from the nursing home.

  COMMENT: Formally or informally this is being done, with bonus incentives offered.

° Personnel policies be developed, reference checks made, annual evaluation of performance based upon adult care home experience.

COMMENT: An employee who was discharged from a facility for abusing a resident was hired by a nursing pool and is working in nursing homes.

° Prohibit the payment of liquidated damages or fees for hiring a pool employee.

COMMENT: If a pool employee wishes to be hired as a fulltime employee by a home, many pools require a contract buy-out.

° Pool carry malpractice insurance on their employees.

COMMENT: About 25-30% don't, with the home left to exposure. A Wichita facility is presently involved in a dispute with a pool over the alleged negligent acts of one of its employees.

SUMMARY:

The nursing shortage is strapping health care providers, particularly nursing homes. Seventy-one percent of the adult care homes in the state had a nursing position open in 1988. Come 1990 adult care homes will be required to increase their nurse staffing compliment under federal regulations. The demand increases; the supply tightens.

As a very last resort do nursing homes turn to employment agencies. The dependency is growing and will continue.

For the well being of our residents, and secondly with a concern for health care costs, do we ask for the favorable reporting of S.B. 184. State registration would drive no legitimate business out-of-the-state; nor would the reasonable regulation of rates.

Thank you for this opportunity.

CONTACT: Dick Hummel, Executive Vice President
Garry Swords, Chairman, Government Affairs Committee

NURSING POOL - NURSING HOME - NURSING POOL DILEMMA

* The higher the wages and benefits paid to pool employees, the more personnel they are able to attract.
  (resulting in labor shortages)

* The higher the wages and benefits paid to pool employees, the higher the rate charged to the client (nursing home).
  (higher cost to nursing home)

* The more personnel they are able to attract from existing facilities, the more critical the shortage of "in-facility" manpower.
  (increased demand for pool labor, potentially untrained)

* The more critical the shortage of the "in-facility" manpower the greater the stress on "in-facility" personnel.
  (reduced care levels)

* The greater the stress on "in-facility" personnel the easier it is for pools to attract/recruit personnel from existing nursing homes.
  (increased labor shortages)

* The easier it is to recruit from existing nursing homes, the greater the shortage of "in-facility" personnel.
  (compound labor shortages)

* The more critical the shortage of "in-facility" personnel, the higher the dependence on pool labor.
  (higher cost of nursing care)

* Nursing homes raise wages, pools increase what they will pay.
  (no wage parity can be attained)

The existance and spiraling cost of pool labor is self-perpetuating.

SUPPORT S.B. 184

gement Services
MTS

T.M.S. INC.

TO: Senate Public Health and Welfare Committee

RE: S.B. 184

Dear Chairman and Committee Members

I am Monte Coffman. I am Vice President of Top Management Services, Inc. Our company leases four facilities with 255 beds and manages one facility with 54 beds. Our facilities are located in rural Eastern Kansas.

From October 1985 through May 1988, we managed two facilities in Phoenix, Arizona. One of the facilities was a 135 bed skilled facility. My experience with nursing pools was extensive at that facility.

Let us set the operating environment nursing homes find themselves in today:

1. Frailer, sicker residents to care for. This means facilities need, more than ever, staffs that are well trained, resident knowledgeable, and permanent.

2. Fewer and fewer nurses available to work. We are in the midst of a grave nursing shortage.

3. Stricter enforcement of regulatory standards. Never have standards been surveyed more tediously. Never has the work detail of individual staff persons been more scrutinized.

4. Inadequate Medicaid reimbursement rates. This fact has been attested to by the 1986 Legislative Post Audit study. The courts have held this. Even the pools acknowledge this fact.

This means we have less purchasing power to hire professionals whose work is harder and more stressful than ever.

We would love to pay more to our employees. The state gave us 1.25% increase in wages two years ago. Last year we received a 2.00% increase. Did the pool charges go up 1.25% and 2.00%? Of course not!! So where are facilities supposed to find the money to cover pool increases? Are we expected to cut staffing levels or supplies to cover pool charges? Maybe let private pay residents? How does this enhance quality care?

SP&W
2-28-89
Attachment 3

P.O. BOX 208 • OVERBROOK, KS 66524 • PHONE 913 665-7114

The observeable fact is that the pools lure employable people out of a labor market that is already inadequate. Then facilities will have to go back to the pools to hire staff.

The pool personnel do not know facility residents nor do they know facility procedures nor do they know the regulations that govern us. This is true because the personnel are not in our facilities every day being trained by us.

Remember we are caring for frailer and sicker people. This concept, especially in our industry and environment, makes as much sense as "rent-a-teacher" or "rent-a-policeman." I would defy anyone to identify one way in which the delivery of long-term care is enhanced by the existence of the nursing pools. I say a negative impact exists.

Nursing home residents need you to support S.B. 184.

Again thank you for this opportunity!

PROVIDENCE PLACE
AT PROVIDENCE-ST. MARGARET HEALTH CENTER

8909 Parallel Parkway Kansas City, Kansas 66112 (913) 299-3030

February 27, 1989

To: Senate Public and Welfare Committee

Subject: Support for Senate Bill 184

My name is Diana Johnson. I have been a professional nurse for over nine years. I worked my way through nursing school as a Certified Nurses Aide. I have been a supervisor, Assistant Director of Nursing and am presently the Director of Nursing at Providence Place Inc. in Kansas City, Kansas. I have been a co-worker of agency employees and have also contracted agency employees as a manager. I feel I have an understanding of the dilemma that faces Nursing Homes and Nursing Agencies.

The ever-spiraling wages and benefits that are paid to pool employees is certinly enough to cause a great deal of 'unrest' among the "close-knit" employees that work for Nursing Homes.

"We unfortunately can't maintain competitive wages to our own employees without charging this back to our private pay Residents or the Medicare, Medicaid programs which cap our reimbursement."

Working in a Nursing Home is often very demanding, both physically and mentally. Employees tend to suffer from "burn-out" with the usual day to day routine, but the problem is enhanced when a nursing pool employee boasts of their higher wages and increased benefits to recruit facility staff. This in turn creates an increase in labor shortage and 'unrest' in a facility. The cycle becomes difficult to break.

New employees in our facility are required to undergo an orientation program concerning specific facility policies and procedures, as well as the life and safety codes. This is to ensure that all new employees will be able to give adequate and safe nursing care to our infirmed and elderly residents. We provide on-going inservice and educational training to ensure that all employees are currently up-dated and prepared to provide good nursing care. I feel this is one important way we can ensure adequate care levels and safe nursing practices and one that should be required of any Agency supplying nursing personnel before their employees be allowed to take care of the sick and elderly in our facilities.

Before hiring any new employees, I feel you must at a minimum check out their references and verify nursing certificates and licenses. There have been several reported cases of a nursing home employee that was discharged from a facility for giving un-safe nursing care and hired by an Agency and sent into the facility (where he/she was discharged) a short time later to work. Another case reported was a registered nurse from a nursing pool was working in an area facility when surveyors came in and checked all nursing licenses. The RN was not licensed in the State of Kansas. The nursing pool had obviously not checked on her license. This is to me an untolerable situation.

SPAW
2-28-89
Attachment 4

The reason behind all the recent Nursing Home (Federal/State) reform regulations is to improve 'quality of care' in nursing homes. The only way we can continue to make positive strides in that direction is to ensure that all nursing personnel (facility or agency) meet at least the minimum requirements by providing care.

In closing, I feel we are all after the same goal to provide the best possible care for our elderly and disabled citizens which include our Mothers, Fathers, and Grandparents. We need assistance and cooperation to accomplish this, I urge you to support Senate Bill #184 for better patient care in our facilities.

Thank you.
Sincerely,
Diana Johnson

Diana Johnson, DON

Regency SM HEALTH CARE CENTER

Senate Public Health and Welfare Commitee
Senator Ehrlich, Chairman
Subject: Senate bill number 184, Nursing Pools

Kansas Health Care Association has submitted a proposal to regulate the practices of and the rates charged to adult care homes by temporary employment agencies, nursing pools. I urge you to support senate bill 184, which would require the registration and regulation of nursing pools in the state and also would establish a maximum rate that pools could charge an adult care home.

The shortage of necessary nursing personnel is clearly evident throughout the long term are industry and has attracted the attention of the media and the goverment . Adult care homes constantly struggle with high turnovers which results in the use of nursing pool services, or worse, low staffing ratios. In many cases this creates an increase in survey deficiencies,fines, and negative action against a facility. Patient care, patient satisfaction, frequency of complaints are also affected.

My experiences with nursing pool services has been mostly negative. Pool personnel are paid more and are less productive than those nurse assistants employed by the facility. And why not be less productive, less responsible, and for the most part, unconcerned and uncaring ? It does not matter to the nursing pool - they get paid by the adult care home no matter what.

A few examples of the negative experiences of nursing pools are:

1) Agency "X" was contacted and they are happy to send an aide to fill a vacant assignment. The aide reports for duty and begins work on the hall. The Charge Nurse assigns them patients to care for and gives a brief report of their needs. At the change of shift, the aide taking responsibility for those patients for the next 8 hours asked me to make rounds with them. I found the first patient lying in bed with a blanket covering him. Under the blanket, he had a urinal between his legs. This urinal was so full, his penis, which was in the urinal, was floating in urine. The other patients assigned to this aide had signs of neglect-dried feces, food on hands and faces, etc.

SP&HW
2-28-89
Attachment 5

400 S. ROGERS ROAD • OLATHE, KANSAS 66062 • 913-782-3350

The nursing pool was called and this situation was reported. The staffing"Executive" said she wasn't surprised, they were aware of problems with this aide.

Why, then, did they send her to work anyway ? Perhaps they thought we wouldn't notice she was incompetant. My concern is, this pool will send this aid to work at some other unsuspecting facility.

This is the first one of many examples related to poor care.

2) Agencies will confirm an individual schedule to work. At least 30% of the time, those individuals scheduled do not report to work. This does not stop the agency from scheduling the same person at some other time. Why not, they have the adult care home over a barrel. When you need help, you need help.

3) Frequently an agency employee will just appear at the adult care home and simply begin work on a hall, even though the adult care home didn't ask for them. This happens especially on the 3-11 and 11-7 shifts. When reporting this to the agencies the frequent response is "Sorry, but they did work, and you have to pay."

4) Agency personnel do not abide by adult care home policies. Aides will leave the facility for breaks and meals and not report their whereabouts. Yet, you can guarantee their time schedule will show a full 8 hours of work.

Health care employees have always been particulary concerned about hiring reliable and trustworthy employees. There is a tremendous responsibility in providing quality patient care. Almost everyone has an opinion about how to improve the quality of long term care. Solutions to many of the problems appear simple. To those of us who work within the industry, we know that the answers are not simple.

A registry of nursing pool employees would help adult care home employees in knowing residents are cared for by at least a competent person.OBRA 87 requires many new standards of competency for nursing home employees and it also requires new standards of continuing education. The nursing pools must be able to guarantee a comparable standard of quality.

Pool labor is quite expensive, yet you do not receive value for your dollars. (Examples cited above) Adult Care Homes cannot begin to compete in terms of increased wages as this simply causes pools to increase their wages, and a war begins. Individuals work for pools for a number of reasons, to name their own hours, to make more money, to have no real responsibility for performance, to have no supervision. Many pool employees tell us they won't return to our facility as they have to work too hard. In fact, one pool aide appeared for the 11-7 shift asking where the bed was for her to rest in between bed checks! Another was angry that she did not have time to study.

In spite of the problems mentioned, nursing pool charges are outrageous. A LPN from an agency costs an average of $20.00 per hour, we start LPN's at $8.50 per hour. A certified nurse's aide from an agency costs an average of $13.00 per hour, we pay an average of $5.00 per hour.

Nursing pools cost appoximately 250% higher than a full-time employee, benefits and all - 250% higher - that is totally unrealistic. Yet, our options are limited.

We have historically been successful in recruiting attempts in the past as we increase our starting wages, offer increased benefits, and offer the most flexibility in work schedules as possible. As soon as we experience some stability in staffing, the nursing pools offer even better wages enticing employees to changemployement.

Staff from agencies working at the facilities are quite proud of the money they earn and brag about their hourly rate. Not only does this make staff consider working for agencies, it causes permanent loyal staff to become disgruntled.

Unless this cycle stops somewhere, unless some controls are placed on the nursing pool rates, nursing homes will never be able to compete int he market place for employees.

Competition for nursing staff will intensify. Success in meeting the challenges depends on how well we manage our human resources. Anyone involved in the provision of care must respond to the delivery of quality care and note the need for legitimate businesses (nursing pools) to regulate their activites.

Sally Gates, Administrator

For More Information Contact:
Elizabeth C. Dayani, R.N., M.S.N.
American Nursing Resources, Inc.
11050 Roe Boulevard, Suite #200
Overland Park, Kansas 66211
913-491-0010
800-333-3369

TESTIMONY IN OPPOSITION TO SENATE BILL 184

February 28, 1989

Senator Ehrlich, Senator Langworthy, and members of the Senate Public Health and Welfare Committee, thank you for allowing me to appear before you. It is a privilege.

My name is Libby Dayani. I am a registered nurse and a resident of Kansas. I have a brief statement to make in opposition to Senate Bill 184 because I believe from the bottom of my heart that it would create more problems than it would solve. You have a very complex issue to consider.

I was raised in Brazil, South America, the daughter of missionaries. As a young girl, I felt a call from God to be a nurse. For almost twenty years, I have devoted myself to helping make nursing a desirable and honorable profession so that competent and caring people would be available to provide the best nursing care possible to sick people who need, want, and deserve the care that only nurses can give. I have taught in nursing schools at Vanderbilt University, Wayne State University, and five years at the University of Kansas where I was a tenured associate professor. I have established clinics and worked as a nurse practitioner in inner-city housing projects and rural under-served areas. I was chosen by Professional Seminar Consultants to lead an educational exchange program for nurses to the U.S.S.R. I was chosen by Good Housekeeping as one of 100 Young Women of Promise.

Six years ago my husband, a businessman, and I went into business to provide home care services and supplemental staffing to health care institutions. Our Kansas-based company has branch offices from Boston to Los Angeles. We employee hundreds of people in Kansas and thousands across the nation. It is an honorable business.

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I am passionate about nursing and even more devoted to helping develop cost effective services to meet the health care needs of society.

You understand probably better than most that we live in a world of limited resources. As legislators, you have the awesome responsibility to decide how and where state resources will be allocated. Your constituents have legitimate needs and often times these needs are conflicting. Your job is much harder than mine.

It comes as no surprise that as society ages, the need for nursing care at all levels and in all settings has increased dramatically. The problem facing us all is that the pool of available workers is shrinking. Thus, the current shortage of nursing personnel. We must attract more people into nursing and keep them in nursing by paying fair wages and treating them with dignity and respect. Enrollment in nursing schools is increasing because the market place forces of demand and supply have raised nursing salaries. Enrollment at the University of Kansas School of Nursing increased by 10% in 1988 alone.

I am concerned about Senate Bill 184 because it would interfere with demand and supply, it would limit free enterprise, it would cap nursing salaries, and it deals with only one segment of the health care system - the nursing homes. Any legislation that caps the salaries of nursing personnel in one setting will simply force them to go to work in hospitals or home care, at best, or to leave the profession altogether. Until this legislature is prepared to regulate reimbursement for all providers across all settings by all payers, I fear that Senate Bill 184 will make it impossible for nursing homes to find any nursing personnel. Short of a national all-payer system, a state rate-setting system would cause nurses to work in other states as has happened in New Jersey. I would much rather see you increase state Medicaid reimbursement amounts to nursing homes so that they can attract and retain the nursing staff that they do need. In a recent report published by the Health Policy Project at George Washington University, "State Financing of Long-Term Care for the Elderly," Kansas ranked 46th in spending on state initiated long-term care services. No wonder the nursing homes in Kansas can not offer competitive salaries.

Finally, I urge you to discourage the passing of Senate Bill 184. Please do not handcuff private enterprise or aggravate the nursing shortage. Thank you for listening to my views. I am available to answer any and all of your questions.

KSNA
the voice of Nursing in Kansas

FOR MORE INFORMATION CONTACT:

TERRI ROBERTS, J.D., R.N.
EXECUTIVE DIRECTOR
KANSAS STATE NURSES' ASSOCIATION
820 QUINCY, SUITE 520
TOPEKA, KANSAS 66612
(913) 233-8638
February 28, 1989

S.B. 184 REGULATION OF TEMPORARY NURSING POOLS

Chairman Ehrlich and members of the Senate Public Health and Welfare Committee, my name is Terri Roberts, R.N., I am the Executive Director for the Kansas State Nurses' Association, representing registered nurses in the state of Kansas.

Thank you for the opportunity to present comments regarding Senate Bill 184.

The Kansas State Nurses' Association has supported efforts by State legislators and the Congress to control health care costs. However, we also support the principal that employees wages and benefits in any work setting should be governed by the forces of the market place. This includes independent negotiations between and employer and an employee. We must oppose any legislation which calls for setting rates for the administrative or operation of so-called "nursing pools", and setting rates for wages and benefits paid to nurses employed by these pools. Temporary nursing pools provide a much needed service to health care facilities in Kansas and across the country. At times of peaks in patient census, both hospitals and long term care facilities are able to engage the services of such temporary pools to meet their own staffing needs, that otherwise they would not be able to meet. Section 8 of the bill, which would restrict nursing pools from receiving payments from adult care homes at a higher rate than the maximum rate established by the secretary of SRS, is the part that we find most objectionable. Why is it that the secretary does not establish minimum rates for what nursing homes may charge their clients or what pharmacies may charge for drugs. We are very supportive of the long term care industry, in their efforts to seek additional compensation through Medicaid for the services they provide to Medicaid clients.

Section 4 of the bill provides that the Board of Nursing would establish, by rules and regulation, minimum standards for the registration operation of the nursing pools. Such regulations would be designated to protect the publics' right to high quality health care by assuring that nursing pools employ competent, qualified nursing personnel, and that such nursing personnel are provided to adult care homes in a way to meet the needs of residents and patients. Generally this provision would look like a very positive provision that we would want to support, however, if you consider that R.N.s and L.P.N.s, which are employed by these temporary nursing pools, are already licensed and, competent and qualified nursing personnel, it's very difficult to understand the need for section 4. It would be very different if the nursing pools employed people without any kind of training, but in Kansas, we have very high standards, even for nursing home aides that they must have 90 hours of training, and this includes those that are hired by nursing pools to be hired out to adult care homes in Kansas. There are already in place quality control measures, licensure for R.N.s and L.P.N.s, and the training that is provided to nursing home aides of 90 hours and the ongoing continuing education requirement that is required of them. We believe that these measures are more than adequate to protect the public's right to competent and qualified nursing personnel and see no need for further legislation such as that proposed by S.B. 184.

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KSNA
the voice of Nursing in Kansas

KANSAS STATE NURSES' ASSOCIATION

AND

AMERICAN NURSES' ASSOCIATION

STATEMENT ON FEE RESTRICTIONS FOR NURSING STAFFING AGENCIES

Nurse staffing agencies provide the services of nurses to health care employers on a temporary full-time or part-time basis. These agencies have become important components of nursing employment and the nursing labor market. In part, this growth reflects the proliferation of temporary employment in the U.S. economy generally. The growing reliance of health care employers on nurse staffing agencies also reflects the impact of the current nursing shortage, the evening, night and weekend employment requirements and the lack of flexible scheduling in nursing. Nurses are attracted to agencies for higher wages and the ability to control their work schedules. For that, they sacrifice job security and benefits offered by traditional employment opportunities.

Because of the increased demand for nurses and the resulting nursing shortage, agencies are raising per diem rates paid to nurses in order to attract sufficient numbers of nurses to meet the staffing needs of health care employers. Consequently, agencies are raising the rates charged health care employers. Efforts are being made to establish maximum rates that can be charged by nurse staffing agencies. Legislation to restrict the fees agencies may charge have been proposed or enacted in several states, and similar legislation may be proposed by the federal level as well.

The Kansas State Nurses' Association and the American Nurses' Association opposes the introduction of fee restrictions which would, in effect, restrict the compensation of nurses employed by nurse staffing agencies. Such actions will also result in the removal of an important source of wage competition. Economic studies have repeatedly documented that improvements in the compensation have a demonstrable impact on the profession's ability to recruit and retain the required number of nurses to meet the demand for nursing care. **Thus, fee restrictions on nurse staffing agencies which affect nurses' compensation will, in the long run, delay the resolution of the nursing shortage.**

ANA Cabinet on Nursing Services
ANA Cabinet on Economic and General Welfare August, 1988
KSNA Board of Directors February, 1989

Kansas State Nurses' Association • 820 Quincy • Topeka, Kansas 66612 • (913) 233-8638
Peggy Erickson, M.N., R.N.—*President* • Terri Roberts, J.D., R.N.—*Executive Director*

Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1256
913-296-4929

Lois Rich Scibetta, Ph.D., R.N.
Executive Administrator

Bonnie Howard, R.N., M.A.
Practice Specialist

Janette Pucci, R.N., M.S.N.
Educational Specialist

TO: The Honorable Senator Roy Ehrlich, Chairman and Members of the Public Health and Welfare Committee

FROM: Dr. Lois R. Scibetta
Executive Administrator

RE: Senate Bill 184 - Nursing Pools

DATE: February 28, 1989

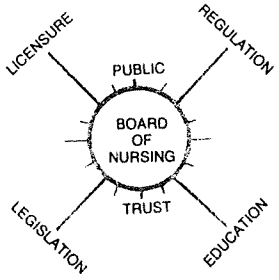
Thank you Mr. Chairman for the opportunity to comment on SB 184. On behalf of the State Board of Nursing, I speak in opposition to SB 184.

The Long Range Planning Committee of the Board of Nursing reviewed the bill, and the opposition to it was unanimous. Several Board Members expressed concern about the regulation of nursing pools, because the Board issues individual licenses, not licenses to "groups", or pools. The Board oppose the educational programs which prepare our licensees, and the providers of continuing education, which is required for on-going licensure.

While the Board understands the concerns of the group who are proposing this legislation, the Board does not believe that regulation is required at this time.

The issue of the Registration of Nursing Pools, is a costly measure, and it is difficult to determine just how this proposed legislation will protect the public. The bill seems designed to limit the cost to the nursing home industry for the nursing pool services.

No one seems to know how many "nursing pools" there are in Kansas. I tried to obtain this information for the fiscal impact statement (attached) and I was not able to do so. The Board has not had complaints about nursing pools per se.



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It would be a conflict of interest for the Board to get involved in issues related to salary and personnel regulations, and/or operational regulations related to nursing pools, which are part of private industry.

In summary, the Board cannot support this bill, and respectfully ask this Committee report the bill out unfavorably.

I will be happy to respond to questions, Mr. Chairman.

LRS:bph

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Educational Specialist

TO: Michael O'Keefe, Director of the Budget

FROM: Dr. Lois R. Scibetta, Executive Administrator

DATE: February 14, 1989

RE: Fiscal Impact SB 184 - Registration of Nursing Employment Pools

1) Analysis of Proposed Legislation.

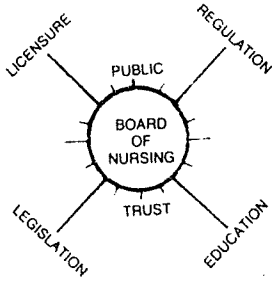
Basically this legislation provides for the registration of Nursing pools, it relates specifically to the utilization of nurses in adult care homes; in terms of the responsibility of the Board. The bill directs the Board to establish employment standards. Some aspects of the bill involve the Department of Health and Environment, and the Secretary of S.R.S. It is an effort on behalf of the profit making nursing homes to set limits of the fees charged by Nursing pools.

2) Effect of Bill on Operation of the Board of Nursing.

The Board will oppose this bill in its current form. It would be a conflict of interest for the Board of Nursing to be involved in employment standards, and the establishment of fees charged by the Nursing pool agencies. This bill was discussed by the Long Range Planning Committee of the Board and it was rejected.

3) Dollar Cost (if any) expenditures/receipts.

If the registration of nursing pools becomes a Board responsibility, it will be necessary to employ at least one clerical person to handle the phones, and the paperwork. In addition, start up computer costs would be involved, and the entire operation would require professional oversight. Postage and administrative costs would also be involved.



3) Cont'd

Office Assistant II - - - - - - - - - - -	$13,488.00	(Annual Salary)
Phone Line - - - - - - - - - - - - - - - -	800.00	
Desk, Typewriter, Chair - - - - - - - - -	700.00	
Postage - - - - - - - - - - - - - - - - -	100.00	
Professional Over-sight 10% - Time - - -	$271.00/Mo x 12 =	$3,252.00
Miscellaneous - (Forms, Materials) - - -	250.00	
	$18,590.00	
Administrative Costs - 10% - - - - - - -	1,859.00	
TOTAL	$20,449.00	

4) Basis For Cost Estimates;

Personnel, equipment, professional oversight, postage, mailing, and administrative costs.

5) Is it possible to meet the intent of the legislation within current staffing and operating expenditure levels?

No.

6) Long Range Fiscal Impact on Board of Nursing: (cover 2 fiscal years)

The start up costs would be the highest however the salary of the clerk, professional oversight and expenditures would be the same. 1st year $20,449.00; 2nd year $19,649.00 = $40,098.00

7) Additional Comments:

It is possible that the Board will be required to register Nursing Agency Pools. At this time, since there are many such nursing pools, it is expected that this would be an involved complicated process. The KSBN does register and license individuals. It would probably be more appropriate that Health and Environment or Social and Rehabilitation Services register the Nursing Pools.

Fees are mentioned, however the board would need to establish a fee to cover the cost of implementing the bill. An initial fee of $150.00 to $200.00 should be considered, and $100.00 per year thereafter to cover the cost of the program.

Signed: Carolyn Letcher, RN, KSBN

Date: 2-15-89

FAVORITE NURSES

Senator Ehrlich, Senator Langworthy, Committee, thank you for the opportunity to talk with you today. My name is Amy Heithoff. I'm the Director of Favorite Nurses and I'm also an ICU nurse. I come to you today on behalf of Favorite Nurses and the 600 plus nurses and nurses aides that we employ. We are strongly opposed to SB 184 for several reasons:

1) Sections 3 and 4 are redundant to what agencies already do. Our nurses are licensed by the same State Board as fulltime hospital and nursing home personnel are. We assure quality in several ways: the first is by stringent testing and reference checking, we require a years experience and send out evaluations to hospitals and nursing homes every three months. We are accountable to the Joint Commission on Hospitals and Health Care Organizations just as our clients are. Our newly formed Kansas Association of Supplemental Health Care Providers (KASHCP), have also deemed it necessary to set our own internal standards to regulate ourselves.

2) Section 6 expands malpractice insurance. Not only do we carry malpractice insurance on all of our employees, but also Worker's Compensation insurance. So there is no liability for hospitals or nursing homes to use us. We are simply there to assist them with staffing crunches. Agency help is cost efficient as stated in the article I've passed to you. We can "tailor meet" needs that might otherwise be left with no one or prove to be overstaffed by fulltime personnel.

3) Section 8 is particularly offensive! To cap only NURSES wages is discriminatory. Placing caps on nurses wages will serve one purpose: it promises to compound the nursing shortage! Who wants to enter into, or stay in a profession in which you can only earn a limited income?

Eunice Turner, RN, Senior Staff Specialist of Government Affairs with the Division of Nursing Practice and Economics, has reinforced the ANA's position statement, by expounding that legislation to restrict the fees nursing staffing agencies may charge would be detrimental in several ways:

A) It would directly restrict the compensation of nurses employed by the agency. Thus, as a taxpayer, she would not pay as much, and as many taxes.

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801 W. 47TH ST., SUITE 419 • KANSAS CITY, MO 64112 • 816-531-3131

B) It would result in the removal of an important source of wage competition. That's the problem with the nursing profession and our salaries. They've been compressed.

C) It would affect the profession's ability to recruit and retain the required number of nurses to meet the demands for nursing care.

Patricia Prescott, RN, Ph.D., found that agency employed nurses spend more time in direct patient care than did staff nurses, thirteen percent more. She also found that agency nurses shared the burden of off shifts and less desirable days. Agency nurses report a greater control over the basic conditions of work. This control and flexibility in scheduling hours, days and shifts of work, are key factors in job satisfaction, and in nurse retention in the profession. Agency nursing prolongs and lengthens nursing careers. Some of my nurses, if they couldn't work for an agency, or myself, would not be in nursing at all. Agencies are serious about providing quality health care and are doing a very good job.

You can help by 1. Supporting nursing education with grant and loan funding. 2. Oppose any legislation to cap rates and to regulate the nursing industry.

Many of you may know or have family members in hospitals or nursing homes. Don't jeopardize their lives by limiting the amount of nursing care they can receive. Agency nurses want to be there not only to take care of, but to pamper your loved ones. Please extend to us that privilege.

Thank You.

FAVORITE NURSES

Amy Heithoff, R.N., B.S.N.
Branch Director
(816) 531-3131
801 W. 47th St., Suite 419 • Kansas City, MO 64112

GUIDELINES FOR THE USE OF TEMPORARY NURSING SERVICES AS DEVELOPED BY THE AMERICAN NURSE'S ASSOCIATION

FAVORITE NURSES

1. INTRODUCTION

A. In the interest of maintaining quality health care standards, these guidelines are provided to assist:
   1. Favorite Nurses' local offices which supply supplemental nursing personnel.
   2. Health Care institutions which utilize Favorite Nurses' supplemental nursing personnel.
   3. Individual nursing personnel who are placed by Favorite Nurses and assigned to provide nursing services in "utilizing institutions."

B. The departments of nursing of Favorite Nurses, Division of Favorite, Inc., promote safe and therapeutically effective nursing care through implementation of standards of nursing practice as defined in STANDARDS OF ORGANIZED NURSING SERVICES developed by the American Nurses' Association. These provide specifically for registered nurse participation in:
   1. Review and revision of nursing care progress as necessary.
   2. Planning, supervision and evaluation of nursing care of each patient.
   3. Assignment of nursing care of each patient according to needs of the patient and the competence of available staff.
   4. Direct nursing care to patients who require his/her judgment and specialized skills.

C. The use of Favorite Nurses should be implemented when it becomes evident that the level of institutional staffing will fall below a safe level, based on the above standards.

D. Supplemental Nursing personnel are defined as nursing personnel provided by Favorite Nurses to:
   1. Care for a patient on a private duty basis in the home or an institution.
   2. Supplement the nursing staff of a health care agency.

2. MUTUAL PLANNING FOR IMPLEMENTATION

A mutual conference between the directors of nursing of Favorite Nurses and the utilizing institution is recommended in order to define:

A. Classifications of personnel needed.

B. Specific position requirements within each classification to include a written modified job description appropriate to the specific classification of nursing personnel in the utilizing institution.

C. Characteristics of patient population:
   1. type of clinical service
   2. number of patients
   3. level(s) of nursing care required

D. Financial arrangements:
   1. Rates paid by utilizing institution for each classification.
      a. regular hourly
      b. overtime
      c. weekend and holiday
      d. shift differential
   2. Payment procedure

E. Service Coordination Procedure:
   1. Type and extent of supervision provided by utilizing institution and Favorite Nurses.
   2. Name or title of Favorite Nurses individual(s) with whom direct contact may be established on a daily 24 hour on-call basis to handle problems as they may arise.

F. Orientation to the utilizing institution shall be mutally prearranged so as to provide individual nursing personnel with written basic orientation when they report on duty at the utilizing institution. Written basic orientation information shall include, but not be limited to the following:
   1. Personnel policies and procedures:
      a. Eating and comfort facilities.
      b. Where to park and how to report on duty, including how to get there.
      c. Dress code.
      d. Reporting of unusual incidents, injuries, etc.
   2. Patient care policies and procedures:
      a. Identity of, and means of reaching immediate supervisor.
      b. Established criteria/standards for nursing practice and related procedures on the assigned nursing unit.
      c. Patient-care emergency procedure and location of equipment and supplies.
      d. Patient identification system.
      e. Location and activation of fire alarm system.

G. Professional Development:
Both Favorite Nurses and the utilizing institution are expected to encourage supplemental personnel to maintain and keep abreast of current standards of nursing care through continuing education programs, institutes, workshops and seminars offered within the nursing and health care community.

H. Performance Evaluations:
   1. Establish system for individual performance evaluations.
   2. Establish system for review of fulfillment of administrative arrangements by both Favorite Nurses and utilizing institution.

I. Utilization of Personnel:
Except under unusual circumstances, neither the practice of assigning nor utilizing nursing personnel to work two (2) consecutive shifts at the same facility, or two (2) different facilities, shall be condoned.

3. RESPONSIBILITIES OF FAVORITE NURSES

A. In accordance with acceptable professional standards, nursing service of Favorite Nurses shall be under the direction of a licensed registered nurse.

B. The nursing service director of Favorite Nurses should be responsible for developing and implementing nursing service policies, procedures and planning staff development.

C. Preferably registered nurses shall select nursing personnel for assignments and perform follow-up supervision for Favorite Nurses.

D. Assignment of personnel to utilizing institutions shall reflect quality standards of nursing practice, consideration of nursing goals and characteristics of patient assignment. Nursing personnel shall be provided in a manner which promotes quality, continuity and safety of patient care.

E. The supplying agency must document and provide the utilizing institutions with evidence that it holds all appropriate business licenses, has an employer identification number (for the submission of relevant State and Federal Taxes) and carries appropriate worker's compensation and professional liability insurance.

1. Nursing personnel should be utilized in critical care areas only when Favorite Nurses and the institution know the competence of the individual.
2. Supplemental nursing personnel should not be used in nurse positions in any health care agency except in the instances where the institution knows the competence of the individual.
3. Practical nurses who are currently licensed under their respective state's Nurse Practice Act as well as other ancillary nursing personnel may be utilized to give nursing care which does not require the skill and/or judgment of a registered nurse.
4. Licensed Practical Nurses and other ancillary nursing personnel shall be qualified by education, training, experience and demonstrated abilities to give such nursing care; their performance shall be directed by a registered nurse(s).
5. LPNs may be permitted to administer medications in any health care facility provided that they present documentation evidence of having satisfactorily completed an approved course in

medication administration as determined by the hiring institution, unless contrary to hospital policy.

F. Minimum qualifications of supplemental personnel shall be:
   1. Verification of:
      a. identity of each individual.
      b. current state license to practice if employed within a licensed category (registered nurse or licensed practical nurse).
   2. Nurses shall have recently (within past 2 years) completed at least one year of satisfactory clinical nursing experience beyond completion of basic preparation. This clinical experience shall be in the area of nursing practice in which one expects to be employed, e.g., medical/surgical nurses—one year in medical/surgical nursing, delivery room nurses—one year in delivery room nursing.
   3. Ancillary personnel shall have successfully completed a recognized pre-service training program, the appropriate on-the-job training program, or if qualified by experience, have been approved by the registered nurse in charge of the agency.
   4. Satisfactory work references.
   5. Annual medical evaluation with TB skin test and/or chest x-ray and other studies including the lack of communicable diseases, to assure fitness to perform required duties.
   6. Evidence of participation in relevant continuing education.

G. Nurses Aides shall have a minimum of one year practical on-the-job experience; also Nurses Aides are subject to a method of evaluation, supervised and approved with the help of the utilizing institution, by the registered nurse in charge of the agency.

H. Job descriptions for each nursing service position classification should delineate the functions, responsibilities and qualifications for each classification, and should be made available to nursing personnel at the time of employment.

I. Except under unusual circumstances, neither the practice of assigning nursing personnel to work two (2) consecutive shifts at the same facility, nor two (2) different facilities, shall be condoned.

4. RESPONSIBILITIES OF UTILIZING INSTITUTIONS

A. Continuity in placement of staffing shall be the primary consideration in utilizing health institutions.
   1. Written administrative and nursing care policies should be developed to guide the use of supplemental nursing staff toward these goals through realistic and attainable objectives. Nursing care policies and procedures should be consistent with professionally recognized standards of nursing practice, and shall be in accordance with the state's Nurse Practice Act. Policies and procedures shall include statements relating to at least the following:
      a. Established criteria/standards for nursing practice and related procedures on the assigned nursing unit.
      b. Planning for the nursing care of patients, including assignment of personnel.
      c. Administering medications.
      d. Documenting patient care.
      e. Noting diagnostic and therapeutic orders.
      f. Infection control policy.
      g. Patient safety policy.
   2. Licensed personnel shall be utilized in accordance with their current license, education and experience.
   3. Favorite Nurses should be included in the utilizing institutions performance evaluations, with special emphasis for personnel assigned to:
      a. critical care areas
      b. charge nurse positions
      When the performance of an individual is below expectation or suspect, the institution is to immediately relieve the individual. Contact Favorite Nurse.

B. The director of nursing of the utilizing institution shall plan with clinical nursing staff for:
   1. Specific policies governing the utilization of Favorite Nursing services.
   2. Basic orientation information which shall be provided to individual supplemental nursing personnel when they report on duty.
   3. Additional orientation upon arrival of Favorite Nursing personnel to the assigned unit.
   4. Preparation of staff for utilizing Favorite personnel.
   5. Verification of identity of individual Favorite Nursing personnel.
   6. Verification of current State licensure of the individual Favorite Nurses.

5. RESPONSIBILITIES OF INDIVIDUAL NURSES EMPLOYED BY FAVORITE NURSES

A. To Favorite Nurses:
   1. To be currently licensed to practice.
   2. To participate in orientation programs approved by the State's Licensing Authority for Continuing Education.
   3. To report on duty promptly, in full uniform, and in good physical and mental condition.
   4. To demonstrate dependability.
   5. To complete time slips promptly and accurately.

B. To utilizing institution:
   1. To be prepared to present current license and other appropriate identification as may be requested.
   2. To participate in the orientation provided by the utilizing institution.
   3. To review and be familiar with the modified job description provided by the utilizing institution and be accountable for his/her functions within that job description.
   4. To observe policies and procedures including fire, safety and other emergency regulations of the utilizing institutions.
   5. To report on duty promptly in full uniform, and in good physical and mental condition.
   6. To complete billing procedures or time slips promptly and accurately.

C. Responsibility of the individual for her/his scope of practice:
   1. To exercise judgment in accepting or rejecting an assignment.
      a. If the nature of the assignment is beyond the scope of the individual's preparation.
      b. If a physician's order which in his/her judgment is not clear or seems inappropriate.
   2. Documentation of patient care:
      a. To plan, implement, record and evaluate nursing care which supports the medical care plan for each patient.
      b. To chart and report patients' condition and/or problems to the charge nurse or supervisor of the utilizing institution.
      c. To document and forward to the charge nurse or supervisor on duty in the utilizing institution and Favorite Nurses, any unsafe or unacceptable quality of care or behavior of other personnel which she/he may observe.

D. Responsibility of the individual to her/himself:
   1. To abide by standards of ethical practice and conduct as defined in the ANA Code for Nurses.
   2. To utilize recognized Standards of Clinical Practice, as defined by American Nurses' Association and State's Nurses Association.
   3. To keep abreast of changes through active participation in relevant programs of continuing education.
   4. To refrain from working two consecutive shifts at the same facility, or at two different facilities, except under unusual circumstances.
   5. To complete billing procedures or time slips promptly and accurately.

FAVORITE NURSES

by THOMAS ALLEN COS

Nursing Registries and Economic Efficiency

Registries may be used reluctantly, but they *are* used — to the fiscal benefit of the hospital.

No hospital budget would be complete without some written attempt by the nursing department to utilize less Registry help in the upcoming year. This seemingly noble gesture must repeat itself throughout the country, in every hospital, every year. The traditional hospital view of registries is riddled with suspicion and misunderstanding, if not contempt. Registries might be used reluctantly, but they *are* used — and to the fiscal benefit of the hospital.

In discussing the role of registries, we must explore the environment in which most nurses work. Much discussion has been offered that nursing shouldn't be treated the way it is presently, but such normative discussion is of little value. Yet there are some areas of common reasoning that offer clear insight as to how to interact positively in the healthcare system: 1) by viewing objectively the characteristics of the healthcare playing field and 2) by revealing the true nature of a market answer to nursing resource allocation within a community.

Nursing monopsony

For the most part, when we decided to become nurses, we also decided to work in a hospital. The effect of having the majority of nurses involved in hospital settings almost defines nursing itself, i.e., to many, a nurse is someone who works in a hospital.

THOMAS ALLEN COSS, BA, RN, has a Business Degree in Economics and is a popular lecturer at nursing conferences and consultant in managerial and labor economics.

The economic effect that hospitals have on nurses is that they essentially face a relationship known as a monopsony (the single buyer of goods). We all know that a monopoly (a single provider of goods) enjoys a position in the marketplace that suggests that they can charge whatever they want for their goods because the buyer has no alternatives. The buyer must pay the price or simply go without. The monopsonist enjoys a similar position in the marketplace, but as a single buyer instead of a single provider. For example, the producers of Saturn-5 rockets for the Space Shuttle have only one buyer of their goods, the United States Government. Should NASA decide that a Saturn-5 Rocket is worth only $5.00 the producers will simply not make any; if the makers of the rocket decide it is worth one trillion dollars, NASA might just say, "Keep it; and by the way you can't sell it to anyone else."

> **The traditional hospital view of registries is one of suspicion and misunderstanding.**

As mentioned earlier, nursing faces a monopsony. There are many areas in which nurses can work, but the overwhelming majority of nurses work for hospitals. When these hospitals get together and share wage information, they begin to act as a monopsony, and this monopsony can affect what nurses will be paid, as well as what nurses will do. Though we possess the license and expertise of "Nursing," yet effectively face a single buyer of nursing services, who is to dictate what nursing will be? If a nurse chooses not to go along with the *status quo* in hospitals, alternatives are relatively few. Admittedly, the monopsonists' effect isn't absolute, but is sufficient to affect the general market price of nurses, as evidenced by the nursing shortage itself. In many metropolitan areas, where some competition for nurses could exist, hospitals may share salary structures through local hospital associations. In Los Angeles, for example, the Hospital Council of Southern California assists in publishing an annual report on salary structures, which it derives from a poll of its member hospitals. Results are shared among all members who choose to buy the report. The effect of such a publication is difficult to assess quantitatively; however, it is difficult to picture any positive effect for nurses.

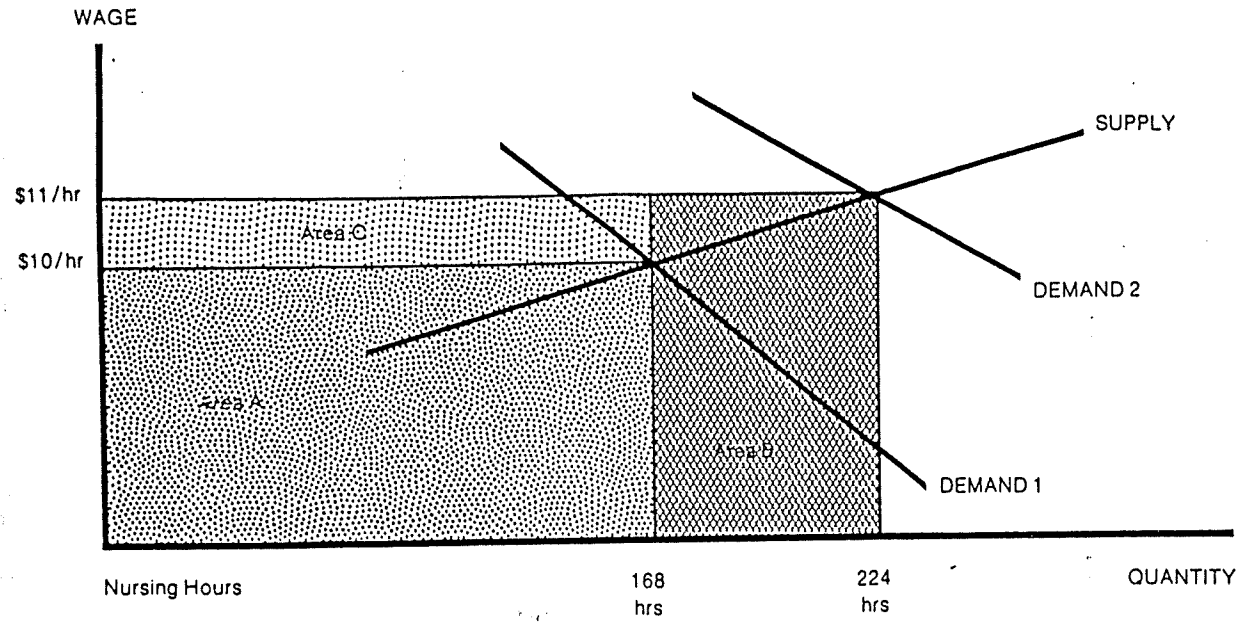
Wage discrimination

Nursing registries are a "market answer" to the intrinsic sluggishness of nursing compensation. They can answer two important questions within the nursing community: just how valuable are nurses, and where are they needed most? The suspicions surrounding nursing registries generally are unwarranted, and the common notion that registries are robbing resources from the hospitals simply is not true.

Nursing registries provide hospitals a mechanism for practicing wage discrimination, i.e., offering different wages to nurses providing

FIGURE I

DYNAMICS OF CENSUS FLUCTUATION



the same service, often at the same time. Each hospital can maintain a minimal nursing staff commensurate with their average daily patient census. Then, when increased census demands, they can augment their staff with registry help. Thus, hospitals need not maintain an under-utilized staff during times of low census. Given hospitals' undying propensity to treat nursing services just like any other variable operating expense, registries should be in the nature of a luxury. However, a close look at the effect of registries suggests that they save hospitals money.

Assume for a moment that registries did not exist in an area faced with a steadily increasing demand for nursing services, i.e., increased patient census. In this scenario all nurses that were willing to work at the prevailing wage have been employed by the local hospital. Now in need of more nurses, this hospital is forced to offer a higher wage in order to entice more nurses to work. As seen in Figure I, the increased demand for nurses is represented by an outward shift in the demand curve (Demand 1 to Demand 2).

This represents a need for one more nurse, or an increase of 56 nursing hours a week (seven days at eight hours a day). If there are no nurses willing to work at $10.00/hr. and no local registries, this hospital would be forced to offer a higher wage in order to attract that nurse. The hospital also runs the risk of paying a new nurse a higher wage than those who have been working there for some time. An even greater risk is the possibility of being forced to raise all nurses' wages, through simple propriety, if not coercion. Reason suggests that if a new nurse is being paid more than those who have been there for some time, problems will arise. This hospital's expenses for nursing staff prior to hiring the new nurse are represented by Area A, representing $1,680 per week ($10 × 168 hrs.). The addition of one more nurse through a registry, Area B, costs $616 ($11 × 56 hrs.). This hospital's new payroll costs would be the sum of areas A and B. With the hospital's ability to wage discriminate by hiring through the registry, the hospital saves $168.00 per week. Area C is the amount that the hospital would surely have to pay once nurses found out that a new nurse was making more. We recognize that registries charge more than the cost of the nurse, but this added expense represents more, the short-term marginal value of the nurse, and affects only the amount of savings or contribution to the capital fund of the hospital. Hospitals can save money by hiring their own nurses, providing these nurses are needed. The use of registry help might be viewed as a good sign of higher than anticipated activity, rather than of poorer than expected management.

Nursing registries are a part of the healthcare system because the marketplace demands them. Registries instill competition in a market where little competition exists, and they are efficient. Nurses who work through registries forego much in the order of security, professional friendships and prestige; but they stay in nursing. Keeping nurses in nursing is a social dividend often overlooked, a dividend that benefits all healthcare consumers. □

9-6

FAVORITE NURSES

SCREENING PROCEDURES

1. **PRE-SCREENING:** The employee is initially pre-screened by phone before an interview is set to assure that the nurse is licensed in the relevant state, and has at least one year of clinical experience, most of which is current within the last year.

2. **LICENSE VERIFICATION:** The nursing license is checked along with the C.P.R. card and a picture I.D. All are copied and kept on file in the local office.

3. **APPLICATION:** An application is completed, including appropriate license verification and past educational and work history.

4. **TESTING:** All licensed applicants are tested for basic nursing expertise and, when appropriate, a relevant specialty test is administered. Nursing assistants are tested with an aide test. A passing grade of 75% or better must be obtained.

5. **INTERVIEWING:** All prospective employees are interviewed by the Director of Nurses, who is a registered nurse. During the interview, emphasis is placed upon work history, nursing expertise and review of the exam. At this time, information and performance requirements are given to the applicant regarding Favorite's policies and procedures, as well as the policies and procedures of the institutions which we serve.

6. **REFERENCES:** At least two work-related references are sent. No Favorite Nurse will be placed without satisfactory references. Telephone references, whenever available, are documented.

7. **HEALTH/TB TEST:** A physician's statement is required signifying that the applicant has had a satisfactory medical examination within the past year. A TB test and/or chest x-ray is also required on an annual basis.

8. **PLACEMENT AND ORIENTATION:** Assignment of employees is made by our Director of Nurses in conjunction with the Favorite staffing coordinators, according to the nurse's skills and the needs of the institution. Exphasis is placed on continuity of service by the same individual whenever possible.

Orientation policies and procedures of the utilizing institutions are adhered to and followed by Favorite Nurses.

9. **EVALUATION:** Per J.C.A.H. recommendations, evaluations of Favorite Nurses are done after the nurse completes 20 shifts in the same institution and at annual intervals thereafter. All evaluations are completed by the Favorite Director in consultation with the supervisory staff of the institution that the nurse services most.

10. **EMPLOYEE FILES:** A complete and current file is kept on all employees; including application, license and CPR certification, test results, references, physician's statement, medical history and any continuing education courses completed. An employee's file also contains appropriate documentation relative to applicant's identity and work authorization as required by INS rules.

11. **CONTINUING EDUCATION:** Favorite Nurses are encouraged to participate in ongoing educational courses by tuition reimbursement as designated by the local office.

12. **SUMMATION:** **Favorite Nurses** complies with all recommendations as set forth by A.N.A. and J.C.A.H.

KHCA
Kansas Home Care Association · 4101 West 13th Street · Lawrence, Kansas 66046 · (913) 841-2833

To: Senate Committee on Public Health and Welfare

From: Linda Lubensky, Kansas Home Care Association

Date: February 28, 1989

Subject: S.B. 184, Nursing Pool Quality Assurance Act

On behalf of the Kansas Home Care Association, I want to thank the Committee for the opportunity to testify today in opposition to S.B. 184, specifically in regards to Section 8's provision for rate setting.

KHCA has always supported reasonable measures in regards to assuring quality within the health care system. However, we are greatly concerned by S.B. 184's attempt to use quality assurance as a vehicle to initiate rate setting for the singular benefit of the adult care home industry.

As with the rest of our nation, the Kansas health care system is feeling the effects of increasing staffing shortages. "Nursing pools" have become a part of our system because the realities of the current marketplace demand them. They provide an important option to the health professional and paraprofessional in offering higher salaries, flexibility, and greater control over work schedules. Although nurses and aides who work through pools forego much in regards to security, professional friendships and prestige, the benefits of the staffing pool concept enable many to remain active in their profession. Keeping nurses and paraprofessionals in their fields is a social dividend often overlooked, a dividend that benefits all healthcare consumers.

Rate setting would severely impact on nursing pools by limiting their ability to competitively bid on the salaries of health professionals and paraprofessionals. Without the nursing pools, flexibility and options are lost, as well as an important source of wage competition. Economic studies have repeatedly shown that improvements in compensation have a noticeable impact on a profession's ability to recruit and retain the numbers necessary to meet the demand. Realistically, rate setting <u>will</u> impact salaries, and, in the long run, compound the staffing shortage problems. The natural process of any competitive market place, that would serve to improve and enhance the professional situations for the nurse, the nurse assistant, and the nurse aide, will have been disrupted.

The provisions detailed in S.B. 184, Section 8, set a precedent that is not only harmful but discriminatory. Is such legislation

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to be the beginning of other salary limits...who will decide what other professions will be singled out? Can we afford to take any steps that will exacerbate our present difficulties in attracting and retaining these health professionals and paraprofessionals in fields long undervalued and under-compensated?

This legislation jeopardizes the options provided by nursing pools. It removes factors which could improve the situation for professions currently in crises. The ramifications of such actions will ultimately be felt by us all. In the Home Care industry, many providers offer staffing services as part of their private duty side. The income generated from this activity helps to offset Medicare losses and provide for cash flow. This cash flow is an important element in an agency's ability to continue patient care and its disruption could have serious effects on other branches operations such as Medicare.

Rate setting is no solution...not for the problems faced by adult care homes, nor for the staffing shortage problems. KHCA urges you to oppose S.B. 184.

Thank you for your consideration. I would be happy to answer any questions or provide any information you might require.

Sincere,

Linda Lubensky

Linda Lubensky
Executive Director

TESTIMONY
KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
WINSTON BARTON - SECRETARY
SB 184

Section 8 of this bill requires SRS to establish maximum rates that registered nursing pools can receive from adult care homes. This puts SRS in the position of establishing rates for a group that we do not purchase services from. In fact, it would establish nursing pool rates for the entire adult care home industry not just those who have Medicaid clients, nor just for the Medicaid client in a home. Currently SRS does establsih a rate that the agency will reimburse a particular provider for a Medicaid or MediKan service. However, these rates set no limits for what providers can charge other clients.

The agency is reluctant to enter this new arena. It certainly changes our fundamental role from one of establishing rates that we will pay for services delivered to our clients to one where we set the rates for an entire segment of providers. This level of govermental control is usually reserved for those services that are granted a monopoly such as public utilities.

This would be an intensive activity that would reqire additional staff. We would need to establish a data base, develop and update rate structures, hear appeals, develop an exception process, monitor compliance and conduct regular audits. The bill is silent on penalties for non-compliance, but surely some mechanism must be put in place to sanction people who violate the maximum rate structure.

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The decision to establish this level of regulation is a weighty one. It establishes a new category of regulations not currently in place.

SRS does not have the staff capacity to carry-out this duty, and has real questions concerning the appropriateness of this as a mission for the agency. In this light SRS would respectively request that if the legislature decides to regulate nursing pools that SRS not be involved in the process. We prefer to continue our role as a purchaser of services instead of a regulator.

KINH Kansans for Improvement of Nursing Homes, Inc.

913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842 3088

TESTIMONY PRESENTED TO
THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE
CONCERNING SB 184

February 28, 1989

Mr. Chairman and Members of the Committee:

KINH has some sympathy with the circumstances which gave rise to SB 184. We recognize, certainly, that the use of nursing personnel from nursing pools is, in general, not desirable from the standpoint of patient care. Temporary employees are unfamiliar with the policies and procedures of the facility engaging them and, even more important, do not know the personalities or needs of the residents they are called upon to care for; their orientation to those matters drains the time and energy of permanent employees, whose efficiency is thus diminished. Temporary employees are costly. The higher wages associated with hiring pool personnel would be better used to hire permanent staff, increasing their benefits and improving their work environment.

Still, they are a fact of life in a time of shortage of qualified nurses and aides. Within the limitations inherent in their temporary status, we have no doubt they offer a needed service and that many, indeed, are versatile and effective employees.

We have no difficulty with the concept of establishing the responsibility of the nursing pool agencies to assure that their personnel are properly registered, licensed or certified according to the standards of their practice, and meet all health standards required by law.

Our principal objection to SB 184 is with Sec. 8, limiting the payment rate to a maximum established by the Secretary of Social and Rehabilitation Services. We do not believe it is fair to isolate certain health care employees for this kind of salary limitation. The only state program we are familiar with that attempts to limit the rates for nursing pool personnel is the Massachusetts system which has a rate-setting commission dealing broadly with regulating health care rates. KINH has no position concerning a rate-setting commission.

We note, also, what appears to be a double standard set out in Sec. 4(b)(3) and Sec. 5 in which the nursing pool's recruitment of new employees from the adult care home is inhibited, but the pool may not limit the recruitment opportunities of the adult care home from among the ranks of the pool agency.

To summarize, KINH would support the concept of registering or otherwise establishing the responsibility of nursing pools to provide qualified temporary help. We oppose limitation of the rates paid to nursing pool personnel.

Since the increasing use of nursing pools is a result of the nurse shortage, we believe that increasing the supply of nurses is essential to relieve the necessity for using pools in the long run, and that paying wages adequate to compete successfully for good nurses and good aides is basic to any solution.

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1786 South Seneca, Suite 7 Wichita, Ks. 67213 / 316-262-CARE

CREATIVE ★ CARE ★

DR. WALTER L. POWERS
President

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K A S H C P POSITION PAPER

The Kansas Association of Supplemental Health Care Providers (KASHCP) opposes Senate Bill No. 184 for the following reasons:

1. Registration of nursing pools by the State Board of Nursing is an unnecessary duplication of the current licensure of such agencies by the State Department of Health and Environment.

2. The proposed corporate disclosure information is already provided annually by law to the Kansas Secretary of State's office and is a matter of public record.

3. Nursing pool personnel already meet all the same state licensing, training, orientation, and continuing education standards required of full-time nursing employees. This is already documented by each agency and by the State Board of Nursing for licensed personnel and the Department of Health and Environment for certificated personnel.

4. By law, nursing pool employees already comply with all regulations of the Department of Health and Environment relating to the health and other qualifications of personnel employed in health care, including a current negative tuberculin skin test or chest x-ray.

5. KASHCP companies incur high costs in the recruitment, training, and placement of their employees. Hence, they believe it only fair that they be compensated if a nursing home or other medical facility recruits and hires one or more of their companies' employees on a full-time basis. Conversely, it is the strict policy of each KASHCP company to prohibit its employees from recruiting employees from any facility to which they are assigned as workers for the KASHCP company.

6. SB 184 proponents' "concern" about quality of care only confuses the real issue...the low level of reimbursement from the Medicaid and Medicare systems. In reality, KASHCP company personnel are all rigorously screened, tested, continuously trained, and constantly evaluated. In addition, all KASHCP companies provide worker's compensation insurance, medical malpractice insurance, as well as general and comprehensive liability insurance for all its employees. It is common practice to provide certificates of insurance to clients using pool services upon request.

7. Importantly, KASHCP companies provide employment for those state certified or licensed medical workers who choose not to work full-time for any one medical entity. A large majority are single parent women who can remain off the welfare roles only because of the extra dollar or two per hour they can earn as supplemental staff relief personnel. A large percentage are minorities who otherwise would earn a substandard wage. Most supplemental workers would not return and work full or part-time in health care if the KASHCP companies were driven out of business by governmental regulation of their rates.

8. KASHCP companies are not part of the nursing shortage problem. They are a large part of the solution by the hundreds of scholarships they provide annually for their employees to become certified or licensed.

9. KASHCP companies are already "regulated" by their very nature of doing business, i.e., health care facilities are under no obligation to use nursing pool services. They can accept or reject services and rates. They can request bids for services since supplemental health care services is a highly competitive business in Kansas.

10. Rate structure comparisons being provided by the proponents of regulation are totally unfair and misleading. They do not take into account the numerous "hidden costs" the average nursing home or other health care facility pays for the services of a staff nurse such as employee benefits, taxes, training, overtime, administrative costs, etc. Yet all these expenses are included (and quoted) in the supplemental staffing agency's rates for inflated comparsion purposes.

11. The allegation that supplemental health care agencies earn "exorbitant profits" is simply not factual and cannot be documented. The average company, if it is profitable at all, earns between 1% and 5% of it's annual gross billings. These financial records are on file in the Secretary of State's office for public scrutiny.

12. Staff relief companies must operate 24 hours-a-day, seven days-a-week, 52 weeks-a-year to meet the emergency needs of medical facilities. Any businessman knows the excess costs involved in operating a 24 hour-a-day business as opposed to an 8 hour-a-day business. Still, Kansas rates for staff relief workers are significantly lower than those of surrounding states.

13. It is important to note that every state (except one, Massachusetts) where similar legislation has been proposed has rejected rate regulations for supplemental health care provider companies including Minnesota, Missouri, Louisiana, Wisconsin, and Washington.

It is our contention that the best interest of the public and nurses are not served by the real intent of SB 184, i.e., rate setting legislation. The number of available nurses and nursing assistants can only be increased by creating market incentives to enter or re-enter the profession. This ultimately will solve the nursing shortage.

TO: Senators on the Public Health and Welfare Committee

Chairperson Roy M. Ehrlich	Vice-Chairperson Audrey Langworthy	
Eugene Anderson	B.D. Kanan	John Strick, Jr.
Paul Burke	Edward F. Reilly	Ben E. Vidricksen
Leroy A. Hayden	Alicia L. Salisbury	Doug Walker

OPPOSITION TO SENATE BILL NO. 184

Thank you for this opportunity to address your committee. My name is Walter L. Powers. I am the president of Creative Care Corporation of Wichita, a supplemental health care staffing agency. Today I am speaking on behalf not only of my company, but of the Kansas Association of Supplemental Health Care Providers (KASHCP), a state-wide trade association of the companies which provide emergency staffing relief for nursing homes and other health care facilities.

I believe I am uniquely qualified to speak to Senate Bill No. 184 since I am involved on both sides of the issue. I am a co-owner of Creative Care Corporation, a nursing pool with offices in Wichita and Topeka, as well as president of Eagle Health Care Corporation, a professional management company, located in Wichita, which operates several nursing homes in Kansas as well as in other states. I employ approximately 500 full-time staff members in the nursing homes I manage, and approximately 300 supplementary, part-time staff relief personnel in my nursing pool business. Both types of workers are absolutely essential to the successful operation of the nursing homes I manage (for several different owners), and I am convinced that passage of SB No. 184 would do irreparable harm to the homes I manage as well as to the nursing home industry in Kansas.

It is quite evident that the real intent of SB No. 184 is to regulate (lower) the wages that supplementary nursing personnel can earn. Every other provision in the bill is a duplication of existing regulations/practices and, I believe, only a "smoke screen" to attain governmental control over rate setting in the supplemental health care staffing industry.

The proponents of SB No. 184 are asking this committee to believe that the current shortage of nursing personnel can be solved by restricting the wages nurses and nursing assistants can earn whether employed by nursing homes or nursing pools. In reality, such a measure would only exacerbate the critical nursing shortage by sending a message to nurses and nursing candidates that their worth in the marketplace will be determined by the state rather than by their education, professional growth and expertise. Common sense tells us that the number of available nurses and nursing assistants can only be increased by the opposite approach...creating market incentives to enter or re-enter the nursing profession.

The proponents of this bill are additionally asking this committee to compare "apples to oranges" when presenting their arguments for regulating nursing pool rates. Specifically, the survey that the Kansas Health Care Association (KHCA) conducted through the offices of the State Department of Social and Rehabilitative Services (SRS) concluded that the average, full-time certified nurse's aide (CNA) [the majority of supplemental worker requested by nursing homes are CNAs] employed by a Kansas nursing home earns $4.63 per hour, while the average nursing pool charged $10.27 per hour for a supplementary CNA. What the proponents have done is quoted the base salary (less the costs of benefits, taxes, insurance, recruitment, training and administrative costs) to keep a full-time CNA employed in a nursing home, while adding these costs to the rates charged by a Kansas nursing pool for a supplementary CNA! As one who employs both full-time CNAs in nursing homes and part-time CNAs in nursing pools, I know the true costs of employing each category of worker. It costs my two companies approximately (depending on geographic location) $7.00 to 7.50 per hour to keep either a full-time or a part-time CNA working on the floor of a nursing home.

It is my understanding KHCA is recommending that nursing pool rates be regulated so that they can charge nursing homes 150% of the average, base pay rate (excluding the costs of benefits, taxes, insurance, recruitment, training and administrative costs) of $4.63 per hour for a CNA or $6.94 per hour (which is .06 to.50 less per hour than the actual cost of keeping a CNA on the floor of a nursing home). This recommendation completely ignores the following additonal costs which both a nursing home and a nursing pool incur to employ a CNA (or an RN, LPN, CMA, or any health care worker):

FICA (Social Security Taxes)
FUTA (Federal Unemployment Taxes)
State Unemployment Taxes
Medical Malpractice Insurance
Workman's Compensation Insurance
Paid Vacation Time
Mandatory In-Service Training Costs
Sick Leave Benefits
Paid Holidays
Meals Allowance
Uniform Allowance
Health Care Benefits
Excess Liability Insurance
Employee Benefits Liability
Underlying Professional Liability
Advertising/Recruitment Costs
Orientation Costs
Scholarships/Schooling
Unscheduled Overtime Premium Costs

By adding these real costs to the average base pay rate of $4.63 per hour for a full-time nursing assistant (as quoted by KHCA), the true pay rate average is

$7.25 per hour. Now, if you apply KHCA's proposed 150% rate regulation to the true hourly rate of keeping a CNA on the floor, then the nursing pool would recieve $10.88 per hour as its regulated rate. Ladies and gentlemen, my company currently charges its clients $9.00 per hour for a CNA. I would be delighted to accept a $1.88 per hour increase in my rates! However, even with a raise in rates, I and the Kansas Association of Supplemental Health Care Providers are vehemently opposed to any governmental regulation of private enterprise.

Also, the allegation of "exhorbitant profits" earned by nursing pool companies simply doesn't hold up. Public records in the Kansas Secretary of State's office clearly demonstrate that, if profitable at all, nursing pool companies earn between 1% and 5% of their annual gross billings. My own company earned a 4% profit in FY 1988 through very conservative management.

For these and numerous other valid reasons, the following states have rejected proposed legislation to regulate the rates of supplemental health care provider companies: Colorado, Connecticut, Minnesota, Wisconsin, Washington, Louisiana, and Missouri.

It is the conviction of the KASHCP membership that governmental regulation of their rates to nursing homes:

(a) will drive full-time nursing personnel out of nursing homes (since their wages will also be indirectly restricted by this proposed legislation) and into unregulated nursing positions where they can benefit from market incentives;
(b) will force the nursing pools out of an unprofitable market;
(c) will worsen the already intolerable nursing shortage in nursing homes;and,
(d) will postpone action by the legislature on the real issue facing all health care providers...the low level of reimbursement from the Medicaid and Medicare systems which is both a state and a national problem.

I sincerely appreciate having had this opportunity to address your committee, and am willing to respond to any questions your membership may have for me.

Message from Kansas Governor Mike Hayden

Hayden

Dear Kansas Business Owner:

We in Kansas are committed to the improvement of our state's economy, and we recognize the important role that small business plays in that effort.

The state of Kansas is virtually a state of small business, with over 98 percent of our businesses employing less than 100 employees. Because of this concentration of small businesses, we realize that every effort must be made to keep these firms starting, growing, and thriving in Kansas. This can only be accomplished through the cooperation of the local, state and federal governments working together with the private sector, a goal to which we are committed.

The entrepreneurs involved with small businesses are truly the pioneers of today. The risks that must be overcome to operate a successful small business are often substantial; the State of Kansas helps to encourage small business development by creating a favorable business climate which minimizes those risks.

I look forward to the continued success of small business in Kansas and the continued cooperation between the public and private sectors toward a strong and vital Kansas economy.

Sincerely,
Mike Hayden
Governor

From the February 13,1989
Edition of
The Wichita Business Journal

KANSAS PROFESSIONAL NURSING HOME ADMINISTRATORS ASSOCIATION

3601 West 29th
Topeka, Kansas 66614
Phone: 913—273-4393

February 16, 1989

Walter Powers
% Creative Care
1786 So. Seneca, Suite 7
Wichita, KS 67213

Dear Walter:

RE: SB 184: Nursing Pool Quality Assurance Act

KPNHAA's Legislative Committee has met regarding many issues facing this year's legislators. It has been the decision of the committee that KPNHAA is not supporting the action sited in the above bill. We are not taking an official position on this issue of any kind.

Discussion from our committee produced the suggestion of either written or verbal communication with those people involved in the nursing pools to present the concerns of our association so that communication might be enhanced in areas of accountability and responsibility for those temporary help personnel be addressed. But this we wanted done on an informal basis and not to be controlled through legislation.

Sincerely,

Jane E. Smith

Jane E. Smith
President, KPNHAA

JES/mp

cc: Smith
Legislative Committee
Office file

CODE OF ETHICS

1. Creative Care employees abide by all the rules and regulations of the state, Creative Care, and each client agency which govern their duties and responsibilities.

2. Creative Care employees work diligently to provide only the highest quality care and services, and graciously accept evaluations of their work.

3. Creative Care employees consistently strive to upgrade their skills and competencies with a personal and professional growth plan.

4. Creative Care employees are totally honest, forthright, and accountable in all their dealings with Creative Care and each client agency.

5. Creative Care and its employees will not discriminate on the basis of race, creed, color, national origin, sex, age, or physical handicap.

6. Creative Care employees are receptive to guidance and counseling services to help improve their work performance.

7. Creative Care employees attend staff development seminars and in-service training programs to keep current in the latest developments in their fields of specialization.

8. Creative Care employees accept only those assignments which are position-appropriate for them.

9. Creative Care employees are scrupulously confidential concerning both patient and client agency information entrusted to them.

10. Creative Care employees are actively involved in helping to improve standards of patient care and in helping to control health care costs.

11. Creative Care and its employees will not knowingly misrepresent their services.

12. Creative Care employees will consistently strive to ensure the safety of those entrusted to their care, and will immediately report any incident of patient abuse or suspected abuse according to law.

13. Creative Care employees will safeguard the property of the client agency used in the performance of their duties.

14. Creative Care employees will not engage in any conduct detrimental to the best interests of the patient, client, co-workers, or Creative Care.

15. Creative Care employees will promote a positive working climate and good public relations for all client agencies.

16. Creative Care and its employees are good citizens and supportive of their local communities.

LITHO IN U.S.A.

EMPLOYMENT PROCEDURES

CREATIVE ★ CARE ★

1. Employees shall be hired by written application/personal interview in the following manner:

   a. application must be made in person;
   b. applicant will be screened for competence at the time of application;
   c. all references will be checked prior to acceptance for employment;
   d. resumes will be accepted only with a written application;
   e. applicant must qualify for position(s) sought per job description(s); and,
   f. applicant may be requested to complete a skills inventory to demonstrate stated competencies.

2. All new employees must attend orientation prior to their first Creative Care job assignment where:

   a. policies and procedures will be explained;
   b. job descriptions will be reviewed;
   c. staff development/in-service responsibilities will be explained; and,
   d. any questions/concerns will be addressed.

3. Employees must agree to keep Creative Care informed of their availability or they will be dropped from the active file.
4. Once assigned to a job opportunity, an employee has the first option of continuing in that job so long as needed by the client agency. If, however, an employee declines to continue, the job is immediately open to any Creative Care employee who wants and is qualified for it. The single exception to this policy would be if a client agency requested that the initial employee not be returned to the job.
5. It is the employee's responsibility to maintain accurate time slips, i.e., with correct time worked, signature of both client and employee, and office copy returned to Creative Care no later than Monday of the following week. Payment for services rendered cannot be made without correct time slips.
6. Payday will be every other Friday provided:

   a. time slips have been correctly submitted; and,
   b. pay is requested only for jobs (shifts) scheduled by Creative Care.

7. Overtime at the rate of time and one-half will be paid for all hours worked over forty per week, beginning with the first shift worked on Saturday and ending with the last shift worked on Friday.
8. Overtime at the rate of time and one-half will be paid for the following holidays: New Year's Day; Easter Sunday; Memorial Day; Fourth of July; Labor Day; Thanksgiving; and Christmas. The only exception is that third shift New Year's Eve will receive holiday pay instead of third shift New Year's Day.
9. Employees will be evaluated periodically by the Creative Care staff with input from employing agencies. The employee will be given a copy of any evaluation and an opportunity to respond to it. Evaluations will include:

   a. job performance/competency
   b. punctuality
   c. personal appearance
   d. attitude
   e. problems/concerns
   f. commendations
   g. professional goals/growth.

10. Counseling meetings with employees shall be scheduled as required with a copy of the results given to the employee who shall have the opportunity to respond.
11. Grounds for termination of an employee's association with Creative Care include, but are not limited to:

    a. incompetence;
    b. violation of state rules/regulations
    c. violation of employing agency's policies;
    d. violation of Creative Care's policies;
    e. "no call, no show";
    f. possession/consumption of alcohol or drugs while on-the-job, or working under their influence; and,
    g. insubordination.

12. Employees of Creative Care may not bill client agencies nor accept gifts or monies from client agencies.

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DRESS CODE FOR NURSING PERSONNEL

As a representative of Creative Care, you are expected to appear, act, and dress professionally at all times. In order to accomplish this, all nursing personnel will comply with the following dress code:

1. you are expected to practice effective daily hygiene;
2. you must wear a clean white uniform, free of stains, tears, and wrinkles;
3. we expect you to know, and wear, appropriate lingerie and hose;
4. your hair must be clean, neat, and worn off the collar;
5. clean white shoes are required (black is acceptable for men);
6. jewelry must be kept to a minimum, with only a watch (with a second hand) and wedding ring preferred; and,
7. you must wear your Creative Care name pin.

DRESS CODE FOR ANCILLARY PERSONNEL

As a representative of Creative Care, you are expected to appear, act, and dress professionally at all times. In order to accomplish this, all ancillary personnel will comply with the following dress code:

1. you are expected to practice effective daily hygiene;
2. you must wear clean navy blue/black slacks/skirt, free of stains, tears, and wrinkles;*
3. you must wear a clean white blouse/shirt, also free of stains, tears, and wrinkles;*
4. we expect you to know, and wear, appropriate lingerie and hose;
5. your hair must be clean, neat, and worn off the collar;*
6. shoes must be enclosed, clean, and polished;
7. jewelry must be kept to a minimum, with only a watch and wedding ring preferred; and,
8. you must wear your Creative Care name pin.

*NOTE: Dietary personnel must wear white uniforms and a hair net.

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REGISTERED NURSE JOB DESCRIPTION

To work as a Creative Care RN, you must currently be licensed in the State of Kansas, preferably with one or more years of experience. The RN will be assigned to a nursing home, hospital, or other medical facility to provide staff relief, where he/she will be responsible to the charge nurse or other designated supervisor. The RN will be responsible and accountable for making decisions and performing procedures based on his/her educational preparation and nursing experience. Job responsibilities will include, but not be limited to:

1. performing nursing procedures for which he/she is professionally prepared such as administering medications, doing treatments, changing dressings, administering oxygen, and assisting with intravenous procedures;
2. providing for basic patient needs such as hygiene, grooming, nutrition, exercise, comfort, and rehabilitation;
3. receiving and transcribing physician's orders;
4. competently recording all pertinent information;
5. receiving and giving report;
6. notifying superiors of changes in patient's condition;
7. providing postmortem care; and,
8. safeguarding equipment and supplies.

The experienced RN may also be required to perform other procedures and treatments allowable under state law/regulations and the employing agency's policies such as starting intravenous fluids and blood transfusions, drawing blood, and performing CPR. RN's with proven competency may also be assigned as relief charge nurses or team leaders.

The RN employed by Creative Care may not perform any procedure for which he/she is not trained and licensed. Additionally, the RN accepts full responsibility for his/her actions/performance, as well as:

1. provides Creative Care with copies of all documents necessary to verify training, licensing, and experience;
2. provides Creative Care with evidence of health status as required;
3. provides Creative Care with the name and the policy number of malpractice insurance held;
4. attends orientation and all staff development programs;
5. works competently within his/her job description;
6. complies with all state regulations;
7. accepts only those assignments for which he/she is qualified;
8. keeps Creative Care informed of his/her availability;
9. communicates with Creative Care about problems/concerns; and,
10. complies with the employing agency's and Creative Care's policies and procedures.

Periodically your work performance will be evaluated by the Creative Care professional staff with input from employing agencies.

Creative Care is a company which provides part time employment only. It cannot guarantee any amount of working hours for any time period. It will work diligently to find temporary employment opportunities for you. Creative Care is not responsible for your transportation to and from any job; this is your responsibility. It is also your responsibility to secure and wear the correct uniform to perform your duties.

I have read, understand, and accept this job description.

_____
Signature

_____
Date

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LICENSED PRACTICAL NURSE JOB DESCRIPTION

To work as a Creative Care LPN, you must currently be licensed in the State of Kansas, preferably with one or more years of experience. The LPN will be assigned to a nursing home, hospital, or other medical facility to provide staff relief, where he/she will be under the direct supervision of a charge nurse (or the director of nurses if placed in a charge position). The LPN will be responsible and accountable for making decisions in the care of patients based on his/her educational preparation and nursing experience. Job responsibilities will include, but not be limited to:

1. providing for emotional/spiritual needs, and for patient safety;
2. assisting in the assessment, planning, implementation, and evaluation of patient care;
3. performing nursing procedures for which an LPN is prepared including assisting with baths, oral hygiene, grooming, TPR, B/P, eating, ambulation, exercising, transferring, rehabilitation, dressing, catheter care, oxygen administration, and postmortem care;
4. recording competently all pertinent observations and treatments;
5. admitting and discharging patients;
6. assisting with physical examinations, and with pre and postoperative care;
7. giving and receiving reports;
8. caring for patients in isolation;
9. informing appropriate supervisor of changes in patient's condition;
10. safeguarding supplies and equipment; and,
11. keeping accurate records of care provided.

The experienced LPN may also be required to take telephone orders, perform CPR, administer medications, or perform other treatments/procedures allowable under state law/regulations and the employing agency's policies.

The LPN employed by Creative Care may not perform any procedure for which he/she is not trained and licensed. Additionally, the LPN accepts full responsibility for his/her actions/performance, as well as:

1. provides Creative Care with copies of all documents necessary to verify training, licensing, and experience;
2. provides Creative Care with evidence of health status as required;
3. provides Creative Care with the name and policy number of malpractice insurance held;
4. attends orientation and all staff development programs;
5. works competently within his/her job description;
6. complies with all state regulations;
7. accepts only those assignments for which he/she is qualified;
8. keeps Creative Care informed of his/her availability;
9. communicates to Creative Care about problems/concerns; and,
10. complies with the employing agency's and Creative Care's policies and procedures.

Periodically your work performance will be evaluated by the Creative Care professional staff with input from employing agencies.

Creative Care is a company which provides part time employment only. It cannot guarantee any amount of working hours for any time period. It will work diligently to find temporary employment opportunities for you. Creative Care is not responsible for your transportation to and from any job; this is your responsibility. It is also your responsibility to secure and wear the correct uniform to perform your duties.

I have read, understand, and accept this job description.

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Signature

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Date

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CERTIFIED MEDICATION AIDE/ORDERLY JOB DESCRIPTION

Training and state certification as a nurse aide/orderly required. Documented training and current certification as a certified medication aide. The certified medication aide/orderly is assigned *ONLY* to a nursing home or convalescent center for staff relief, where he/she will be under the supervision of a charge nurse (or of the director of nurses if the CMA is placed in a charge position). The CMA will assist in providing quality nursing care by performing those nursing tasks for which he/she is trained and certified. Job responsibilities will include, but not be limited to:

1. assisting with bathing, eating, exercising, range of motion, ambulation, preparation for surgery, and postmortem care;
2. providing oral hygiene, personal care (hair, nails, etc.), and morning/evening care;
3. turning/positioning patients, as well as transferring patients to bed, chair, and commode;
4. giving bedpans/urinals and back rubs;
5. taking and reporting TPR and blood pressure;
6. cleaning of a patient's unit;
7. making occupied, unoccupied, and preoperative beds;
8. measuring/recording intake and output;
9. supervising activities of daily living;
10. applying hot water bottles and ice bags;
11. safeguarding supplies and equipment;
12. informing charge nurse of changes in patients' condition; and,
13. keeping accurate records of observations and care given.

In addition, the CMA, under the supervision of a licensed nurse, may;

1. administer approved medications; and,
2. give approved treatments.

A Creative Care CMA/orderly may not perform any procedure which requires a professional nursing license. Furthermore, a CMA/orderly may not perform any procedure for which he/she is not trained. Additionally, as an employee of Creative Care it is the responsibility of the CMA/orderly:

1. to provide Creative Care with copies of all documents necessary to verify training and experience;
2. to provide Creative Care with evidence of required physical examinations prior to employment;
3. to provide Creative Care with the name and policy number of malpractice insurance held;
4. to attend orientation and all required in-service training;
5. to keep Creative Care informed of his/her availability;
6. to work within one's job description; and,
7. to abide by all rules and regulations of the state, of the employing agency, and of Creative Care.

Periodically your work performance will be evaluated by the Creative Care professional staff with input from others in a supervisory and administrative capacity.

Creative Care is a company which provides part time employment only. It cannot guarantee any amount of working hours for any time period. It will work diligently to find temporary employment opportunities for you. Creative Care is not responsible for your transportation to and from any job; this is your responsibility. It is also your responsibility to secure and wear the correct uniform to perform your duties.

I have read, understand, and accept this job description.

_____
Signature

_____
Date

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CREATIVE
★ CARE ★

NURSE AIDE/ORDERLY JOB DESCRIPTION

Training as a nurse aide/orderly and state certification are required. The nurse aide/orderly will be assigned to a nursing home or hospital for staff relief, where he/she will be under the supervision of a charge nurse. The nurse aide/orderly will assist in providing quality nursing care by performing those tasks for which he/she is trained. Job responsibilities will include, but not be limited to:

1. assisting with bathing, eating, exercising, range of motion, ambulation, preparation for surgery, and postmortem care;
2. providing oral hygiene, personal care (hair, nails, etc.), and morning/evening care;
3. turning/positioning patients, as well as transferring patients to bed, chair, and commode;
4. giving bedpans/urinals, and back rubs;
5. taking and reporting TPR and blood pressure;
6. cleaning of a patient's unit;
7. making occupied, unoccupied, and preoperative beds;
8. measuring/recording intake and output;
9. supervising activities of daily living;
10. applying hot water bottles and ice bags;
11. safeguarding supplies and equipment;
12. informing charge nurse of changes in patients' condition; and,
13. keeping accurate records of observations and care given.

A Creative Care nurse aide/orderly may not administer medication nor perform any procedures which require a professional nursing license. Furthermore, a nurse aide/orderly may not perform any procedure for which he/she is not trained. Additionally, as an employee of Creative Care it is the responsibility of the nurse aide/orderly:

1. to provide Creative Care with copies of all documents necessary to verify training and experience;
2. to provide Creative Care with evidence of required physical examinations prior to employment;
3. to provide Creative Care with the name and policy number of malpractice insurance held;
4. to attend orientation and all required in-service training;
5. to keep Creative Care informed of his/her availability;
6. to work within one's job description; and,
7. to abide by all rules and regulations of the state, of the employing agency, and of Creative Care.

Periodically your work performance will be evaluated by the Creative Care professional staff with input from others in a supervisory and administrative capacity.

Creative Care is a company which provides part time employment only. It cannot guarantee any amount of working hours for any time period. It will work diligently to find temporary employment opportunities for you. Creative Care is not responsible for your transportation to and from any job; this is your responsibility. It is also your responsibility to secure and wear the correct uniform to perform your duties.

I have read, understand, and accept this job description.

_____
Signature

_____
Date

13-15

K A S H C P POSITION PAPER

The Kansas Association of Supplemental Health Care Providers (KASHCP) opposes Senate Bill No. 184 for the following reasons:

1. Registration of nursing pools by the State Board of Nursing is an unnecessary duplication of the current licensure of such agencies by the State Department of Health and Environment.

2. The proposed corporate disclosure information is already provided annually by law to the Kansas Secretary of State's office and is a matter of public record.

3. Nursing pool personnel already meet all the same state licensing, training, orientation, and continuing education standards required of full-time nursing employees. This is already documented by each agency and by the State Board of Nursing for licensed personnel and the Department of Health and Environment for certificated personnel.

4. By law, nursing pool employees already comply with all regulations of the Department of Health and Environment relating to the health and other qualifications of personnel employed in health care, including a current negative tuberculin skin test or chest x-ray.

5. KASHCP companies incur high costs in the recruitment, training, and placement of their employees. Hence, they believe it only fair that they be compensated if a nursing home or other medical facility recruits and hires one or more of their companies' employees on a full-time basis. Conversely, it is the strict policy of each KASHCP company to prohibit its employees from recruiting employees from any facility to which they are assigned as workers for the KASHCP company.

6. SB 184 proponents' "concern" about quality of care only confuses the real issue...the low level of reimbursement from the Medicaid and Medicare systems. In reality, KASHCP company personnel are all rigorously screened, tested, continuously trained, and constantly evaluated. In addition, all KASHCP companies provide worker's compensation insurance, medical malpractice insurance, as well as general and comprehensive liability insurance for all its employees. It is common practice to provide certificates of insurance to clients using pool services upon request.

7. Importantly, KASHCP companies provide employment for those state certified or licensed medical workers who choose not to work full-time for any one medical entity. A large majority are single parent women who can remain off the welfare roles only because of the extra dollar or two per hour they can earn as supplemental staff relief personnel. A large percentage are minorities who otherwise would earn a substandard wage. Most supplemental workers would not return and work full or part-time in health care if the KASHCP companies were driven out of business by governmental regulation of their rates.

8. KASHCP companies are not part of the nursing shortage problem. They are a large part of the solution by the hundreds of scholarships they provide annually

for their employees to become certified or licensed.

9. KASHCP companies are already "regulated" by their very nature of doing business, i.e., health care facilities are under no obligation to use nursing pool services. They can accept or reject services and rates. They can request bids for services since supplemental health care services is a highly competitive business in Kansas.

10. Rate structure comparisons being provided by the proponents of regulation are totally unfair and misleading. They do not take into account the numerous "hidden costs" the average nursing home or other health care facility pays for the services of a staff nurse such as employee benefits, taxes, training, overtime, administrative costs, etc. Yet all these expenses are included (and quoted) in the supplemental staffing agency's rates for inflated comparsion purposes.

11. The allegation that supplemental health care agencies earn "exorbitant profits" is simply not factual and cannot be documented. The average company, if it is profitable at all, earns between 1% and 5% of it's annual gross billings. These financial records are on file in the Secretary of State's office for public scrutiny.

12. Staff relief companies must operate 24 hours-a-day, seven days-a-week, 52 weeks-a-year to meet the emergency needs of medical facilities. Any businessman knows the excess costs involved in operating a 24 hour-a-day business as opposed to an 8 hour-a-day business. Still, Kansas rates for staff relief workers are significantly lower than those of surrounding states.

13. It is important to note that every state (except one, Massachusetts) where similar legislation has been proposed has rejected rate regulations for supplemental health care provider companies including Minnesota, Missouri, Louisiana, Wisconsin, and Washington.

It is our contention that the best interest of the public and nurses are not served by the real intent of SB 184, i.e., rate setting legislation. The number of available nurses and nursing assistants can only be increased by creating market incentives to enter or re-enter the profession. This ultimately will solve the nursing shortage.

American Nurses' Association
Washington Office

AMERICAN NURSES' ASSOCIATION

Statement on Fee Restrictions for Nurse Staffing Agencies

Nurse staffing agencies provide the services of nurses to health care employers on a temporary full-time or part-time basis. These agencies have become important components of nursing employment and the nursing labor market. In part, this growth reflects the proliferation of temporary employment in the U.S. economy generally. The growing reliance of health care employers on nurse staffing agencies also reflects the impact of the current nursing shortage, the evening, night and weekend employment requirements and the lack of flexible scheduling in nursing. Nurses are attracted to agencies for higher wages and the ability to control their work schedules. For that, they sacrifice job security and benefits offered by traditional employment opportunities.

Because of the increased demand for nurses and the resulting nursing shortage, agencies are raising per diem rates paid to nurses in order to attract sufficient numbers of nurses to meet the staffing needs of health care employers. Consequently, agencies are raising the rates charged health care employers. Efforts are being made to establish maximum rates that can be charged by nurse staffing agencies. Legislation to restrict the fees agencies may charge has been proposed or enacted in several states, and similar legislation may be proposed at the federal level as well.

The American Nurses' Association opposes the introduction of fee restrictions which would, in effect, restrict the compensation of nurses employed by nurse staffing agencies. Such actions will also result in the removal of an important source of wage competition. Economic studies have repeatedly documented that improvements in compensation have a demonstrable impact on the profession's ability to recruit and retain the required number of nurses to meet the demand for nursing care. Thus, fee restrictions on nurse staffing agencies which affect nurses' compensation will, in the long run, delay the resolution of the nursing shortage.

ANA Cabinet on Nursing Services
ANA Cabinet on Economic and General Welfare

August, 1988

American Nurses' Association
Washington Office 1101 14th Street, N.W. Suite 200 Washington, D.C. 20005 (202) 789-1800
ANA – An Equal Opportunity Employer

by THOMAS ALLEN COSS

Nursing Registries and Economic Efficiency

Registries may be used reluctantly, but they *are* used — to the fiscal benefit of the hospital.

No hospital budget would be complete without some written attempt by the nursing department to utilize less Registry help in the upcoming year. This seemingly noble gesture must repeat itself throughout the country, in every hospital, every year. The traditional hospital view of registries is riddled with suspicion and misunderstanding, if not contempt. Registries might be used reluctantly, but they *are* used — and to the fiscal benefit of the hospital.

In discussing the role of registries, we must explore the environment in which most nurses work. Much discussion has been offered that nursing shouldn't be treated the way it is presently, but such normative discussion is of little value. Yet there are some areas of common reasoning that offer clear insight as to how to interact positively in the healthcare system: 1) by viewing objectively the characteristics of the healthcare playing field and 2) by revealing the true nature of a market answer to nursing resource allocation within a community.

Nursing monopsony

For the most part, when we decided to become nurses, we also decided to work in a hospital. The effect of having the majority of nurses involved in hospital settings almost defines nursing itself, i.e., to many, a nurse is someone who works in a hospital.

THOMAS ALLEN COSS, BA, RN, has a Business Degree in Economics and is a popular lecturer at nursing conferences and consultant in managerial and labor economics.

The economic effect that hospitals have on nurses is that they essentially face a relationship known as a monopsony (the single buyer of goods). We all know that a monopoly (a single provider of goods) enjoys a position in the marketplace that suggests that they can charge whatever they want for their goods because the buyer has no alternatives. The buyer must pay the price or simply go without. The monopsonist enjoys a similar position in the marketplace, but as a single buyer instead of a single provider. For example, the producers of Saturn-5 rockets for the Space Shuttle have only one buyer of their goods, the United States Government. Should NASA decide that a Saturn-5 Rocket is worth only $5.00 the producers will simply not make any; if the makers of the rocket decide it is worth one trillion dollars, NASA might just say, "Keep it; and by the way you can't sell it to anyone else."

The traditional hospital view of registries is one of suspicion and misunderstanding.

As mentioned earlier, nursing faces a monopsony. There are many areas in which nurses can work, but the overwhelming majority of nurses work for hospitals. When these hospitals get together and share wage information, they begin to act as a monopsony, and this monopsony can affect what nurses will be paid, as well as what nurses will do. Though we possess the license and expertise of "Nursing," yet effectively face a single buyer of nursing services, who is to dictate what nursing will be? If a nurse chooses not to go along with the *status quo* in hospitals, alternatives are relatively few. Admittedly, the monopsonists' effect isn't absolute, but is sufficient to affect the general market price of nurses, as evidenced by the nursing shortage itself. In many metropolitan areas, where some competition for nurses could exist, hospitals may share salary structures through local hospital associations. In Los Angeles, for example, the Hospital Council of Southern California assists in publishing an annual report on salary structures, which it derives from a poll of its member hospitals. Results are shared among all members who choose to buy the report. The effect of such a publication is difficult to assess quantitatively; however, it is difficult to picture any positive effect for nurses.

Wage discrimination

Nursing registries are a "market answer" to the intrinsic sluggishness of nursing compensation. They can answer two important questions within the nursing community: just how valuable are nurses, and where are they needed most? The suspicions surrounding nursing registries generally are unwarranted, and the common notion that registries are robbing resources from the hospitals simply is not true.

Nursing registries provide hospitals a mechanism for practicing wage discrimination, i.e., offering different wages to nurses providing

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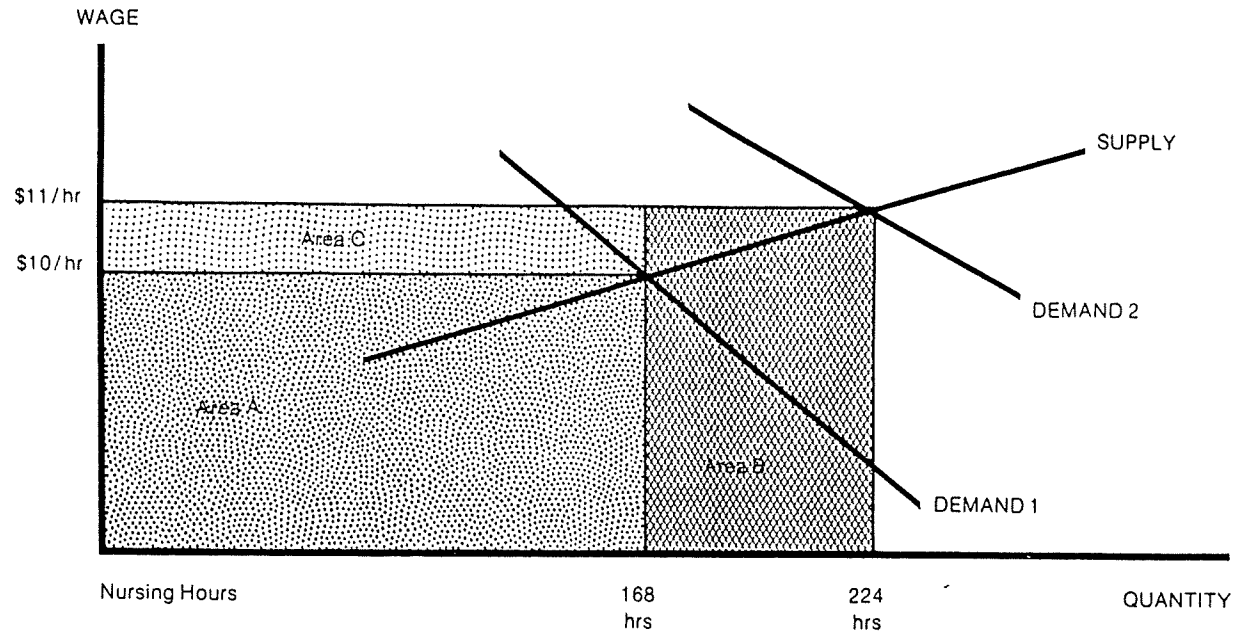
FIGURE I

DYNAMICS OF CENSUS FLUCTUATION



the same service, often at the same time. Each hospital can maintain a minimal nursing staff commensurate with their average daily patient census. Then, when increased census demands, they can augment their staff with registry help. Thus, hospitals need not maintain an under-utilized staff during times of low census. Given hospitals' undying propensity to treat nursing services just like any other variable operating expense, registries should be in the nature of a luxury. However, a close look at the effect of registries suggests that they save hospitals money.

Assume for a moment that registries did not exist in an area faced with a steadily increasing demand for nursing services, i.e., increased patient census. In this scenario all nurses that were willing to work at the prevailing wage have been employed by the local hospital. Now in need of more nurses, this hospital is forced to offer a higher wage in order to entice more nurses to work. As seen in Figure I, the increased demand for nurses is represented by an outward shift in the demand curve (Demand 1 to Demand 2).

This represents a need for one more nurse, or an increase of 56 nursing hours a week (seven days at eight hours a day). If there are no nurses willing to work at $10.00/hr. and no local registries, this hospital would be forced to offer a higher wage in order to attract that nurse. The hospital also runs the risk of paying a new nurse a higher wage than those who have been working there for some time. An even greater risk is the possibility of being forced to raise all nurses' wages, through simple propriety, if not coercion. Reason suggests that if a new nurse is being paid more than those who have been there for some time, problems will arise. This hospital's expenses for nursing staff prior to hiring the new nurse are represented by Area A, representing $1,680 per week ($10 × 168 hrs.). The addition of one more nurse through a registry, Area B, costs $616 ($11 × 56 hrs.). This hospital's new payroll costs would be the sum of areas A and B. With the hospital's ability to wage discriminate by hiring through the registry, the hospital saves $168.00 per week. Area C is the amount that the hospital would surely have to pay once nurses found out that a new nurse was making more. We recognize that registries charge more than the cost of the nurse, but this added expense represents more, the short-term marginal value of the nurse, and affects only the amount of savings or contribution to the capital fund of the hospital. Hospitals can save money by hiring their own nurses, providing these nurses are needed. The use of registry help might be viewed as a good sign of higher than anticipated activity, rather than of poorer than expected management.

Nursing registries are a part of the healthcare system because the marketplace demands them. Registries instill competition in a market where little competition exists, and they are efficient. Nurses who work through registries forego much in the order of security, professional friendships and prestige; but they stay in nursing. Keeping nurses in nursing is a social dividend often overlooked, a dividend that benefits all healthcare consumers. □

Lin Carney Weeks
Elisabeth Vincent Tsubai
V. Randolph Gleason
Carol Ann Cavouras

Hospitals and Agencies: Allies or Adversaries?

Hospitals and temporary staff agencies have historically engaged in adversarial relationships. The current nursing shortage, however, mandates that opportunities be created for collaboration, not conflict. This article describes a pilot program developed by a Houston medical center teaching hospital and a supplemental staffing agency that collected information about the competency of agency nurses.

Most nursing and other healthcare executives would agree that a competent nursing staff deters litigation as well as ensures patient satisfaction and compliance with regulatory and government standards. Although competence can be readily defined (del Bueno, 1978; del Bueno, Barker, & Christmyer, 1980; Hall, 1980), its measurement is problematic. Furthermore, for an individual nurse to be judged competent by physicians, patients, families and other nurses, a complicated array of factors must be measured. Primary among these factors is the manner in which the nurse performs skills with a perceived measure of self-confidence.

Certain components of an individual's actions can be audited or measured. For example, one can measure whether a nurse follows hospital policy in connection with selected technical skills by identifying critical elements of a procedure and observing the nurse's compliance with those criteria. Or one can review documentation pertaining to the care of a patient on a concurrent or retrospective basis. But critical thinking — not only doing the thing right, but doing the right thing — is based on a combination of experience, knowledge, skill, intuition, and ego strength (Benner, 1984; del Bueno, 1983; del Bueno & Kelly, 1980; Fenton & Steele, 1986).

Historically, educators have measured nursing ability by paper and pencil testing of individual knowledge. But sufficient literature exists to support the point that although competence and knowledge clearly are related, knowing what to do does not mean that it will be done (del Bueno, 1983; del Bueno & Kelly, 1980; Weeks & Spor, 1987). The measurement of competence must lie then in what individual nurses do with what they know.

In 1984, Hermann Hospital, a 908-bed teaching hospital in Houston, Texas, purchased a commercially available system (Performance Based Development System, Travenol, Inc.) and developed a method by which all new nurses would be oriented to their specialties (del Bueno, Weeks, & Stewart, 1987; Weeks & Spor, 1987). Upon employment, both new graduates and experienced nurses are assessed in three areas of nursing specific to their specialties: technical skills, critical thinking, and interpersonal relationships. This multiple assessment takes place in the Hermann Assessment Center and permits a sampling of the skills required for competent practice and development of a learning plan that is based upon that assessment. Figure 1 depicts the process of learning, practicing, and validating. For experienced nurses, the process may be completed in less than

LIN CARNEY WEEKS, MS, RN, is Administrative Director, Hospital Education, Hermann Hospital, Houston, TX.

ELISABETH VINCENT TSUBAI, MS, RN, is Instructor, Hospital Education, Hermann Hospital, Houston, TX.

V. RANDOLPH GLEASON, JD, is General Counsel, Hermann Trust/Hermann Hospital, Houston, TX.

CAROL ANN CAVOURAS, MS,RN, is Vice President, Nursing Affairs, Hermann Hospital, Houston, TX.

ACKNOWLEDGMENT — The authors wish to acknowledge the contributions provided by Jody Blumberg, RN, Vice President, Carlton Medical Specialists, Houston, TX.

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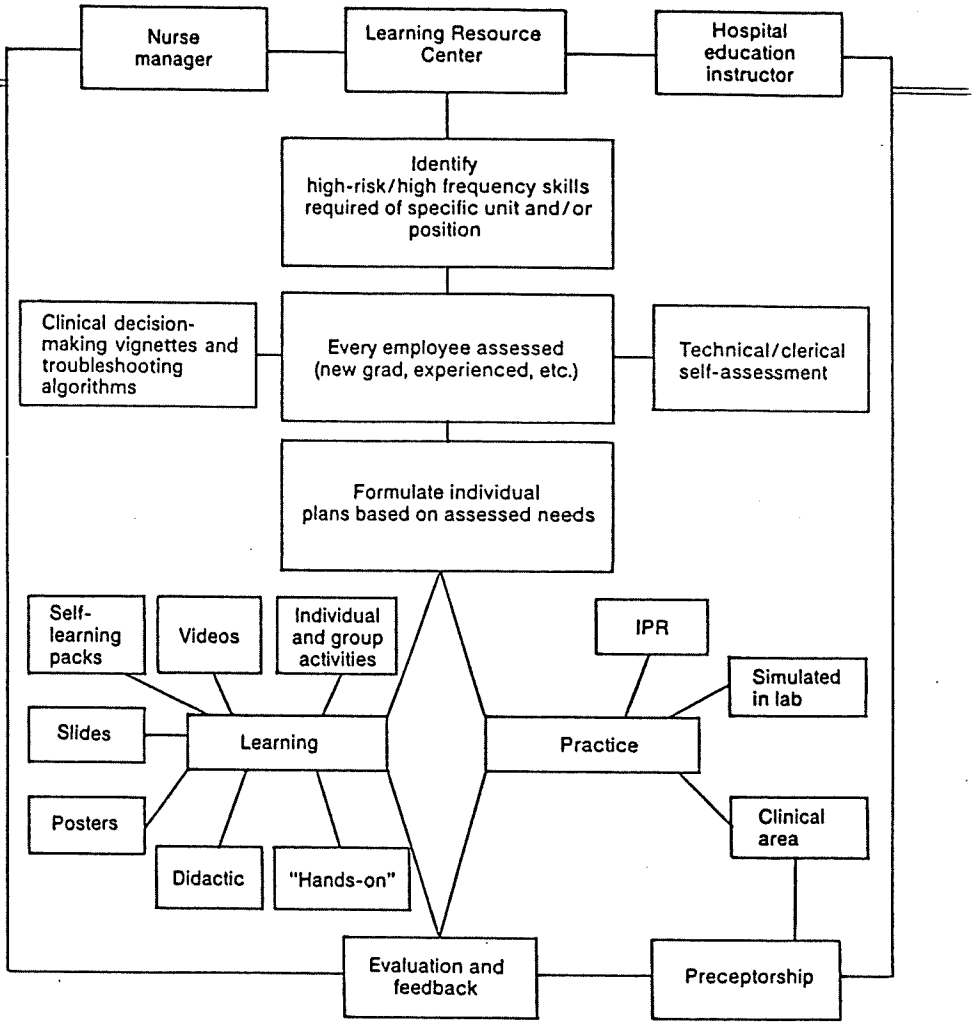
Figure 1. Blueprint of Learning Resource Center Orientation for New Licensed Employees (RNs and LVNs)



5 days while inexperienced nurses may require several weeks or months.

Because orientation is performance based and must vary with the needs of the individual, our experience has demonstrated that orientation time frames may not be predictable. For example, a nurse without previous experience in a specialty may require more time than a new graduate to become competent in the same specialty. Since the assessment tools can be used for learning as well as assessment, learning options such as self-learning packages, media, small group exercises and games are stored in the Assessment Center and used by new or current employees.

The initial investment in the performance-based development system has yielded excellent results. Overall, the cost of orienting groups of new employees to critical care has been decreased by approximately 25%. The major cost reduction has been accomplished through elimination of unnecessary classroom instruction (Weeks & Spor, 1987). New employees consider the orientation to be a strength of the hospital and appreciate the brevity, individuality, and practicality of the program. Nurse managers are more comfortable with the overall perceived competence of new employees and flexibility of the program. Although the need for didactic education remains, the cost of providing such education has decreased without affecting the quality of the educational program at Hermann (Weeks & Spor, 1987). Additional benefits have included team building among nurses in orientation programs, enhancement of communication skills and training of unit-based preceptors — a critical link in the orientation process.

Statement of the Problem

In mid-1986, staffing shortages at Hermann Hospital forced the nursing administration to break an over 10-year tradition by contracting with supplemental staffing agencies to provide coverage. Many factors contributed to the staffing shortages experienced at the hospital — factors that are no different from the social, economic and political issues creating the current national shortage (Aiken & Mullinix, 1987). The situation at Hermann is further exacerbated by Houston's economic recession and Hermann's location in the Texas Medical Center, a complex of 36 institutions where competition for nurses is fierce.

The decision to bring agency staff into the institution solved one problem: the number of nurses available to provide care increased immediately. But the solution created new problems. The hospital had little or no knowledge of the competence of agency nurses. Although systems were established to provide assurance of licensure, cardiopulmonary resuscitation certification, and knowledge of medications, there was no practical way to assure overall baseline competence for agency nurses working at Hermann Hospital. The hospital

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works with as many as seven agencies, each of which assigns nurses all over the Texas Medical Center. Furthermore, the supplemental agencies' high fees made the hospital want to be sure it was not using nurses of questionable competence.

In the eyes of the hospital staff nurse, the double bind continues. While staff nurses may appreciate the good intentions of hospital administration in its attempt to provide for safe nursing care, they nevertheless observe an individual who is earning more but who knows little or nothing about the institution and may be perceived as incompetent in the specialty of assignment. Also, because the hospital nurse may not work with the same agency nurse twice in one month, there is little opportunity to develop relationships.

Historically, hospitals and supplemental staffing agencies have competed for bedside nurses. When shortages occur, the competition becomes fierce and tensions rise between agencies and hospitals. Because our need was so great at Hermann Hospital, we decided to pursue a pilot program that would benefit us and the supplemental staffing agency.

The Hospital/Agency Program

A pilot program between Hermann Hospital and Carlton Medical Specialists, a supplemental staffing agency, was designed to gather information regarding the competence of registry nurses. Following a series of contract negotiation meetings between hospital and agency representatives, a contract between Hermann and Carlton Medical Specialists was signed. This agreement contained more than the basic elements of such contracts, such as a description of the service to be provided, cost of the service, and the agreed period of time covered by the contract.

Provisions were made to reduce the probability of an untoward occurrence rather than only to plan how to spread the risk of loss in the event of liability. Such provisions included: (a) a requirement that the agency screen and assess all nurses before assigning them to the hospital, (b) mandatory hospital orientation and skills assessment in Hermann's Assessment Center for all assigned agency nurses, (c) designation of hospital supervisory staff for ongoing evaluation of agency nurses in collaboration with agency supervisory staff, (d) mandatory health screening of agency nurses for certain communicable diseases, and (e) an absolute power on the part of the hospital to dismiss immediately and without recourse any agency nurse deemed by the hospital to be unacceptable.

Due to liability considerations raised by Hermann's legal counsel, additional contract provisions were negotiated in order to better manage the hospital's risk of liability related to the activities of the agency nurses.

To reduce the hospital's workers compensation exposure, the agreement provided that the agency nurses would be considered employees of the agency only and that the agency would carry workers compensation insurance. This provision could also serve well to reduce the hospital's risk of vicarious liability for negligent acts of agency nurses; yet to afford further protection, the agency agreed to maintain $1 million of professional liability insurance coverage for itself and its nurses.

The Process

Once the contract was finalized, a series of meetings were held with the agency's vice president, the administrative director of hospital education, and the assessment center staff. A proposal for the assessment process was developed that listed the options available in the areas of technical/clerical, critical thinking, and interpersonal skills. The assessment specifically included the critical care, intermediate care, and general medical/surgical areas.

Product review. In addition, the entire line of educational products was reviewed to give a clear picture of the total process and to suggest options for meeting needs that might be identified during the assessment process. These products include: (a) learning via a variety of options (self-paced modules, videotapes, slide programs, directed study, and/or didactic presentations); (b) practice of skills in the simulated setting; (c) validation of skills according to criterion checklists containing the critical elements of each skill; and (d) structured clinical practicums (focused on identified learning needs and preceptor-guided).

The decision was made to focus on the assessment of technical/clerical and critical thinking (clinical judgment) skills. Several options for interpersonal skills assessment were proposed but deferred because the results were less objective than the other two categories and the analysis was considered too time-consuming. The next step involved selecting the specific tools to design a suitable assessment "package."

Instruments. The technical/clerical instrument was a self-assessment of competence in "high risk/high frequency" skills, using a checklist format. High risk is defined as a potential hazard to the patient or institution if the skill is not performed according to critical criteria. High frequency indicates

Figure 2. Example of Selected Critical Care Skills Checklist

Self-Assessment				
For each skill listed, answer the two questions indicated. Competence means that you are able to perform safely, legally, correctly, and efficiently.	Have you ever done this skill?		Do you feel competent performing?	
Technical/Clerical Skill				
Airway: Nasal				
Airway: Oral				
Ambu bag: Bag to tube				
Ambu bag: Bag to mask				
Arterial puncture				
Blood product administration				
Cardiac monitor: Portable				
Cardiac monitor: Nurse's station				
Cardioversion				
Central line care				
Chest tubes: Set-up				

that the skill is performed at least weekly. Skills checklists from Hermann's critical care, intermediate care, medical, and surgical nursing resource pools were used. The checklist asks the participant to answer two questions regarding each skill: "Have you ever performed this skill?" and "Do you feel competent (performing this skill)?" An affirmative answer to both questions indicates learning and/or practice are not required and the participant may move directly to a simulated situation or to the clinical area to validate performance of the skill. Validation of skills performance was not done formally because of constraints of time and money. An answer of "yes/no" indicates the need for practice or review of the skill, and an answer of "no/no" indicates the need for learning. Participants were advised to be candid because the results would be dealt with constructively, rather than punitively. Examples of the skills checklists are demonstrated in Figure 2.

Critical thinking or clinical judgment was assessed using two types of instruments. Clinical judgment vignettes are video simulations of hospitalized patients in which actors play the parts of patients. Each vignette lasts approximately 2 minutes and contains a number of visual and auditory cues, clues, signs, and symptoms. Very little verbal direction is given. The participant must synthesize the information and answer in writing two questions: (a) What is the patient's priority problem? and (b) What immediate nursing actions (in order of priority) should be taken to correct, reduce, or modify the identified risk to the patient? These vignettes can be mixed and matched to provide a sample of clinical problems representative of a particular area. Assessment samples usually consist of 10 to 15 vignettes.

The other type of instrument used for clinical judgment/critical thinking is the troubleshooting algorithm. These algorithms are useful for assessing the ability to identify problems and initiate effective actions associated with specific invasive technologies/modalities such as intravenous (IV) lines, arterial lines, pulmonary artery catheters, cardiac monitors, and dysrhythmia recognition. The algorithms show common problems that can occur with these invasive technologies. The participant is asked to identify, in writing, the problem and effective action(s) to solve the problem. For example, the arterial line algorithm includes problems of dampened waveform and air on the transducer.

Preparation time. Preparation time for the assessment of the agency nurses' group identified in Tables 1-5 was approximately 30 hours and included meetings, proposal development, selection and preparation of tools, evaluation summary development, memoranda, telephone calls, and clerical time.

Conducting the Assessment

Upon completion and approval of the package design, the actual assessments were ready to be scheduled. Because explanation of the assessment process to participants is important, a 1-hour introduction was given to each of two large groups of agency nursing staff. The assessments themselves were done in four small proctored groups, each on a separate date. Assessment time averaged 4 hours per participant. Each nurse was paid his or her hourly salary by the agency, and Hermann Hospital re-

Table 1. Clinical Judgment Vignettes — Critical Care Results

	% Priority Problems	% Interventions	Median Score
#1 RN	100	100	100
#2 RN	90	80	85
#3 RN	85	90	87.5
#4 RN	85	95	90
#5 RN	100	80	90
#6 RN	85	75	80
#7 RN	75	65	70
#8 RN	95	100	97.5
#9 RN	70	90	80
#10 RN	85	80	82.5
#11 RN	75	75	75
#12 RN	100	100	100
#13 RN	95	95	95
#14 RN	85	90	87.5
#15 RN	90	85	87.5
#16 LVN	60	50	55

Situations reviewed: Hypovolemic shock, congestive heart failure, blood transfusion reaction, peritonitis, pulmonary edema, hyperglycemia, disseminated intravascular coagulation, brochospasm after extubation, adult respiratory distress syndrome (advanced series), diabetes insipidus (advanced series).

	Cardiac Monitors	Arterial Lines	Pulmonary Artery Catheters	Dysrhythmia Recognition
#1 RN	100	100	80	80
#2 RN	80	80	85	85
#3 RN	92.5	100	97.5	77.5
#4 RN	100	100	100	82.5
#5 RN	92.5	100	80	87.5
#6 RN	100	70	100	87.5
#7 RN	77.5	80	82.5	85
#8 RN	100	97.5	67.5	95
#9 RN	97.5	100	65	87.5
#10 RN	100	80	70	80
#11 RN	100	100	70	95
#12 RN	100	100	97.5	95
#13 RN	100	100	87.5	90
#14 RN	100	100	70	80
#15 RN	100	100	96	95
#16 LVN	52.5	87.5	57.5	32.8

ceived a per capita consultation fee from the agency. Twenty-three nurses (RNs and LVNs) were assessed, 16 in critical care, 2 in intermediate care, and 5 in medical-surgical skills.

Analysis. The most difficult part of the process was the analysis of the assessment data, particularly the clinical judgment answers, which took considerable time. Each answer had first to be compared to a "model" answer and notations made, then given to another reviewer to ensure objectivity. A detailed analysis (largely qualitative) of the response to each vignette and algorithm problem was prepared in summary form regarding each participant and forwarded to the agency. The summaries were strictly descriptive of the participants' ability to identify problems in simulation. No reference was made to perceived ability or level of competence; the purpose of the assessment was to provide information only. The technical/clerical analysis was somewhat simpler and easily quantified.

The assessment center staff spent a total of 14.5 hours analyzing the data and preparing the summaries. Each participant's summary was reviewed with the agency's vice president who was satisfied with the information format and overall results. The vice president, in turn, reviewed the summaries with each participant.

Results

The technical/clerical results were summarized by tallying the number of skill responses to each question ("yes/yes," "yes/no," "no/no"). Specific skills that required learning and/or practice were listed for each participant. However, most of the participants' self-reported competence in the majority of skills listed. Because

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Table 3. Clinical Judgments Vignettes — Medical/Surgical Results

	% Priority Problems	% Interventions	Median Score
#1 RN	95	90	92.5
#2 RN	85	85	85
#3 RN	80	70	75
#4 RN	65	50	57.5
#5 RN	100	90	95

Situations reviewed: Diabetic ketoacidosis, acute abdomen, increased intracranial pressure, transient ischemic attack, alcohol withdrawal, blood transfusion reaction, hypoglycemia, bleeding disorder, hypovolemic shock, hepatic failure, sepsis, probable myocardial infarction, asthma.

Table 4. Troubleshooting Algorithm — Medical/Surgical Results, IV Troubleshooting

	% Priority Problems	% Interventions	Median Score
#1 RN	100	100	100
#2 RN	80	85	82.5
#3 RN	80	75	77.5
#4 LVN	80	70	75
#5 RN	100	100	100

Table 5. Clinical Judgment Vignettes — Intermediate Care Results

	% Priority Problems	% Interventions	Median Score
#1 LVN	90	85	87.5
#2 LVN	75	80	77.5

Situations reviewed: Increased intracranial pressure, acute renal failure, blood transfusion reaction, hypertensive crisis, pulmonary embolism, acute MI, pericarditis, digitalis toxicity, lidocaine toxicity, pneumothorax.

this is a self-assessment or self-reporting exercise, evaluation of skill competence can only be done by observing performance of the skill. Validation of skill performance was not provided for in the contract and therefore not done. The self-reporting exercise was included in the assessment package to try and pinpoint learning and practice needs with the option for the agency to purchase validation of skills competency as an additional product.

The results of the clinical decision-making vignettes and algorithms are contained in Tables 1-5. Competence is defined here as the ability to recognize priority problems and interventions (in simulation). Of the total 23 participants, 17 were able to make clinical decisions using the video vignettes (see Tables 1, 3, and 5). The results for the troubleshooting algorithms are demonstrated in Tables 2 and 4.

Because our operational definition of competence for assessment is "the ability to do the job" and all of the nurses had been working at Hermann for varying lengths of time, the results of the assessment were considered by the agency and the hospital in relation to the employees' past performance as well as the current requirements of their jobs. Those agency employees, who did not meet the assessment criteria but were found to be meeting performance standards and job expectations in the clinical setting, did not need further learning. However, the assessment results were reviewed individually with each participant for the purpose of pointing out potential problems; this in itself provides learning.

As shown in Tables 1 and 2, one LVN's performance was unacceptable in both the troubleshooting algorithms and identification of priority problems. The role of the LVN within critical care is necessarily limited by licensure; thus ability to interpret dysrhythmias or to monitor physiological status is not a job expectation.

Evaluation and Summary

A total of 23 registry nurses (18 RNs and 4 LVNs) were assessed during the pilot. The total time investment by the Hermann staff was 20 hours for assessment and 14.5 hours for analysis and preparation of reports. For the agency, the direct cost included the consultation fee paid to the hospital for the project as well as indirect costs incurred by the agency's vice president due to meetings with the agency's staffing coordinator and nurses before and during the project.

The project was considered successful for the following reasons.

First, based on our experience with using the critical thinking exercises to predict clinical success and based on the role of the individual agency nurses in the assigned areas, there were no instances in which the assessment revealed deficits requiring action by the hospital or staffing agency. On the part of the agency, there were no surprises. The results confirmed their established perceptions of employees' abilities and learning needs, that is, the agency received "validation" for the competence of its nurses. Anecdotal

and direct comments from the agency nurses indicated enthusiasm for the assessment process and a sense of satisfaction with their performance and self-perception of competence.

Second, the project was helpful to the agency's image. The agency's vice president received calls from nurses working for other agencies who expressed willingness to work for Carlton if they could participate in the project.

Third, the project and its results were received positively within our institution. Developing such a program demonstrated both our understanding of the problems incurred by using supplemental staff and our desire to resolve the problems. However, although managers and staff thought the assessment pilot was a good idea, they repeatedly expressed the need to put *all* agency nurses through the assessment center.

Conclusions

The current nurse shortage is by all estimates more serious than the previous ones and is predicted to have a more lasting effect (Aiken & Mullinix, 1987). Historically, supplemental staffing agencies have been considered arch enemies of hospitals. Our profession will survive the turbulence of these times only if we rid ourselves of previous biases and create opportunity for collaboration, not conflict. Through this experience with Carlton Supplemental Staffing Agency, we have found that a hospital and a staffing agency can become allies and can develop a symbiotic relationship. Currently, we are working with another supplemental staffing agency on a similar program. In this next phase, we plan to double the assessment time (8 hours per nurse) in order to perform generic skill validations but believe the time and expense to be well worth the cost. $

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LETTERS

N.U.R.S.E.
Nurses United for a Responsible Safe Health-Care Environment
To the Editor:

We are the founding members of N.U.R.S.E. — Nurses United for a Responsible Safe Health-Care Environment. In response to the recent AMA proposal for the creation of a new health-care worker and in response to the American Nurses' Association's (ANA) request to have nurses at a grassroots level begin to oppose this proposal, we established this organization. Our objectives are generally to keep the members of the nursing profession and the members of the lay public aware of how this proposal impacts on the delivery of health care in this nation.

We held a rally in Philadelphia at the Judge Lewis Quadrangle, at the site of the Liberty Bell, September 29. To support our cause we would appreciate your publishing this letter and our attached mission statement in your journal.

Thank you for your assistance in this matter.

Gloria J. McNeal, MSN, RNC, CCRN
Joe Hovanes, RN, DIP
Philip Dominic, RN, ADN
Directors of N.U.R.S.E.

N.U.R.S.E.
MISSION STATEMENT

We, the founding members of N.U.R.S.E., believe that our mission is to expedite the dissemination of clear, factual information, regarding the AMA-RCT Proposal, in an organized and timely manner to all nurses. We are a grassroots organization composed of registered nurses from all three levels of basic preparation, and represent all areas of nursing practice. Through the utilization of the communications media, the channels of professional nursing organizations, and the support of lay organizations sensitive to nursing issues, we intend to present the facts in an unbiased manner. We are *not* endorsed by any one group of organized nursing; but rather we are a collective group of nursing professionals striving toward one goal.

We propose to conduct our mission by

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Another Round of Nurse Shortage

Patricia A. Prescott

Interest in inadequate nurse staffing of hospitals waxes and wanes, and yet staffing appears to be a chronic problem. This persistent and often severe shortfall in the number of nurses has received considerable attention from at least two perspectives: economics and nursing. Efforts to reconcile the economic and professional views of nursing have been frustrated, in part because of the complex and fundamentally different conceptualizations of the problem and its solutions. Previous approaches to relieving shortages have relied heavily on recruitment of nurses from a large pool of new graduates. This reliance on recruitment without simultaneous concern for retention actually may have contributed only to making shortages worse.

This paper seeks to highlight the views of the economic and nursing perspectives and to apply key concepts from each toward an understanding of the nurse shortage in hospitals. The current situation is placed in the context of previous shortages, and the consequences of selected efforts to deal with nursing shortages in hospitals are discussed.

Economic Perspectives on Nurse Shortage

A shortage exists when the demand for something exceeds the supply available at a specific market price (Yett, 1975). The key terms are "supply," "demand," and "price," each of which has a precise meaning in economics. Supply, for example, refers to the number of available workers; demand is differentiated from want or need and refers to the employer's willingness to purchase a quantity of workers or services at a prevailing wage or price. Demand for hospital nursing services often is measured as budgeted, unfilled positions for which an employer is actively recruiting.

Basic to the economic perspective are assumptions regarding how markets operate, with price being inversely related to supply, and with supply, demand, price and employment level constantly adjusting toward equilibrium in a competitive marketplace. There are numerous economic models that depict these and other factors predictive of labor force participation (Feldstein, 1979; Schramm, 1982; Sloan, 1975; Sloan & Richupan, 1975; Yett, 1975).

It has been argued that the operation of nurse labor markets is not well explained by economic models. There are a number of reasons for this. Of particular importance to interpreting imbalances in supply and demand is the idea that the nurse labor market is not fully competitive because of monopsony or oligopsony. Monopsonistic or oligopsonistic market conditions exist when there are too few employers to stimulate meaningful wage competition. Under these conditions wages are artificially restrained, and they do not operate to balance supply and demand as in a freely competitive market. In a competitive market, when demand increases, so do wages to attract the needed supply. In an oligopsonistic market, however, wages are artificially set and do not freely rise in response to changes in demand. As Yett (1975) has demonstrated, under these conditions employers will express demand in excess of the supply that the prevailing wage will purchase; that is, they would like to hire more nurses, but they are not willing to raise wages sufficiently to do so. The excess demand is expressed as vacant positions that the employer wishes to fill at the prevailing wage. While full explanation of this phenomenon is beyond the scope of this paper, its importance lies in the fact that vacant positions may be in part an artifact of market conditions rather than a true indicator of a shortage.

Yett (1975) describes two types of nurse shortage: "equilibrium," resulting from oligopsonistic market constraints, and "dynamic," resulting from imbalances between supply and demand. This distinction is important because the appropriate solutions for the shortage depend in part on the type of shortage. In an equilibrium type of shortage, the logical solution is to remove wage constraints so that rising wages will balance supply and demand. Yett argues that the traditional approach to solving the nurse shortage has focused mistakenly on increasing the supply of new nurses entering the market. This approach may actually have increased the problem by further holding down wages, which normally would be expected to rise relative to other wages to attract new nurses into the labor market (Aiken & Blendon, 1981; Yett, 1975).

Others (Bognanno, Hixson & Jeffers, 1974; Sloan & Richupan, 1975) have argued that the nursing shortage is not caused primarily by depressed wages because of oligopsonistic markets. Instead, they attribute the shortage to geographic maldistribution, the functioning of local rather than national markets, the "inelastic" nature of the nurse market, and demographic factors predictive of labor force participation.

Within the economic perspective on nurse manpower there are a variety of models and viewpoints. While all are concerned with supply, demand, price, and quantity of goods and/or services, there are few unambiguous conclusions that can be drawn. Whether or not the nurse market is oligopsonistic, economists have debated as to whether or not the market is inelastic (Sloan & Richupan, 1975). Some who suggest that nurse markets are inelastic argue that increasing wages for nurses only drives down the number of hours that nurses are willing to work. This explanation is based on the argument that the nurse market is relatively insensitive to wage changes (inelastic) (Bognnano, Hixson & Jeffers, 1974). It would mean that nurses determine the extent of their participation in the labor force more in terms of spouse income, age of children, and other sociodemographic factors than they do in terms of wages.

Despite their differences, economists share a global perspective concerned with the aggregate functioning of nurse markets. This perspective is important for determining policy, especially at the federal level; for example, the economic orientation of the Nurse Education Act, by subsidizing nursing education, has steadily increased the supply of Registered Nurses entering the market.

Economic theories and models used to study nursing manpower are useful for understanding the operation of national markets and shifts in the aggregate supply and/or demand. The-

PATRICIA PRESCOTT, R.N., Ph.D., *Alpha Eta*, is Professor and Chair of the Graduate Department of Psycho Physiological Nursing at the University of Maryland School of Nursing. Correspondence to School of Nursing, 655 W. Lombard Street, Baltimore, MD 21201.

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and models developed using one un... of analysis, however, ...en are not directly transferable to another unit of analysis (Burnstein, 1980; Hannan, 1971; Herman & Hulin, 1972; Roberts & Burnstein, 1980; Rousseau, 1982). Thus predictors of labor force participation at the level of individual hospitals may not be useful in understanding nurse shortages at other levels of analysis such as at the aggregate national level. For example, turnover among nurses is often cited as a cause of nursing shortages. By definition, this is true at the institutional level since nurses who resign create vacant positions at that hospital. At the aggregate level, however, turnover does not explain nursing shortages unless nurses who leave their position in a particular hospital also leave the labor force for other occupations or join the inactive pool of nurses and hence withdraw from the market.

Turnover data suggest that the large majority of nurses who leave their jobs do not leave nursing; rather they take a similar job in another hospital, usually in the same local nurse market (Aiken, 1982; Weisman, 1982; Weisman, Alexander & Chase, 1981). Supporting this view are data from a study conducted from 1980 to 1984. Staff nurses who resigned from selected patient care units in 15 hospitals in various geographic regions of the country were interviewed by phone and asked to complete a brief questionnaire regarding both their reasons for resigning and their current employment status.[1] Of the nurses who participated, 89 percent ($N = 111$) were employed in some capacity in another hospital, and 8 percent were employed outside of the hospital but were still in nursing and hence were not lost to the labor market (Prescott & Bowen, 1987). This shows that turnover functions much like a revolving door at the aggregate level and therefore is not a cause of shortage at that level, as it is in institutions.

This lack of isomorphism of theories from one unit of analysis to another is important because administrators and others attempting to deal with institutional shortages often have applied the aggregate economic perspective to the strategies that they have pursued. In particular, many nurse and hospital administrators have assumed that turnover is both inevitable and beyond the control of hospitals because nurses' decisions about participation in the labor force are determined largely by sociodemographic factors beyond the hospital's control. This assumption has fostered "supply side" solutions to the shortage in hospitals as well as at the national level. The inevitability of turnover assumption is played out by focusing hospital efforts on recruitment of new nurses rather than on retention of existing staff members. Data indicate, however, that much turnover is not inevitable; nurses in the study actually gave more work-related than nonwork-related reasons for their resignations. Most frequently mentioned were scheduling factors—days, shifts and hours of work. Other factors in descending order of importance were problems with administrators, especially head nurses; a lack of stimulation and dissatisfaction with the practice of nursing; inadequate salary; poor nurse staffing; the desire for new experiences; and problems in staff interpersonal relationships (Prescott & Bowen, 1987).

The success of the approach that emphasizes recruitment over retention rests on four conditions: (a) a steadily available and increasing supply of new nurses; (b) economic conditions that make it less costly to replace rather than retain staff; (c) the assumption that nurses essentially are interchangeable employees; and (d) the assumption that adding new nurses to fill vacant positions will solve the hospital nursing shortage. Before a discussion on the viability of these assumptions, it is important to turn to the nursing literature to examine the perspective with which nursing views the shortage problem.

Nursing Perspectives on Nurse Shortage

From the perspective of nursing, the definition of the term "shortage" is an ...adequate number of nurses ...re for patients at some professionally determined level of adequacy. This definition is quite different from that used in economics because it includes the concepts of need and want, which are excluded in the economic definition. The nursing perspective considers some of the same factors identified in the economic view such as wages and benefits, but, given the broad definition of shortage implicitly used in nursing discussions, it is not surprising that this perspective attributes shortage to a wide range of conditions reflecting job dissatisfaction. While different authors order factors somewhat differently, there is remarkable consistency in their lists, which may be grouped into three general categories: (a) salary and benefits, (b) control over basic working conditions (e.g., hours, days, shifts and units and adequate numbers and the correct mix of nursing and support personnel), and (c) professional issues (including control over nursing practice, adequate autonomy for patient care, respect from others, especially physicians and administrators, and opportunities for growth and promotion). A fourth factor found in some shortage discussions is change in hospital demand for nursing as a result of increasingly complex technology, increasing patient acuity, and changing patient demographics, especially age (Aiken, 1982; American Hospital Association [AHA], 1981, 1987; American Nurses Association [ANA], 1983; Fagin, 1980; Institute of Medicine, 1981; Jacox, 1982; Prescott, Dennis, Creasia & Bowen, 1985).

In general most of the factors cited in the literature have to do with why nurses are dissatisfied with their particular jobs in hospitals. These factors are relevant to understanding shortages at the institutional level through the link between job dissatisfaction and turnover since nurses leave particular hospitals because they are dissatisfied. However, as long as they simply move around among employers, and do not change fields within nursing or leave the occupation altogether, job dissatisfaction and turnover do not explain nurse shortage at the aggregate level of analysis.

Interestingly, although the professional literature has focused primarily on the institutional level and has identified job dissatisfaction, the action strategies of individual hospitals seem mostly concerned with solutions drawn from the aggregate economic perspective—increasing the nurse supply via recruitment—and are only secondarily concerned with addressing the job dissatisfaction, or retention. While there are exceptions, and some efforts to improve working conditions and provide for advancement are seen in the form of flexible scheduling options, development of career ladders and the like, the reason these factors have not been more seriously addressed is economic (Sloan, 1975). To explain, it is necessary to understand the concept of marginal costs and how they influence salary and benefit decisions.

A hospital with empty nurse positions to fill has two choices: It can raise nursing salaries in the hope of attracting new nurses to the hospital or it can seek per diem assistance; hiring the needed nurses on a temporary basis. Often, to get the needed supplemental nurses, hospitals have chosen the second approach even though they may pay as much as twice the hourly rate paid to regular staff members. The reason this approach is chosen is it costs less for the hospital to hire some highly paid workers than it would to raise the wages of *all* of the regular staff members to the level required to recruit nurses to fill vacant positions on a permanent basis. Consider a hypothetical hospital with 200 nursing positions and 50 vacancies. If temporary services were used to fill the 50 vacancies, the cost for one eight-hour shift (with staff nurses being paid $10/hr plus 20% fringe benefits and agency nurses being paid $15/hr, no benefits and a 20% agency fee) would be $21,600. If instead the hospital raised the nursing wage to $11.50 and tried to recruit 50 new nurses, the per shift cost would be $22,080. Thus, given the conditions of this example, as

ng as the hospital fills less than 30 p ent of its total positions ith the more expensive temporaries, the marginal labor costs will be less than if the wage rate of the permanent staff members were raised (Prescott, 1982). Hence the easiest and least costly staffing remedy may serve to increase the long-term problem by holding down nurses' wages. Unless the temporary services bring increased competition to the hospital nurse market, and unless the higher wages paid these nurses translate into higher wages for permanent employees, the agencies may contribute to the dynamic shortage rather than serve a role in its solution.

There are numerous other actions taken by hospitals in attempting to cope with the nurse shortage at the institutional level. Unfortunately many of them have been cosmetic and not aimed at serious, long-range solutions to the major job dissatisfactions. Clinical ladders are a popular example of what is often a cosmetic change. The clinical ladder is designed to encourage nurses to stay in clinical nursing by providing promotional opportunities to reward clinical experience and/or advanced education. Unfortunately, in many situations advancement up the rungs of the ladder often means that the nurse is held responsible for more work, which is not rewarded with meaningful salary increases. Today the differential between a beginning and an experienced nurse remains very slim, with staff nurses in practice 5 years or less averaging approximately $22,000 per year, and nurses with 6 to 10 years' experience averaging $25,000 and gaining little thereafter ("Nursing Pay," 1985).

Many of the other actions taken by hospitals to cope with the nurse shortage actually make the problem worse. Perhaps the best example of this is what has been termed the negative staffing cycle. This exists when by choice or necessity a hospital attempts to function as usual in the face of a shortage of nurses. In this situation the existing staff members work harder, longer and more often and are responsible for more; this leads to what has been dubbed "burnout," which in turn leads to turnover among the permanent staff members (Prescott, Dennis, Creasia & Bowen, 1985). This process advances in a steadily downward spiral until the hospital finds itself no longer able to attract new workers. Cutting support staff members, "floating" nurses to other areas of the hospital, and failing to close beds or otherwise reduce demand for nursing services are other examples of actions that may actually worsen the nursing shortage at an institutional level. In general, short-range strategies that increase demands on existing staff members, coupled with actions that hold down wages of the permanent staff members would seem to work against any long-term solution to shortages at the hospital level. Before discussing this point further, we might first examine the current nurse shortage and comparing it with that experienced in the late 1970s and early 1980s.

The Current Shortage Versus The Past

Supply

In comparing the supply of nurses in 1985 with that of 1980 and 1978, it is clear that the number of nurses has grown and that the nurse supply has grown faster than has the general population (Aiken, 1987) (see Table 1). The number of nurses employed increa 36 percent during this perio itionally, the labor force participation rate of nurses has ased from 72.7 percent in 1977 to 78.7 percent in 1984; thus not only are there more nurses, but more of them are working (ANA, in press).

TABLE 1. Number of Employed Nurses, 1985, 1980, 1978

Year	Total Employed Nurses	Nurses Per 100,000 Population	Registered Nurse FTE Per 100,000 Population
1985	1,531,200	641	533
1980	1,272,900	560	470
1978	1,123,200	506	425

SOURCE: American Nurses Association (in press) Facts on Nursing, *Kansas City, MO: The ANA.*

The majority of working nurses are employed by hospitals. Despite often-heard statements about how nurses are being drawn off into the ambulatory care sector, the percentage of nurses employed in hospitals has increased from 61.4 percent in 1977 to 68 percent in 1984 (Division of Nursing, 1986).

Also of concern when considering the nurse supply are those nurses employed outside of nursing, those unemployed but seeking positions in nursing and those unemployed and not looking for employment. The percentage of licensed nurses employed outside nursing is low and essentially the same as in 1977. Nurse unemployment rates remain low in comparison with average female unemployment and slightly lower when comparing 1977 with 1984 (see Table 2).

The characteristics of the inactive pool are important when evaluating the nurse supply. While there has been considerable attention given to refresher courses and other means to draw nurses into the labor market, Johnson (1980) pointed out that a substantial portion of the inactive pool consists of individuals not likely to seek hospital staff nurse positions. For example, in 1977, 30 percent of those not employed in nursing were 60 years of age or over; in 1984, 36.5 percent of these nurses were 60 years of age or over; today even fewer of the inactive pool are likely to return to the labor force (Division of Nursing, 1986).

The supply of nurses licensed and available for work is at an all time high. In 1982 Aiken concluded that the nursing shortage in the early 1980s was at historically low levels, as evidenced by the large numbers of nurses and low levels of hospital vacancies. The situation now indicates an even larger nurse supply. Thus the currently experienced shortfall in hospital nurses cannot be attributed to a fall in the number of nurses available to work. Nor can it be attributed to nurses leaving hospitals for other health care sectors or for other fields of employment.

The immediate future, however, suggests quite a different picture than that seen during the 1970s and early 1980s. It is clear that the number of nurses entering the labor market has begun to decline (Green, 1987). Enrollments have been decreasing since 1983–1984, and these declines (5.3% in 1983; 8.1% in 1984;

TABLE 2. Percentage of Registered Nurses Employed Outside of Nursing and Not Employed, 1977 and 1984

Year	Not Seeking Nursing Position Employed Outside Nursing	Not Employed But Seeking Nursing Position	Not Employed Not Looking	Average Registered Nurse Unemployment Rate	Average Unemployment Rate Women 25–54 Years
1977	4.4	3.0	27.2	2.6	6.4
1984	4.6	1.9	14.6	2.0	6.3

SOURCE: *Division of Nursing (1986).* The registered nurse population: Findings from the national sample survey of RN's, November 1984 (Accession No. HPR. 0906938). National Technical Information Service, U.S. Government, Springfield, VA 22161.

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% in 1985) have begun to influenc e number of nurses duating, which decreased 2.5 percen in 1985–1986. These decreases are expected to accelerate in the near future (Rosenfeld, 1985).

During the period of federal support for nursing education, nurse enrollments increased steadily. Now, with declines in the federal subsidies for nursing education, it is likely that nurse enrollments will be more sensitive to such market forces as salary, with enrollments declining in periods of small salary growth and accelerating in periods of relatively large salary increases. In 1980 and 1981, when the nurse shortage was perceived as being acute in hospitals, salaries increased substantially, as compared to the increases seen in the 1970s (Aiken, 1982, 1987). These increases were followed by increases in the 1982–1983 enrollments, which tapered off as the salary increases slowed in the 1983 to 1986 period.

The historical trend of a steadily increasing supply of nurses growing more rapidly than the population probably is over. Enrollment data suggest that the supply of new nurses is in a modestly declining trajectory and can be expected to continue for at least the next four or five years as the smaller classes work their way through the educational system and enter the labor market.

Demand

Interpreting available data about the demand for nurses is more difficult than evaluating the nurse supply because there is less reliability and validity of the data, and their meaning are less clear. Demand for hospital nursing services is generally measured in terms of vacant positions—a measure that is less than ideal. Vacancies may be artifacts of restricted market conditions rather than true indicators of excess demand relative to supply. Hospitals are not disinterested parties in the definition of nurse supply and demand because they benefit from policies that make sufficient numbers of nurses available at existing wage rates; and hospitals may express their desire or need for nurses rather than a "demand" in the economic sense by reporting vacant positions for which they have no available funds (as is the case when "frozen positions" are reported as vacancies). These factors influence the statement of nurse demand which may be an underestimate or overestimate; vacancy statistics must be interpreted cautiously.

Nurse vacancy rates peaked in the early 1960s when hospitals reported an average of more than 23 vacancies per 100 budgeted positions. In response, salaries rose rapidly (twice as fast as did those of teachers and female professionals or technical and kindred workers), and the supply of nurses increased as both labor force participation and nursing school enrollments increased (Aiken, 1982). During the 1970s wages fell behind comparable groups as well as the rate of inflation, and by the end of the decade hospitals again were reporting vacancy rates in the range of 13 percent. The cycle repeated itself, with salaries rising relative to other occupations between 1980 and 1982 and vacancy rates declining to approximately 8 percent. Beginning in 1982 and continuing in 1983, demand for nursing services was curtailed in part by the general economic downturn of that period and in part by what appears to have been anticipation by the hospitals of the financial impact of prospective reimbursement. From 1983 until 1986 salary increases were low (under 5%) ("DRG's Stymie Wage 1987), and vacancy rates remained low until 1986 when they increased to 13 percent—the same level reported a decade ago (AHA, 1987). The increased demand for nurses expressed by the current 13 percent vacancy rate may be in part the result of substitution of Registered Nurses for other lesser skilled personnel, a phenomenon that occurs when the wages of Registered Nurses are low relative to the wages of LPNs and Aides (Aiken, 1982). Hospitals may also be using Registered Nurses in a variety of roles (e.g., ality assurance, discharge p , and home care coordination). However, given the ercent increase in the nurse supply since 1978, and given the fact that hospital occupancy rates remained below pre-prospective payment levels (69% in 1985 vs 77% in 1982), it is difficult to understand the increase in demand for nursing services.

Using vacancy rates as indicators of there being a nurse shortage is problematic also because of lack of consensus regarding the importance of a given level of vacancy. For example, in 1980—when more than 28 percent of hospitals had no vacant RN positions; 39 percent had 1 to 9 vacancies; 34 percent had between 10 and 19 openings and the remaining 15 percent had 20 or more vacant positions—the vacancy rates were interpreted by some as indicating a severe and widespread shortage (Mullner, Byre & Whitehead, 1982). Similarly, the AHA (1987) currently reports that 59 percent of hospitals report that fewer than 10 percent of their positions are vacant, but the average vacancy rate of 13.6 percent is interpreted as a shortage. Given the size of most nursing service departments, the number of vacant positions in the majority of hospitals would not seem to constitute a serious nursing shortage, and in historical terms the hospital vacancy rates were the same in 1977–1978, when vacancy rates were at 13 percent.

Patient acuity and changing patterns of patient care are other factors associated with demand for resources. Clearly, patient acuity has increased, as has the age of the population and the technological sophistication of the treatment. However, factors having had a dampening effect on demand (e.g., a decline in the number of hospital beds, the transfer of much care to the ambulatory, home care sectors) can also be identified. Iglehart (1987) suggests that there has been a dramatic decline in demand (based on 46.7 million fewer inpatient days in 1986, as compared with 1980), declining hospital occupancy rates (75.9 in 1980 to 63.4 in 1986), and closure of 414 hospitals (accounting for a loss of 56,628 beds). Aiken (1987) asserted that changing case mix may provide a partial explanation for the increased demand for nurses. However, it is unlikely that case mix alone could account for the current expression of demand.

Given the current supply, demand and wage situation, what can be concluded about the current nurse shortage, as compared with that of 1980? In the aggregate national market, the available labor force is larger than that in 1980. While many institutions experienced difficulty in recruiting and/or retaining RNs, many others did not; it would appear that the perceived nursing shortage was limited to selected hospitals and was of the equilibrium type resulting from market constraints and to some degree from geographic maldistribution of nurses at the aggregate level. The current situation seems much the same as it did almost 10 years ago with one very critical difference: the declining nursing school enrollments. With a steady or increasing demand for nurses and a dwindling supply of new graduates, supply-demand imbalance characteristic of dynamic shortages can be forecasted into the foreseeable future.

Remedies

Previous efforts to deal with the nursing shortage at both the aggregate and the institutional levels have emphasized recruitment as opposed to retention. Also, solutions appropriate at one level of analysis are not necessarily effective at another level, and it is important to include these distinctions in considering solutions. Lastly, it seems that the two major types of shortage, dynamic and equilibrium, call for different approaches; this also should be part of a discussion of solutions.

At the aggregate market level, the key factors seem to be wages, working conditions and competition. Economic theory suggests that the remedy for a dynamic shortage is to allow a freely competitive market to bid up wages to the level that rela-

tive to other occupations, nursing becomes attractive to individuals making career choices. Additionally, as adolescents and their parents consider occupational options, nursing will have to look attractive in comparison to the psychic rewards now available in business, law, medicine and other fields previously relatively closed to women.

Factors with a potentially positive effect on the nurse supply are those that raise salaries through such methods as collective bargaining or implementation of salary scales based on comparable worth evaluation studies or that stimulate competition. Competition, stimulated by pressure from other employers as well as from large-scale purchasers of health care, is for more nurse-provided services as an alternative to using more costly providers. Interestingly, supplemental agencies as competing nurse employers seem to have had only a transient impact on the nurse market since their higher wages have had little effect on marginal labor costs associated with permanent employees and hospitals have discontinued their services with any softening in demand. At this time hospitals have increased their control over the nurse market, and until this changes it is unlikely that alternative employers will provide sufficient competition to bid up wages.

Large-scale purchases of health care may create a demand for nurses in their search for cost-effective health care. This increased demand is only a potential; historically nurses have not marketed their services or attached clear costs to them. Increased consumer demand for nursing services could increase nurses' economic value in hospitals, thereby having a positive impact on wages. However, for this to happen, nursing would have to become more visible and articulate in defining nursing services, their value to patient care and their costs.

Factors with a potentially negative effect on the nurse supply include the surplus of physicians and the continuing and intensifying concern for cost containment in hospitals. The surplus of physicians has been well documented and is predicted to have lasting effects well into the twenty-first century. The cost-containment environment within which the health care industry functions places hospitals at greater fiscal risk than it had previously. As these pressures intensify, so too will competition among hospitals as they attempt to position themselves favorably within the prospective payment system. The effect of these pressures on nurse wages will be negative, and, as previously shown, wage suppression is a major factor in the creation of manpower shortages.

On balance, the search for cost-effective health care should favor nursing from the point of view of employers, consumers and other payors. To realize this potential, however, nursing will have to separate its services from those of others, price those services, demonstrate their value and market them. Success in these endeavors should translate into enticing new people into the occupation. While the labor force participation of the existing nurse supply is at historically high levels, the concern with increasing the supply of new recruits is critical to the examination of the dynamic shortage anticipated at the aggregate level.

At the institutional level, the concern with recruitment is different than at the aggregate level. For hospitals, recruitment means attracting people who are already in the occupation to work in a particular institution, and in the past the success of the recruitment approach has been to a large degree dependent on a continuing supply of new graduates. But the supply of new nurses is now on the decline, making reliance on recruitment alone a less successful strategy than in previous years. The incentives for focusing on retention rather than recruitment have not been great. Sloan (1975) has shown that replacement costs have been inexpensive relative to the marginal labor costs associated with retaining staff members. While, in economic terms, this may still be true, the case for retention should be viewed more broadly to include organizational and administrative considerations for the skill mix needed to care for patients and the stability and maturity needed in staff members to prevent a negative staffing cycle in a time of changing demands. This is increasingly important as care becomes technologically more complex and specialized and nurses cannot be assumed to be interchangeable.

Many of the factors that nurses associate with a nursing shortage have only partially to do with vacant positions. There are four kinds of shortage, only one of which was the result of difficulty in filling vacant positions (Prescott et al., 1985). The other three shortage situations were the result of policies of hospitals that staffed so "thinly" that there were inadequate numbers of nurses to meet the nurse-defined need even on units where all vacant positions were filled. *Transient* shortages were short-term problems resulting from unplanned changes in patient acuity, staff absences, "floating" nurses and use of inadequately skilled or experienced staff members in place of permanent ones. While these problems were difficult to forecast, they were frequent especially in areas using large numbers of supplemental staff members on units with relatively unstable patients. *Scheduling* shortages were regularly occurring events planned for weekends, holidays, and off shifts when staffing is often at skeleton crew levels. Scheduling shortages are made worse by the simultaneous closing of many hospital support services such as patient transportation, social services and housekeeping. *Position* shortages result from allocating too few, or the wrong mix of, positions to a unit to meet patient care needs. This kind of shortage is widespread, planned and predictable and, even when all existing positions are filled with the right kind of skilled and experienced people, there simply are not sufficient numbers of staff members. The problem of position shortage has been aggravated in recent years by the planned reduction in nursing aides, ward clerks and other nursing support personnel.

Each of these situations can occur alone or, as is frequently the case in practice, in combination with other types. The result, particularly if the situation is allowed to exist for a prolonged period, is overextension and burn out of existing staff members. Patient care also is known to suffer because the nurses are less diligent in monitoring patients, preventing errors and troubleshooting. Continuity of care also suffers greatly under conditions of shortage.

Clearly, part of the institutional shortage relates to difficulty in filling vacant positions, which may impart be because of aggregate supply issues. However, as much or more of the problem can be traced directly to hospital staffing policies that are both changeable and under the direct control of hospital and nursing administrators. These problems will not be solved solely by reliance on recruitment of new nurses. Rather a careful look at the job dissatisfactions identified in the nursing literature would focus the attention of administrators on retention of existing staff, improvements in staff competence, tailoring of the staff mix, and otherwise the establishment of policies and procedures with an eye toward long-term rather than short-term effectiveness and efficiency. Serious attention to job dissatisfaction will not be inexpensive since hospitals will have to pay a greater proportion of their budgets for nursing services, but the long-term payoff is high for individual institutions, for patient care and for health care costs.

Holding down nursing wages in an effort to deal with cost containment pressures will make the long-term shortage problem worse. Since increased salary costs can no longer be passed along to payors, institutions will have to reallocate internally the increasing hospital budget. By almost any estimate, nursing services are a hospital's best bargain, representing some 20 per-

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ent of hospital charges. It is time th.. hospitals recognize and reward rather than burn out the source of this bargain.

Making the hospital a pleasant place to work in the fullest sense, (i.e. improving basic working conditions, paying competitive wages and benefits, providing opportunities for growth, stimulation and advancement and positively valuing the contribution of nurses to patient care), creates what has been referred to as the magnet hospitals, or those places that have little difficulty in recruiting and retaining nursing staff (ANA, 1983). Serious attention to making hospitals better places to work should translate into creating psychic incentives to individuals who are considering nursing as an occupation. A focus on retention of existing staff members by redress of the sources of job dissatisfaction can also play an important role in the long-term recruitment of new nurses.

The problems associated with nurse staffing in hospitals are complex and long standing. These problems are best addressed by a combination of the economic and nursing perspectives with a view toward long-term effectiveness and efficiency of the health care system. Nurse leaders can and should play an important role in using both perspectives and integrating their views to encourage a balanced approach to recruitment and retention of nurses.

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Message from Kansas Governor Mike Hayden

Hayden

Dear Kansas Business Owner:

We in Kansas are committed to the improvement of our state's economy, and we recognize the important role that small business plays in that effort.

The state of Kansas is virtually a state of small business, with over 98 percent of our businesses employing less than 100 employees. Because of this concentration of small businesses, we realize that every effort must be made to keep these firms starting, growing, and thriving in Kansas. This can only be accomplished through the cooperation of the local, state and federal governments working together with the private sector, a goal to which we are committed.

The entrepreneurs involved with small businesses are truly the pioneers of today. The risks that must be overcome to operate a successful small business are often substantial; the State of Kansas helps to encourage small business development by creating a favorable business climate which minimizes those risks.

I look forward to the continued success of small business in Kansas and the continued cooperation between the public and private sectors toward a strong and vital Kansas economy.

Sincerely,
Mike Hayden
Governor

KANSAS PROFESSIONAL NURSING HOME ADMINISTRATORS ASSOCIATION

3601 West 29th
Topeka, Kansas 66614
Phone: 913—273-4393

February 16, 1989

Walter Powers
% Creative Care
1786 So. Seneca, Suite 7
Wichita, KS 67213

Dear Walter:

RE: SB 184: Nursing Pool Quality Assurance Act

KPNHAA's Legislative Committee has met regarding many issues facing this year's legislators. It has been the decision of the committee that KPNHAA is not supporting the action sited in the above bill. We are not taking an official position on this issue of any kind.

Discussion from our committee produced the suggestion of either written or verbal communication with those people involved in the nursing pools to present the concerns of our association so that communication might be enhanced in areas of accountability and responsibility for those temporary help personnel be addressed. But this we wanted done on an informal basis and not to be controlled through legislation.

Sincerely,

Jane E. Smith

Jane E. Smith
President, KPNHAA

JES/mp

cc: Smith
Legislative Committee
Office file

Thank you for the opportunity to address this committee. My name is Linda Baker. I am a branch manager for Quality Care, a division of Kimberly Quality Care, my agency does supplemental staffing and home health. I also represent two other branches; Kimberly Services of Leawood, Kansas and Kimberly Quality Care of Wichita, Kansas. I also represent our national service center, located in Overland Park, Kansas.

We oppose Senate Bill 184 on several grounds all adversly affecting our employees. We feel that passage of this bill would add a redundant layer of regulation to the health care system. We are all licensed by the State of Kansas to do home care. We are surveyed on a regular and ongoing basis. The fact that we retain our licensure demonstrates that we are already meeting the standards set forth in Senate Bill 184. As a condition of employment we require a personal interview, reference check, testing, physician health exam, proof of educational preparation and professional licensure. We evaluate all of our employees yearly and we do carry malpractice insurance.

We further oppose Senate Bill 184 on the grounds that Section 5 would prohibit us from collecting liquidated damages. This is an interference with our common law freedom of contract as well as an unconscionable attempt to prevent us from protecting our most valuable resource, our employees.

Section 8 of this bill, addressing rate setting, would have a devastating effect on an industry that is 25 years old. Kimberly Quality Care is a major employer in the Kansas City area; ranked 47th out of 500 area private and publically held enterprises, Kansas City Star, 7/10/88. If we are driven out of business because of rate setting there would be an immediate and negative effect on the local economy. Agencies offer nurses options, both economic and work, that keep them in nursing. Passage of this bill would exacerbate our already critical nursing shortage.

Members of the committee, I urge you to vote for nurses, for our sick, for our elderly and against Senate Bill 184.

Respectfully submitted in opposition of Senate Bill 184, for the record. Thank you for your attention.

Linda Baker
Linda Baker
Branch Manager
Quality Care

Deb Walter
Deb Walter
Branch Manager
Kimberly Services

Diane Steeves
Diane Steeves
Branch Manager
Kimberly Quality Care

SP&W
2-28-89
Attachment 14