

PUBLIC HEARING

before

SENATE LABOR, INDUSTRY, AND PROFESSIONS COMMITTEE

on

SENATE BILLS 107, 108 and 109
(Reimbursement for Nursing Services)

Held:
November 13, 1980
Assembly Chamber
State House
Trenton, New Jersey

MEMBER OF COMMITTEE PRESENT:

Senator Eugene J. Bedell, Chairman

ALSO:

Patricia E. Turner, Research Associate
Office of Legislative Services
Aide, Senate Labor, Industry, and Professions Committee

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SENATE, No. 107

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1980 SESSION

By Senator BEDELL

AN ACT to provide for the reimbursement for nursing services under medical service corporation insurance contracts, and supplementing P. L. 1940, c. 74 (C. 17:48A-1 et seq.).

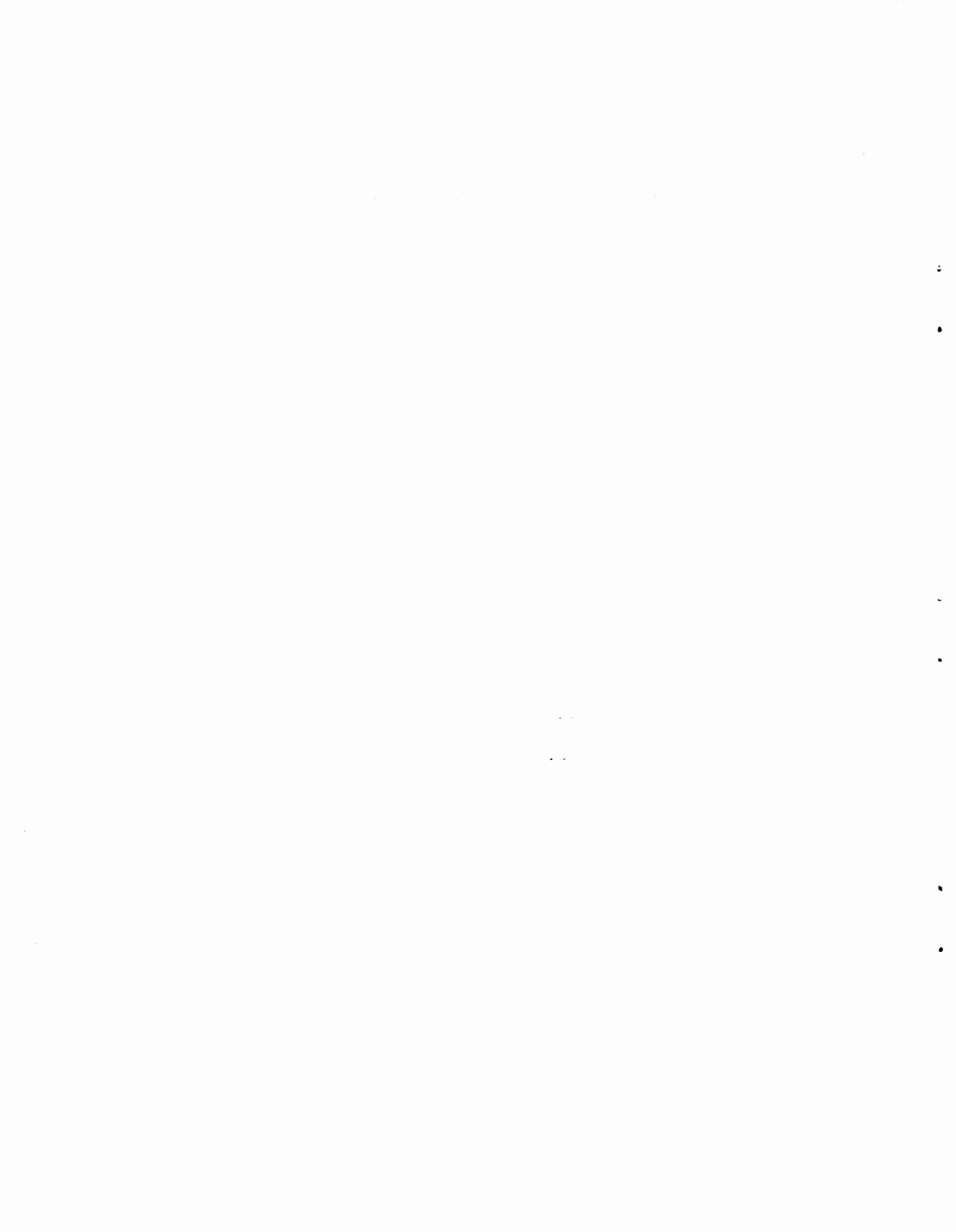
1 BE IT ENACTED *by the Senate and General Assembly of the State*
2 *of New Jersey:*

1 1. Notwithstanding any other provision of the act to which this
2 act is a supplement, a policy may, at the option of the subscriber,
3 provide reimbursement for any nursing service within the lawful
4 scope of practice of a duly licensed registered professional nurse;
5 provided, however, that such licensed registered professional nurse
6 is not concurrently being paid a salary by any health care provider
7 for the duties so performed. Such benefits may be payable subject
8 to deductible or coinsurance provisions, and a policy providing
9 such benefits may contain a limitation on the number of benefit days
10 payable under the contract.

1 2. This act shall take effect 90 days following its enactment.

STATEMENT

This bill would permit direct reimbursement to professional nurses under medical service corporation insurance contracts, providing that the nurses are not concurrently being paid a salary for performing the same services by a health care provider. The bill provides that such benefits would be included in a contract at the option of the insured, and may be payable subject to deductible or coinsurance provisions. The policy may contain a limitation on the number of benefit days payable under the contract.



SENATE, No. 108

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1980 SESSION

By Senator BEDELL

AN ACT to provide for the reimbursement of nursing services under certain individual health insurance contracts and supplementing chapter 26 of Title 17B of the New Jersey Statutes.

1 BE IT ENACTED *by the Senate and General Assembly of the State*
2 *of New Jersey:*

1 1. Notwithstanding any other provision of this chapter, a policy
2 may, at the option of the insured, provide reimbursement for any
3 nursing service within the lawful scope of practice of a duly
4 licensed registered professional nurse; provided, however, that
5 such licensed registered professional nurse is not concurrently
6 being paid a salary by any health care provider for the duties so
7 performed. Such benefits may be payable subject to deductible or
8 coinsurance provisions, and a policy providing such benefits may
9 contain a limitation on the number of benefit days payable under
10 the contract.

1 2. This act shall take effect 90 days following its enactment.

STATEMENT

This bill would permit direct reimbursement to professional nurses under individual health insurance contracts, providing that the nurses are not concurrently being paid a salary for performing the same services by a health care provider. The bill provides that such benefits would be included in a contract at the option of the insured, and may be payable subject to deductible or coinsurance provisions. The policy may contain a limitation on the number of benefit days payable under the contract.



SENATE, No. 109

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1980 SESSION

By Senator BEDELL

AN Act to provide for the reimbursement of nursing services under certain group and blanket health insurance contracts, and supplementing chapter 27 of Title 17B of the New Jersey Statutes.

1 BE IT ENACTED *by the Senate and General Assembly of the State*
2 *of New Jersey:*

1 1. Notwithstanding any other provision of this chapter, a policy
2 may, at the option of the policyholder, provide reimbursement for
3 any nursing service within the lawful scope of practice of a duly
4 licensed registered professional nurse; provided, however, that
5 such licensed registered professional nurse is not concurrently
6 being paid a salary by any health care provider for the duties
7 so performed. Such benefits may be payable subject to deductible
8 or coinsurance provisions, and a policy providing such benefits
9 may contain a limitation on the number of benefit days payable
10 under the contract.

1 2. This act shall take effect 90 days following its enactment.

STATEMENT

This bill would permit direct reimbursement to professional nurses under group and blanket health insurance contracts, providing that the nurses are not concurrently being paid a salary for performing the same services by a health care provider. The bill provides that such benefits would be included in a contract at the option of the insured, and may be payable subject to deductible or coinsurance provisions. The policy may contain a limitation on the number of benefit days payable under the contract.



SENATOR EUGENE J. BEDELL (Chairman): This is a public hearing of the Senate Labor Industry and Professions Committee. The subject before us today is three bills: Senate 107, 108 and 109, of which I am the prime sponsor. I must apologize to you for our late start. Unfortunately, as you know, being a legislator is not a full-time job. Most of us have another field of endeavor in which we engage, and sometimes our two jobs are in conflict, which happened to me this morning. As the City Manager of Long Branch, New Jersey, I had to be there for a little while this morning. I got here as soon as I could. I had hoped other members of my Committee would have been present to start the hearing and you would not have been inconvenienced, as you have been. So, you have my apology.

We have a list of people who have signified their intentions to speak before the Committee. Anyone who wishes to speak who is not on the list should contact the Committee Aide, who is seated to my immediate right, and we will be very happy to call on you in due course.

With that, we will start the hearing by calling upon Dr. Lucille Joel, President of the New Jersey State Nurses Association.

D R. L U C I L L E J O E L: Thank you, Senator Bedell, for the opportunity to give testimony on this important issue.

I am Lucille Joel, President of the New Jersey State Nurses Association, Associate Dean for Clinical Affairs at Rutgers College of Nursing, and a self-employed nurse offering care to patients on a fee-for-service basis who has experienced a serious constraint in my own practice due to the absence of direct reimbursement. I can personally document the fact that patients requesting service from me are often forced to select alternate providers because they cannot be reimbursed for nursing.

Professional nurses fill an indispensable role in all aspects of the contemporary health care delivery system. They are educationally prepared and legally licensed to be responsible for their own acts. Over the years, the majority of nurses have become salaried employees of health care agencies. Because of this employment pattern, restrictive reimbursement practices have become established and continue to exist.

I am here to offer testimony in support of direct third party reimbursement to nurses for services consistent with their scope of practice as defined within the Nurse Practice Act of the State of New Jersey. The prevailing arguments in favor of adding nurses to directly reimbursable providers are related to cost and accessibility.

Escalating health care costs are of common concern to every citizen. This inflationary spiral may at least partially be attributed to the fact that the physician has been maintained as the "gatekeeper" of the delivery system, and access to providers has been dependent on physician approval or prescription. The net result of this physician dominance has been an underutilization of nurses and innovative health care settings, both of which represent less costly approaches to service. Conversely, there is an overutilization of physician, medical technology and acute care hospitals which are the most costly options. These trends converge in a pattern which rewards illness instead of health and promotes rapidly increasing health care costs -- or we could more appropriately say sick care costs.

Consumers are neither apprised of their right to use options to the

physician-provider and less traditional settings for care, nor is the use of more economical alternatives encouraged. Essentially, I am saying that there are some things which can be legitimately done by either a physician or a nurse. Who provides the services should reflect economic prudence, using the least expensive but adequately prepared provider. More important, the choice should be the prerogative of the client. The issue is not always one of substitution of service; in fact, more frequently the unique services of the nurse are the therapy of choice. There are times when patients have an obvious and personally diagnosed need for nursing care. The client should have the right to contract for services on his own behalf. Present reimbursement policies in this State deny this right to choice.

The unique services offered by the nurse stress the patients' strengths, encourage responsibility for one's own care and decisions related to that care, and search for family and community support systems which can be mobilized in the service of the individual. The ultimate goal is to restore the patient to some degree of self-sufficiency, and decrease his dependency on the system. Nursing services are equally appropriate delivered in the hospital or delivered in the home. Both the therapeutic and cost effectiveness of nursing services have been well documented. Where vigorous and clinically sophisticated community nursing service is available and access enabled through reimbursement, a 10 to 15 percent decrease in the hospital length of stay has been verified. Home care of the terminally ill, even intensive home care requiring multiple daily visits from the nurse, has proved to cost considerably less than institutional care, while simultaneously providing family members opportunity to begin the work of grieving. Objective measures show patients availed of this service use less medication and complain less of pain. Comparability studies show that intensive home care costs a fraction of the price for hospital care or even nursing home placement.

Both the consumer and the third party payor are becoming more "pennywise." Cost containment in health care has become a mandate rather than meaningless rhetoric. A person's right to free choice and access, and the provider's right to work are equally relevant and timely issues.

The employment patterns of nurses are slowly but decisively changing. More nurses are self-employed. More consumers personally identify a need for nursing service. The absence of direct reimbursement decreases nurses' marketability. Specifically, their right to earn income and offer service is constrained. If such restrictions were ever justified, it is surely obsolete in 1980. It is inconceivable, illogical and undemocratic to think that permission for one legally and independently licensed professional to function should be contingent on authorization by another professional licensed under an entirely distinct practice act.

Successful models for direct reimbursement to nurses are currently operating in both Maryland and Washington. A New York State reimbursement bill received overwhelming support in both the Senate and the Assembly during this legislative session, but was subsequently vetoed by Governor Carey, presumably because of technical inadequacies of the legislation. Nationally, nurses are directly reimbursed for services to non-uniformed employees of the military services through CHAMPUS.

The American Nurses Association has actively supported efforts to

secure direct reimbursement to nurses for over twenty years. The New Jersey State Nurses Association has been equally vocal since 1973. The New Jersey State Nurses Association approaches these hearings with a great sense of responsibility, and an awareness that the profession must directly address the issue of quality assurance. Existing mechanisms for consideration include the State laws governing nursing practice and guidelines issued by the Board of Nursing, peer review processes, and voluntary national and state certification programs.

I am here to speak specifically in support of S 107, 108 and 109 which would enable direct reimbursement to nurses. I also support the concept that a specific service should not receive double compensation. Thus, if a nurse renders services as a salaried health care provider, the client may not be directly billed by the nurse for the same unit of service. However, many nurses may choose to hold both salaried positions and provide direct service for a fee to clients through either a self-employment model or as a member of a group practice. The imposition of inappropriate constraints on direct reimbursement for nursing services; such as, restrictive number of benefit days, unrealistic deductible and coinsurance provisions, optional exclusion of benefits, has the net effect of playing games with the public. The passage of S 107, 108 and 109 could provide an opportunity to reorient the health care system to wellness in the State of New Jersey, to address the maldistribution of health care providers here, to impact inflationary patterns in health care, and to remedy inequity by allowing an independently licensed group of professionals access to a market for their services.

I thank you for this opportunity to offer my comments in the name of the officers, Board of Directors and membership of the New Jersey State Nurses Association. (See page LX for Appendix A to Dr. Joel's statement.)

SENATOR BEDELL: I want to thank you, Doctor; that was an excellent presentation. As a matter of fact, some of the questions I had jotted down to ask you at the completion of your statement were answered during the course of your presentation and I don't have any questions at this point.

I might say to you and everyone else present, if you have never attended a public hearing before, I hope you are not disappointed by the absence of many members of the Committee. But the purpose of a public hearing on a specific issue is that your testimony, whether pro or con, is made a public record. As you can see at the present time, the testimony is being taken stenographically. A transcript is prepared and made available to the legislators who will deliberate on these bills, and also to the general public. That is the reason for having this public hearing and your presence and your testimony today are welcomed by us.

Thank you very much.

Mr. Arthur Fried from Blue Shield.

A R T H U R F R I E D: Senator Bedell, I am Arthur Fried, New Jersey Blue Shield.

I have no statement, per se. We think it is an excellent bill. But we are concerned about the medical necessity. As written, the bill would authorize the hiring of a registered professional nurse virtually as a companion and with no regard to the medical necessity. We would ask that you look into that matter and propose that on line 3 of the bill providing reimbursement for any nursing service, there be added, "which is ordered by a physician for the care or treatment of a covered sickness or injury." We think that is an integral part of the bill.

We also have another thought with reference to line 2 of the bill where it relates to the subscriber. We differ considerably from the commercial companies because our members are in three particular groups. They are in experience rated groups. That is those that are one hundred or more lives. We have the community-rated groups that are under a hundred lives. Then we have the direct-pay subscriber. So, in place of the term subscriber, we would like to see, experience-rated groups, community-rated groups or direct-pay subscriber, inserted in place of the term subscriber. That would enable all of our members to be eligible for this type of coverage.

SENATOR BEDELL: Might I ask, Doctor, if you have any objection to this suggestion? It merely amplifies the definition of subscriber. Is there any technical difficulty from your point of view?

DR. JOEL: I would object to the initial comment of the gentleman that nursing service would have to be prescribed under supervision of a physician. That I would object to, not the other.

SENATOR BEDELL: I would too.

MR. FRIED: I don't believe I said under the supervision of a physician.

DR. JOEL: Prescription referral.

MR. FRIED: Referral - okay.

SENATOR BEDELL: Thank you very much, Art.

Nancy Anderson.

N A N C Y A N D E R S O N: Thank you, Senator Bedell.

My name is Nancy Anderson and I am here to encourage the passage of legislation that will give our citizens an option, not a mandate, to purchase direct nursing services. I speak as a nurse who has spent seven years in the community providing services to families which ranged the gamut from birth to death. The community that I worked in was a blue-collar type community of 40,000 residents where many citizens were too "wealthy" for government sponsored health coverage, yet not "wealthy" enough to acquire good medical coverage.

Since one of the purposes of a public hearing is to familiarize the legislators with the issue in question, I would like to share some of the information that I acquired in 1978 during a graduate research study that I did, in which I surveyed several states across our country as to their third party reimbursement practices for nursing services. I also studied all of the state and federal legislation which addressed this issue at the time. There were a total of 18 bills. Some of my findings were encouraging, but many more clearly point out that there are too many misconceptions about (1) the role of nursing, (2) the physician-nurse relationship, (3) the "health care" system and (4) methods of reducing health care costs.

First, the good news.

(1) In 1973, legislation was passed in Washington State which required commercial insurance companies to pay for the services of licensed Registered Nurses. It does not, however, include Blue Cross, which covers 60 to 70 percent of the state.

(2) California reimburses Private Duty Nurses and Nurse Anesthetists under state law without physician supervision required.

(3) Maryland has passed two bills requiring all health insurers to pay for

the services of Nurse Midwives and Nurse Practitioners without requiring physician supervision.

(4) In Vermont, no legislation has been passed, but the Secretary of the Agency of Human Services has included Psychiatric Nurses with an MS degree or higher, with Psychiatrists and licensed Psychologists as "licensed mental health professionals" and has instructed third party payers to reimburse for their services. Also, Blue Cross-Blue Shield of New Hampshire/Vermont currently reimburses for independent nursing services in two Vermont based health facilities. The purpose of the clinic is to provide health maintenance and preventive care rather than to treat emergencies.

(5) Wisconsin reimburses some services of Master's prepared Nurses under law in certain mental health settings with no physician supervision required.

(6) In Connecticut, the Phoenix Mutual of Hartford Insurance Company has reported no influx of cost as a result of its "Nursing services at home benefit." In addition, this company reports no cases of misutilization of the benefit. American Health of Baltimore cites a similar benefit with the same successful results.

(7) The Rochester, New York, Home Health Care Association studied the results of early release of patients from hospitals to home health care programs. Results showed an estimated reduction of 13,713 patient days and a saving of \$1,055,000 in 1970 and an estimated reduction of 12,579 patient days and a savings of \$1,068,000 in 1971.

(8) The Denver Department of Health and Hospitals studied the results of its Early Hospital Discharge Program and showed a savings of \$515,729 in hospital costs for medicare patients in 1970 as a result of early discharge of 292 patients from hospitals to home care programs.

The major portion of care rendered in the Denver and Rochester studies was rendered by Registered Nurses and all care was coordinated by Registered Nurses.

(9) In Ohio, a court decision relative to the practice of nursing was reached in March, 1973. The case involved three licensed Registered Nurses who billed directly to the insurance company for their services. The Nurses were notified by the Department of Public Welfare that they could no longer bill directly since this was contrary to the Ohio State Medical Practice Act. The Nurses pursued the matter in court. In 1973, the judge declared the ruling of the Department of Public Welfare to be erroneous, unreasonable and unlawful. He stated, and I quote: "This court holds that the fiction of an employee-employer relationship between a Nurse and a Doctor, cannot be conjured up with reference to the Medical Practice Act and the Nursing Practice Act. Such a fiction cannot be implied. Nurses, therefore, may submit billings for their services independent of such fictions."

(10) In Arizona, Phoenix Mutual has voluntarily modified policies to permit subscribers to seek Nursing services at their own discretion.

(11) The Maine Department of Human Services has received funds from an experimental program in Medicaid reimbursement, for patient education.

The objectives of the patient education component are: 1) to demonstrate that focused health education services delivered to patients having problems which result in consistently high rates of care utilization, or, patients with certain selected chronic disorders, under controlled circumstances, improve patient health care, 2) to develop guidelines for specifications of health education services which should be reimbursed, routinely, by Medicaid, including consideration:

on: reimbursement procedures, provider qualifications, quality assurance, rate setting and service model. I spoke to the director of this project this week and the prospects look very good for Blue Cross Coverage of Patient Education programs directed toward Diabetes, Hypertension and Chronic Obstructive Pulmonary Diseases.

(12) A Nurse directed program of patient education, at Washington Adventist Hospital in Maryland has succeeded in obtaining reimbursement from Blue Cross, Medicare and Medicaid through private negotiations. These negotiations included cost effective arguments based on data from Washington Adventist Hospital.

(13) Mississippi Nurse Practitioners and Nurse Midwives are reimbursed for the services they provide in non-profit clinics with joint protocol of Physicians since 1977.

(14) On the federal level, the Rural Health Bill, HR8422, was passed and signed into law in December, 1977. In this bill, services being performed by a Primary Care Practitioner in rural clinics are covered. Also, where there is no Home Health Agency, home health services of Registered Nurses and licensed Practical Nurses who follow a written care plan are covered under Medicare.

(15) U. S. Senator Inouye has sponsored several bills to liberalize reimbursement policies toward Nurses. He has stated - and I quote - "While the scope of Nursing knowledge and expertise has increased significantly over the past few years, the preconception of Nurses as mere handmaidens to the Physician still remains with us. It is ironic that although we try to better our health services and reduce medical costs by cutting corners, we neglect to tap our valuable Nursing resources."

Now, the bad news.

(1) At the time of my study, Colorado, Massachusetts, Missouri, New York, South Carolina, South Dakota, and Virginia had no pending legislation on third party reimbursement for Nursing services.

(2) Nurses have persistently been referred to as "Physician Extenders" in federal legislation introduced in the House and Senate promoting changes in the reimbursement practices of Medicare and Medicaid.

(3) Marilyn Goldwater, Maryland State Legislator, made the point that we make constant reference to a "Health Care" system when in reality we do not have a "Health Care" system - we have an "illness system." The major emphasis of medical care treatment today is on pathology - its identification and treatment. There is a shameful lack of emphasis on preventive care and health maintenance.

We spend billions of dollars a year on this "illness system" and projections indicate that we will spend much more in the future. Yet, even as these cost figures climb, so do the figures on preventable diseases. The rising rate of Venereal Disease and the strong comeback of communicable childhood diseases we thought we had conquered are evidence enough that we are not buying better health with those billions of dollars. When we consider the cost of treating the victims of these diseases, we are forced to the conclusion that a greater emphasis on prevention would produce a healthier economy as well as a healthier population.

If we are to meet the demands of our citizens for better health care and more accessible health care for less money, then we have to turn away from the old "illness system" and develop a real "health care" delivery system.

(4) In 1975, an American Nurses Association Reimbursement Task Force looked at a variety of aspects of the "Health Care" system including its financial

structure and concluded that the traditional "health care" system fails to provide incentives for both providers and consumers to seek out and use less expensive, alternative sources of health care services.

(5) Also in 1975, an article was written in an Albany, New York, newspaper concerning a woman and her 97 year-old aunt who lived alone and suffered with crippling arthritis. The aunt's doctor died and none of the doctors in her area would take new patients. The Visiting Nurse who had been attending the aunt informed the family that nursing visits to the aunt would no longer be reimbursed until a doctor wrote an order for the continued service. The Visiting Nurses' Association assured the family that they would not abandon the aunt, but they would have to have a doctor's order eventually.

As a former Public Health Nurse, I can so easily relate to this situation. Working in a government agency that did not qualify as a Home Health Agency, we were not reimbursed for nursing services. However, through community funds, we provided a wide range of health services to the members of our community. But the sad fact of the matter was that we were taught, and quickly learned, that we did not have the capacity to follow through on every request for home care. And we knew that when we made referrals to the Visiting Nurse Service that the patient would need a doctor's order first.

Earlier in my presentation, I referred to the misconception about the nurse-physician relationship and I made reference to the sad fact that in federal legislation the nurse is referred to as a "Physician Extender." The reason this is sad is because by doing this, by continuing to view the Nurse only as an extension of the physician, we are prohibiting our citizens from receiving nursing care - not medical care - nursing care that may prevent them from needing medical care.

Please don't take this as a statement against medical care. I am making this comment with the full awareness that we need good medical care. I simply would like to make the point that the goals of nursing care are different from the goals of medical care. As Lucille Kinlein stated in her book, "Independent Nursing Practice with Clients:" "Philosophically speaking, the formal object of medicine is disease, the diagnosis and treatment thereof; whereas the formal object of nursing is the person-body, mind and soul."

Nurses have their own profession, their own licenses, and a Nurse Practice Act which spells out limitations, responsibilities, and penalties for violations. They are accountable for their professional actions. They do not practice medicine any more than physicians practice nursing.

And yet, the message behind current reimbursement seems to be that if one cannot get physician directed or executed care, one is not entitled to receive any health care.

(8) My final comment under, "the bad news" has to do with an objection that Prudential made to the New Jersey Nursing Reimbursement bills three years ago when they were first introduced, worded exactly as they are today, and I quote: "The option (and this option is third party reimbursement for nursing services) should pertain only to services ordered by a physician for the care or treatment of covered sickness or injury. Without change, the option could cover a nurse who is teaching or is counseling in health education."

This statement reflects the misconception that many people in our society share as to what "medical care" is and what "nursing care" is.

If a person is diagnosed by a physician as a diabetic and does not know how to administer injections, schedule meals to accommodate his/her insulin use and know the signs of diabetic shock and coma, this person will be no healthier after the physician diagnosis of him/her than before. The nurse in the hospital starts the adjustment process; the nurse in the community follows through. I can add numerous other examples.

In conclusion, through my interaction with members of the community in which I worked, I believe that the public needs this legislation because it means greater accessibility to health care, freedom of choice in the kind of care that is sought, and the possibility of entering the "health care" system at a level other than that of the physician.

It certainly is not the total solution to our health care problem, but it is a move in the right direction.

Physicians should welcome this legislation because it promises early detection and referral of serious problems and the benefits of follow-up care that is not generally provided.

And government should welcome this legislation because it means broadening the base of health care and contributing to the goal of better health care at lower costs. Government should not only welcome the trend, but should do all they can to encourage it.

We are the only state in the country, to my knowledge, who has requested optional, not mandatory, coverage for nursing service for our citizens. It seems ludicrous to think that by not passing legislation that will give our citizens an option to purchase independent, professional nursing care, that we are in essence refusing them a service that they would be requesting and be willing to pay for. And yet, we mandate practically in the same breath that we confirm our commitment to reducing the cost of health care that our citizens pay a doctor to receive permission to purchase nursing care.

Thank you.

SENATOR BEDELL: Thank you very much, Nancy. Was this a research paper?

MS. ANDERSON: The paper wasn't. The information ---

SENATOR BEDELL: Did you get the grade you wanted? Did you get an A?

MS. ANDERSON: Yes, I did.

SENATOR BEDELL: It was an excellent presentation. If you retire from the nursing profession sometime, I would suggest you look to the field of law. It was a very good presentation. Thank you very much.

Mr. Joseph Frankel.

J O S E P H F R A N K E L: My name is Joseph Frankel. I am Vice President of Government Relations for the Prudential Insurance Company of America, in Newark. I am also here on behalf of the Health Insurance Association of America and the American Council of Life Insurance, two associations which have member companies that write most of the health insurance in the State of New Jersey.

I am going to confine my comments this morning to Senate Bills 108 and 109, the two bills dealing with the private insurance industry. As the previous speaker just said, I was the gentleman who testified three years ago before Assemblyman Bornheimer's Assembly Banking and Insurance Committee on the predecessor

to the bills that you are considering today. The bills are exactly the same today as they were three years ago.

We have some problems with this legislation. There are really three problems. The prior speaker alluded to our main concern which is that the option in the insurance should pertain only to services ordered by a physician for the care or treatment of a covered sickness or injury. Without this change, the option could cover a nurse who is teaching or who is counselling in health education. The third line of Section 1 should be changed to read: The policyholder would provide reimbursement for any nursing service which is ordered by a physician for the care or treatment of a covered sickness or injury and is within. . . , and I will complete the total paragraph when I make my other comments.

We are also concerned that the option should be available only under a policy providing a broad range of expenses, such as major medical expense insurance. If the bill is not changed, the option might be available under loss of time policies and under policies covering only a narrow range of services, such as hospital services. I will complete that sentence at the end of my comments.

We also feel that the optional coverage should not have to cover nursing services provided by a "close relative." In our major medical, we define that term to include the insured, his spouse and a child, brother, sister or parent of the insured or his spouse. We have a suggested paragraph which could be inserted in the two bills that I have mentioned and it would read as follows: Notwithstanding any other provision of this chapter, a policy providing benefits for the expenses of hospital and physician's services may, at the option of the policyholder, provide reimbursement for any nursing service which is ordered by a physician for the care or treatment of a covered sickness or injury and is within the lawful scope of practice of a duly-licensed, registered professional nurse, provided, however, that such licensed registered professional nurse is not concurrently being paid a salary by any health care provider for the duties so performed and is not a close relative of the patient.

With these changes, Mr. Chairman, this would be legislation that we support. We think these comments have been around for a long time, as have the bills. But they are not reflected in the legislation at this time. We appreciate the opportunity to be here and I will be happy to answer any questions you may have.

SENATOR BEDELL: Thank you, Joe. I have no questions at this time. But, of course, your suggestions will be mulled over by the Committee before the legislation is finally adopted.

MR. FRANKEL: Thank you.

SENATOR BEDELL: Terry Morton.

T E R R Y M O R T O N: Senator Bedell, thank you. Good morning.

I am speaking as a concerned consumer. I am also a nurse, but I am not speaking so much from that standpoint this morning. As a consumer, I have been receiving out-patient mental health services and I was getting those services from a clinical nurse specialist at \$20 per session. Because I was a graduate student and also becoming divorced and had no moneys of my own, I very much needed those services reimbursed. The services from a clinical nurse specialist, as you are hearing this morning, are not reimbursable. Therefore, I sought out the services of a different mental health provider and that was a clinical psychologist who in this State is covered by Prudential major medical coverage that I had.

I would like to speak to the cost of that because I believe this legislation

should be favorably adopted. The clinical psychologist now charges me \$50 a session, of which Prudential pays 80 percent. Therefore, Prudential is paying \$40. Had the reimbursed the clinical nurse specialist, they would have paid \$16. Therefore, they would have saved \$24. So, I think it is in the consumer's benefit and the insurance company's benefit to provide services that are cost effective. In addition, the services are of equal quality between the clinical nurse specialist and the psychologist. As a nurse, I can say that both services are highly competent.

As a consumer, it makes me agry that I cannot choose the mental health practitioner that I want; but that because of the dictates of my financial condition, I have to see who the insurance company says is qualified for third-party reimbursement. I just think that is appalling.

SENATOR BEDELL: Thank you very much.

Joe, I know you were discussing something side bar when this was going on and I do know you have some objections to the legislation as it is currently written. But addressing this area of cost containment which is a major contemporary issue, do you find any fault with the legislation encompassing that?

MR. FRANKEL: Absolutely not. I feel kind of like the guy who was afraid after he leaves here today to go to any hospital in the State of New Jersey. I guess it is part of being "the heavy." We just have felt - and I have expressed this to Miss Slattery for a long time and her predecessor - this is a policy of long standing in our business about the physician involvement. I think these things are all good as far as cost containment is concerned and Prudential supports that. I testified before your Committee the other day on home health care legislation, which we support, in the issue of cost containment. So, we are in favor of it. We just have a hangup on this particular section.

SENATOR BEDELL: I just wanted to have that reinforced.

Yes, Ms. Morton.

MS. MORTON: Going again with the line of cost containment, I question the idea of nurses having to get a doctor's order. That is going to cost me, the consumer, a doctor's visit. In addition, Prudential is going to have to pay for that. That is my objection consumerwise. As a nurse, these are services that under the Nurse Practice Act nurses with given experience and education are qualified to do without a doctor's order. I think it takes us back to the handmaiden status again.

SENATOR BEDELL: I think that is a fundamental issue here. I think Joe's concern, as I understand it, is not so much the fact that if this were implement we could reduce the cost. I think he is more concerned that the legislation might open a myriad of other areas which are not currently reimbursable. Therefore, although in this particular instance, the cost might be less, there might be a number of more cases than his company is currently mandated to provide for.

MR. FRANKEL: Let me say this, Senator: As I said, we have made these same remarks before on similar bills. If there were amendments to the bill, maybe they wouldn't be the exact language that we have recommended here today. Maybe it would be different things to tighten up the legislation. I would be more than happy to take that proposal back to my company and to the Health Insurance Association and the American Council of Life Insurance. We do not want to be obstructionists to something that is good, solid legislation. I can assure you of that.

SENATOR BEDELL: But, Joe, you are in favor of the major premise of

the legislation, are you not?

MR. FRANKEL: No question about it.

SENATOR BEDELL: Thank you.

Judy Miller.

J U D Y M I L L E R: Good morning. I am Judy Miller. I am the Assistant Director of Services of MCOSS Nursing Services, in charge of maternal and child health services. I am speaking on behalf of our agency.

Just to let you know a little bit about who we are, MCOSS is a large private, non-profit, community health nursing agency in Monmouth County, providing a variety of services: home care, including services by both nurses and home health aides, physical therapy, speech pathology, nutrition, maternity clinics and child health clinics.

We support Senator Bedell's bills, numbers 107, 108 and 109. We support the independent practice of nursing within the scope of practices defined in the Nurse Practice Act and a means of reimbursement for same.

Other professional services, such as physical therapy and speech pathology, currently receive third party reimbursement. We feel nursing should qualify for reimbursement of professional services as well.

A nursing agency such as ours, beginning to investigate, develop and provide the program of long-term care at home, strongly supports the concept of the nursing assessment of patient condition and level of care.

Here I am going to add a few things to what you have in front of you. In community health home care, we already have the ability for some reimbursement through third party payment, such as, Blue Cross-Blue Shield and Prudential's Medicare-Medicaid, but it is limited and a physician's signature is required. A couple of examples of that are: We are able to receive reimbursement by a third party for health education in a couple of specific instances. One is parenting if there is a family that is having a great deal of difficulty. Working with a specific situation, we are able to go in and help them with the parenting and, therefore, prevent something more drastic, such as child abuse. We are able to do limited diabetic teaching, which is paid for, for example, by both Medicaid and Medicare. However, it is limited. If the patient is not ready to care for their diabetes on their own, we must either bear that cost ourselves or the patient is on his own without proper training.

To talk a little bit more about the long-term care type of program, we would like to see an evaluation visit by a nurse where the nurse can go in and plan nursing care. There again, I am speaking of nursing care, not medical care. We too do not want to see medical care opted out in favor of nursing care. A nurse could go in and supervise a home health aide, for example. A nurse can go in and provide some range of motion, not to a fractured hip, but to an aging person who could stay at home and be more economically cared for at home. We could then refer to medical care as appropriate, which may happen earlier than the patient might normally go to a doctor - again, more cost effective.

This independent assessment by nurses must qualify, we feel, for reimbursement by a health insurance mechanism without a physician's signature. If this is on preventive maintenance, levels of wellness and client participation in determining the care mandates the expanded role of nurses in the provision of and planning for services. Thank you.

SENATOR BEDELL: Thank you very much. That is the MCOSS of Monmouth

County you said, did you not?

MS. MILLER: Yes.

SENATOR BEDELL: I hope you will convey the personal wishes of the chair to Mrs. Stanley with whom I have worked in the past and for whom I have a great deal of admiration. Thank you.

Joan McNahan. (Not present.)

Sandra Havill.

S A N D R A H A V I L L: Good morning. I am Sandra Havill, a Pediatric Nurse Practitioner. I am employed by MCOSS in Monmouth County. I am just here to say that I support the passage of these bills and hope very much that third party reimbursement for nurses will be secured through these bills.

Thank you.

SENATOR BEDELL: Thank you very much.

Dr. Smoyak, Rutgers University. (Not present.)

Kevin McNally, Ironbound Community Health Project.

K E V I N M C N A L L Y: Good morning, Senator. My name is Kevin McNally and I am Manager of Child Health Services for the Ironbound Community Health Project. I have given you written testimony and rather than take your time by reading it, I will just try to hit the highlights of it.

The Child Health Screening Program of the Ironbound Community Health Project is a well-child screening program. We provide services to Medicaid and medically indigent children up to the age of 12 in our neighborhood, which is the Ironbound Section of Newark, New Jersey. Since we began the program in April 1979, we have screened more than 900 children. We do this with two Pediatric Nurse-Practitioners, who are supervised by a physician.

The program came about because a group of parents and teachers in our community were concerned about the lack of child health services. The Ironbound Section of Newark has 14 family doctors and 7 pediatricians to cover medical care for 60,000 residents. We have one small hospital, St. James, which does not have a pediatric clinic and there are no health centers. The hospital's emergency room is really the "family doctor" for many residents of our community, particularly for the children.

We don't see ourselves as competition for the other services in our community. We see ourselves as a supplement. The physicians practicing in our community, because there are so few, have very heavy patient loads. They really have time only to deal with the immediate problems or symptoms that the patient comes in with. There isn't time for them to go into a comprehensive physical assessment of a child if they come in for an illness. Periodic visits for well-child care are not encouraged. They are not discouraged, but they are not really encouraged either. We provide the type of comprehensive screening that many of these children need. In the process of this, we find asymptomatic problems with vision, hearing, anemia, lead poisoning, development, etc. We find these usually at the early ages of children, children at the pre-school ages, where when these problems are identified they are treatable and usually reversible, correctible; but they can develop into much more serious problems, even handicaps later in life, if left untreated. Out of the 900 children we have screened, 40 percent of these children have needed referral for further medical diagnosis and treatment.

We, as a program, won't benefit directly from the three bills

that are proposed, in that our reimbursement comes primarily from Medicaid and from the City of Newark.

However, we are testifying today because we see this as an important first step - an important precedent - towards providing very needed services. We think that the kind of services in the Ironbound Health Project are the kinds of services that are appropriate for nurses to provide and the kinds of services which will become more prevalent if the legislation that you have proposed does become law.

In particular, there are three aspects of this issue that we feel are important enough to talk about in some detail. The first is cost. This was alluded to earlier. We pay our nurse-practitioners \$12 an hour; we pay our pediatrician \$25 an hour. It takes the same amount of time for a physician to do the screening as a nurse. There is no gain in productivity because a physician is doing this. Quite frankly, we could not afford to run our program under current reimbursement if all our screenings had to be done by a physician.

The second issue is the appropriate use of personnel. Having worked at the College of Medicine and Dentistry of New Jersey for three years, I am quite aware that doctors are trained to recognize and treat disease. Nurses, on the other hand, receive more training than doctors usually in things like health education, counseling and other areas of disease prevention. There is increasing recognition of the value of prevention and education in reducing total health care costs. I was disappointed in hearing the comments earlier today by the representatives of Blue Cross-Blue Shield and of Prudential, saying those reimbursements should be limited only to treatment of medical illness and injury. I thought the greatest long-term potential for cost containment and cost effectiveness in the health care system is bringing in this kind of reimbursement for preventive services that nurses are appropriate to provide. I was disappointed because both those organizations have put out some very excellent literature on aspects of disease prevention, some of which we use and give out in our health project. Unfortunately, from the testimony this morning, I could only conclude that these organizations are not willing to put their dollars where their rhetoric is at this point.

Another aspect of the utilization of personnel is that many physicians in group practices currently utilize professional nurses to do these kinds of services, but they bill for the services under their own names since the nurses are not directly reimbursable at this point. What that means is that the physician has to handle the reimbursement paperwork. I think that we would all agree that very valuable and expensive physician time is much better spent in direct patient care than it is in handling paperwork kinds of things.

The third issue is the issue of quality assurance, which has been mentioned before; that is: Who assures the adequacy of the care provided by professional nurses if they are able to practice independently under direct reimbursement? I think the answer is that they are under the existing State licensure authority in the State Board of Nursing, just as physicians in private practice are under the existing State licensure authority for physicians in the State Board of Medical Examiners. Also, like physicians, nurses must be concerned with the patient's power to sue for malpractice.

That is all I have to say. I am open to any questions that you might have for me. Thank you.

SENATOR BEDELL: I do appreciate your testimony, Mr. McNally. You have deliberated on the heart of the controversy. You have reinforced your position quite well. Thank you very much.

MR. MC NALLY: Thank you, Senator.

SENATOR BEDELL: At this time, we will take a five-minute break for the stenographer.

(Short Recess)

SENATOR BEDELL: Ladies and gentlemen, we are going to reconvene at this time.

I would like to call upon Marilyn S. Wrable.

M A R I L Y N S. W R A B L E: My name is Marilyn Wrable and I am speaking as a provider.

I strongly believe there is a need for third party reimbursement for consumers who decide to contract for mental health services with a master's prepared psychiatric nurse. At the present time, the consumer has the full financial burden because there is no third party reimbursement for these services and I view this as discrimination against the consumer by third party providers.

There is an increased need for mental health services and the consumer with third party coverage has the right to choose whichever discipline best meets his or her needs. Third party reimbursement for mental health services rendered by a master's prepared psychiatric nurse is imperative for the consumer in need of such services.

Also, I would like to add, the master's prepared psychiatric nurse is autonomous and doesn't need to be under the supervision of a physician by virtue of his or her training and peer review. Thank you.

SENATOR BEDELL: Thank you very much.

Dr. John Wrable.

D R. J O H N W R A B L E, J R.: My name is Dr. John Wrable, Jr. I am a physician. You are going to hear the other side.

First of all, I would like to focus on the patient. It seems that we always get away from the patient. My concern is: What is the patient's right when he is insured and what is his right to reimbursement from the insurance company? They make contracts out. It seems to me that in some of these contracts there should be reimbursement for nursing on all levels if that is what they want to contract for.

I don't agree with the bill that reimbursement for all nursing services should be made. I think specific nursing services should be reimbursed. And that is by virtue of the nurse's training and certification. There is no question there is a need out there for these nurses - no question about it. But the need is for specific nurses, highly skilled and trained.

I know the psychiatric nurse clinician because my wife is one. I have watched her over the years training in theoretical and clinical psychiatry and she is a highly qualified person. That is the type of person that should be reimbursed; the qualified and the certified - that is where the reimbursement should be made.

I see no need for doctor referral because they are qualified and in areas such as the clinical area, probably more so.

That is about all I have to say. But I think the bill should be more

specific; it is too broad. You talk about cost containment. I think the cost, if it is so broad, will be just as bad as it is now.

SENATOR BEDELL: Doctor, to get more specific, are you saying that nurses giving counselling or educational services should not be reimbursed, that we shouldn't go that far?

DR. WRABLE: If they are qualified in counselling --- Listen to what I am saying. The nurse should be qualified and qualified by virtue of her educational level and certification. Nurses have certifications, such as psychiatric nurses, who become certified in their area. I think by level of their education and by their certification, those are the people who should be reimbursed. To just broadly reimburse all nurses for counselling and things like that, without qualifications, I don't believe should be done.

SENATOR BEDELL: Thank you, sir.

Ann Williams.

A N N W I L L I A M S: My name is Ann Williams and I am going to read from my statement.

I am a nurse, but I come here this morning from the viewpoint of the consumer because sometime ago I rather suddenly developed a bleeding ulcer which required a brief hospitalization and the services of a medical specialist. Within a few days, the doctor discharged me with instructions about diet and medicine and a recommendation that I avoid stress. After a couple of weeks, I returned to work and gradually resumed my responsibilities within my family. I was uneasy about many of my activities and wondered whether some of them might have created the stress that was thought to have caused the ulcer. I also began to feel uncertain of myself, almost like a beginner in a new job, while, in reality, I was an experienced nurse, thoroughly familiar with and before my illness confident and comfortable in my job. My doctor assured me that the ulcer had healed very well and that I had no reason to worry.

Although the doctor's reassurance allayed my concern about the ulcer itself, I continued to feel uneasy. It was apparent that although I had no medical problem and, therefore, did not need a doctor, I still didn't feel normal. From the medical standpoint, I was cured, but I seemed to be having a human response to illness that I didn't fully understand. I engaged the services of a nurse clinical specialist and, with her assistance, was able over a period of a few months to identify several ways to eliminate or reduce stress in my life without drastically changing my life-style.

I noticed that anytime I thought about changing my life-style drastically by dropping family responsibilities or maybe quitting my job or becoming part time, I felt extremely stressed.

I remain in the same job, again, getting great satisfaction from it and feel well and quite content with my life and comfortable with my life-style. I believe this has been possible because, at a crucial time, I was able to engage a professional whose role is "maintaining and promoting health, preventing illness and caring for and rehabilitating the sick and disabled." That is from a definition of "nursing" by Martha Rogers, a nursing theorist.

Through my husband's employer and mine, our family has two Blue Cross-Blue Shield policies and two separate kinds of major medical insurance. None of these included coverage for the professional service I have described, even though such service played a significant role in my return to full health. It would seem

more effective and less expensive in the long run to the individual, to the insurer, and to society itself, to pay for professional service which assists in maintenance and return to health rather than to pay only for care during illness.

SENATOR BEDELL: Thank you.

Jo Namerow.

J O N A M E R O W: Good afternoon, Senator Bedell.

As a gerontological nurse practitioner, I speak in favor of Senate Bills Numbers 107, 108 and 109. The older population in New Jersey is not receiving needed health services. A review of the 1977 New Jersey Health Statistics indicates the needs of New Jersey's aging and aged citizens. The mortality rates point out the health care problems faced by New Jersey's aged citizens. The overall mortality rate in New Jersey is 893.3 per 100,000 population. This rate is above the national average of 871.1 per 100,000 population. In the age group 65 and over, the mortality rate in New Jersey is 5,675.3 per 100,000 population compared to the national average of 5,284.9 per 100,000 population.

Furthermore, the mortality rate in New Jersey for the age group 65 and over is significantly higher for 5 of the 10 leading causes of death in the United States. Of the 21 counties in New Jersey, 13 exceed the national death rate for heart disease; 14 for cancer; and 14 for diabetes.

I speak in support of direct third party reimbursement for nurses - S 107, 108 and 109. The health needs of New Jersey are not being met. Older adults rely on third party mechanisms to pay for their health care. Reimbursement for nursing services, a health-oriented, illness-preventing service, will increase the accessibility of the care to the citizens of this State. Reimbursement mechanisms have proven that current policy makes health care, or should I say illness care, a privilege, not a right, to those privileged few who have access to service.

The institutionalized and home-bound elderly need access to health services. The inner-city and rural elderly of New Jersey need access to health services.

Gerontological nurse practitioners are prepared to provide care to older adults in their homes with the goal of preventing expensive, usually to the taxpayer, nursing home placement. Nurses are prepared to care for those inner-city and rural residents. Nurses need access to these consumers. Consumers need the reimbursement vehicle for nursing service. This legislation is that mechanism.

Thank you.

SENATOR BEDELL: Thank you.

JoAnn Chasnow.

J O A N N C H A S N O W: Good afternoon, Senator. Thank you for allowing me to testify this afternoon.

My name is JoAnn Chasnow and I am Chairperson of the New Jersey Medically Needy Coalition. I am a consumer and I am not a nurse.

There are several issues which I would like to address today. The first has to do with the general orientation of our health care delivery system. Being a member of the Central Jersey Health Planning Council, it has become quite evident to me that our system is, first, a system of disease care and crisis intervention; and, second, not interested in dealing with some of the basic issues behind cost containment.

It is necessary for us to carefully examine the most appropriate uses of

non-physician health care providers, including registered nurses, nurse practitioners, certified nurse midwives, and physician's assistants, to enable them to function within the scope of their education.

This State has certainly been consistently reluctant to allow and encourage these providers to practice within the full limits of their education, particularly, within the areas of primary care, health promotion and disease prevention.

It has been extensively documented, in addition, that health promotion is extremely cost effective and yet many of those who can provide such health promotion are being restrained in their abilities to function.

I am aware of present efforts by the State Department of Health and the State Department of Insurance to make recommendations to include certain preventive services within health insurance policies, as was mentioned at a recent Senate Subcommittee hearing on insurance and health care costs. It would clearly be within the best interests of the third-party payers, to encourage reimbursement of non-physician health care providers. Additionally, without third party reimbursement, there would be a general restriction of the consumer's right to choose.

Lastly, the issue of accessibility must be addressed. By allowing for third party reimbursement and so increasing the number of available providers, we will be advocating increased awareness of health maintenance.

I have one general reservation. It seems to me that there is one major oversight. Although third party reimbursement would increase accessibility for all consumers who are covered by the Blues and private insurance companies, it will not increase accessibility for Medicaid recipients.

I have one general recommendation and that is, as we may require third party reimbursement for non-physician health care providers, we must also expand Medicaid to reimburse these important groups of health care providers and simultaneously require that these providers accept a certain percentage of Medicaid recipients. Unfortunately, this is not presently required of physicians. But I know that we need to insure improved access for low-income people as well.

I will be glad to entertain any questions.

SENATOR BEDELL: Thank you very much.

Elaine Templin.

H. E L A I N E T E M P L I N: Senator Bedell, I speak as a nurse, but primarily as a consumer of the existing health care delivery system. Please consider the consumer. We want to go to qualified persons of our choice and yet receive insurance coverage for the services rendered.

I would like to interject some personal history if I may. I sought out a certified psychiatric clinical specialist five years ago and soon after that quit. I am a middle-class working woman with children in college and I am sure, if you have experienced that, you know how expensive that is. About a year and a half ago, it was discovered that a family member had a neurological condition and that was hard for me to accept. I returned to the same competent, independent nurse practitioner.

I do not understand why I, a consumer, am arbitrarily denied insurance coverage because I choose to seek out a nurse who is trained in a specialized area rather than a member of another discipline. I urge you not to make insurance

coverage so restrictive, but to allow consumers the freedom of choice to select nurse professionals in whom we have confidence without being economically penalized.

As I understand it, the elected representatives protect such freedoms as our freedom of choice of health care practitioners without having to bear the burden of economic repercussions.

SENATOR BEDELL: I want to thank you very much. I share your views and your concern that legislators make it possible to provide that kind of service for people who are not getting it at the present time. Thank you.

Ruth Mitchell, New Jersey State Nurses' Association.

R U T H D. M I T C H E L L: My name is Ruth Mitchell and I am speaking as a community health nurse. I want to thank you for this opportunity to speak this afternoon.

It seems that anyone who resides in New Jersey has at some point heard chuckles and various remarks regarding some aspect of our State. Our reputation often seems to be one of being "behind the times" and of possessing a host of undesirable qualities. Our image is usually not that of a leader and an innovator. Yet, in one field, we have been a leader. In certain aspects of health care in New Jersey, we are leading. These two areas are diagnosis-related groupings (a method of reimbursement for hospitals) and hospice care (a type of care for patients with end-stage disease). With these two programs, we are evidencing a desire to take chances, to try something new and to incorporate fresh approaches into the established health care system. This is not to judge the DRG method or hospice care; they are already a reality. But other states do not have the DRG system, nor do many states have a coordinated and wide network of hospice care where providers are working closely with third party payors to establish reimbursement for a new service. These two areas are two examples of New Jersey emerging as a leader in health care.

Now New Jersey has another opportunity to lead - to be one of the first few states to reimburse nurses for the care we provide. Such reimbursement complements and strengthens the two previously mentioned programs quite readily, in addition to suiting other settings where nurses provide care. In particular, I will address community health care settings, as some of the other speakers have.

Various factors in addition to the DRG system and hospice care are increasingly responsible for keeping patients in the community or returning them to the community more rapidly than ever before. Nurses have been, and are more frequently, becoming a source of primary health care to those in the community. These nurses are known by various labels: visiting nurse, public health nurse, community health nurse, board of health nurse, clinic nurse, the nurse and "my" nurse. Whatever the title, these professional nurses often are an entry level for the public to receive care. What kind of care? Nurses provide an array of nursing services in the community. For example, a patient is discharged from the hospital following surgery. The patient will need to learn care for the surgical wound, as well as incorporate and adjust to life-style changes. In order to facilitate this adjustment, the patient's family will also need to be educated about these changes. In such a situation, either the family or the hospital might contact the agency providing home care. A nurse goes to the home to provide the care. Visits normally are forty-five minutes to an hour and a half in duration.

Care would continue daily or several times per week until the patient and the family were independent and knowledgeable in the care and the patient's level of functioning had increased satisfactorily.

A second example might be a referral for home care initiated by the patient or family. For instance, an elderly person or the family often requests a nurse if the person is having bowel elimination problems. The nurse would visit the patient, evaluate the situation and then make recommendations, such as dietary alterations. Physical care, such as an enema, might also be done by the nurse in the home. The thrust is not only to resolve the immediate problem but to prevent its recurrence through teaching.

Other examples of care for patients in the home are: the monitoring of the cardiac status by auscultating the lungs, reviewing the proper administration of medications and evaluating the patient's activity level; counseling the families of chronically ill patients and providing support, teaching and direct care to patients with end-stage diseases. In all the aforementioned situations, nurses make many decisions, both large and small. They are alone with the patients and families in homes with no back-up assistance readily available as there is in a hospital or nursing home setting. This necessitates a high level of clinical expertise on the part of the nurse and the ability to make independent judgments within the practice of nursing.

In the ambulatory care setting, a nurse might provide counseling to a young woman about methods of birth control and help her to choose a method and use it effectively. Again, in this setting, the nurse is providing direct care that is carefully geared to the individual patient, and includes a great deal of counseling and teaching.

Under the current reimbursement system when services in the home are rendered by nurses, as explained in the above examples, the patient must be seen by a physician initially and periodically thereafter. If a visit is initially impractical, as in the case of the person with a bowel problem, then telephone contact must be made with the patient's physician before actually visiting and providing care. If the patient does not have a regular physician whom the patient has recently seen, then the patient must go to a hospital emergency room. Obviously, this can be a very expensive and draining experience for a patient who may only need a change in diet. At times, the regulation mandating visits to a physician is readily met because the patient has medical problems necessitating diagnosis and treatment as well as nursing problems.

In the ambulatory care setting, there is no mechanism for reimbursement of nursing services at all.

Often patients must see and pay physicians when the nurse is a more appropriate care-giver in a particular circumstance. In order for the ambulatory care center to effectively play "the numbers game" the patient sees the physician so that a third party payor might be billed and the nurse then provides the direct care for no acknowledgment by the third party payor.

In my experience in home care, many physicians recognize the nurse's role and the fact that the nurse has ready accessibility to patients, the family situation is well known and, most importantly, the nurse is capable and licensed to provide a certain kind of health care independent of a physician. Physicians have frequently been heard to tell the nurse by phone that "you know what to do, just send me the treatment plan and I'll sign for whatever you think is best."

A professional nurse is very much aware of the limitations on practice of the New Jersey Nurse Practice Act. It is not ignored and physicians are readily informed when medical judgment and treatment are needed for a patient. However, the system breaks down when nursing problems that are in actuality being appropriately handled by professional nurses must be rubber-stamped by a member of another profession. Needless visits to physicians are artificially generated resulting in higher costs to the patient. Another aspect to the situation is the fact that many referrals are initiated by the public. They often have an accurate sense of the most appropriate health professional to provide the care. And this same public finds it difficult to comprehend why they must incur a bill from one professional when they sought care from a different professional.

As hospitals decrease the length of stays for patients and the community demands alternatives to institutional care, the role of the nurse will have even greater impact. New Jersey must be cognizant of these changes and take the opportunity to be a leader in the health field. Thank you.

SENATOR BEDELL: Thank you very much.

Glenna Slattery.

G L E N N A S L A T T E R Y: My name is Glenna Slattery and I am the Legislative Agent for the New Jersey State Nurses' Association.

Thank you for allowing me to speak. I hadn't intended to speak today. But as I am listening to the testimony, I appreciate the opportunity to present something that I think should be in the document.

The New Jersey State Nurses' Association has historically been interested in consumer protection. In 1903, this Association lobbied successfully for the licensing of the registered nurse in New Jersey to assure the quality of those services rendered. The first Nurse Practice Act was passed that year.

In 1913, the Association sought successfully accountability and regulation by statute; and the statute was passed that made the Board of Nursing as a reality. We monitor and account for ourselves, by ourselves.

Much of today's testimony has revolved around the statutory right of a nurse to practice independent of another discipline. In order to clarify for those who will read this testimony, I would like to read into the record the definition of the practice of a registered professional nurse which was placed in the statute under the current administration with intensive lobbying by the New Jersey State Nurses' Association in 1974. It is the present framework within which the 75,000 licensed registered professional nurses practice in New Jersey today. It is Public Law 1947, Chapter 262, as amended, An Act to regulate and control the teaching and practice of nursing and to provide penalties for the violations thereof. (Reading) "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being and executing medical regimen as prescribed by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means the identification of and discrimination between physical and psychosocial science and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic

measures essential to the effective management and execution of the nursing regimen. Human responses means those signs, symptoms, and processes which denote the individual's health need or reaction to an actual or potential health problem."

It is within the framework of this definition that my people wish to be reimbursed, for there is much that could be delivered through this definition by the way of health. In the rereading of the definition, you will see, as nurses, we take the acute pathological condition as only part of the human existence. Thank you very much for the opportunity to speak.

SENATOR BEDELL: Thank you.

Is there anyone else present who wishes to speak at this time?

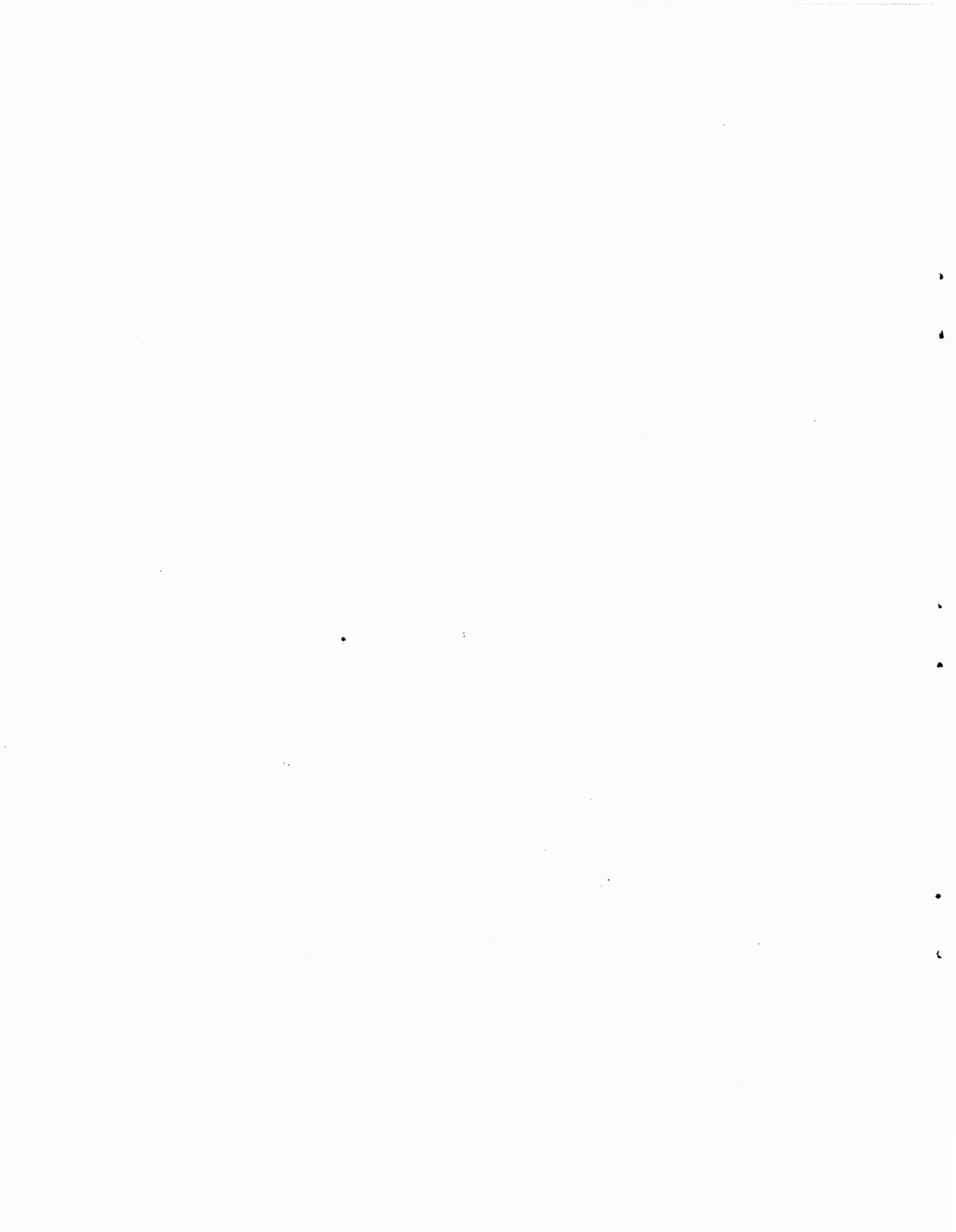
(No response.)

I want to thank all of you for giving us the benefit of your views and your time today. I assure you that what has been advocated or opposed will be fully considered by the legislators. Hopefully, we will get some action on this legislation which, to my mind, is long overdue, in the very near future. Thank you all for coming.

The hearing is now closed.

(Hearing Concluded)

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APPENDIX A

Comparative Costs, Non-Institutionalized vs. Institutionalized Health Services*

1. 74-year old male, post-stroke:

<u>17 weeks intensive home care</u>	<u>equivalent hospital care 119 days</u>
visits by registered professional nurse and others, totalling 50 visits; visits by home health aide totalling 34 hours	@ \$100 per day
Cost: \$1,230	Cost: \$11,900

SAVINGS: \$10,690	

<u>on-going home maintenance care</u>	<u>equivalent nursing home care per week</u>
one visit every 2 months by nurse, and 3 hours per week by home health aide	
Cost: \$25.00 per week	Cost: at least \$150 per week

SAVINGS: \$125 per week	

2. 90-year old female, post-stroke, congestive heart failure -terminal prognosis:

<u>5 weeks intensive home care</u>	<u>comparable institutional care 35 days</u>
visits by nurse and physical therapist totalling 29 visits	per diem costs only
Cost: \$349.13	Cost: hospital - \$2,695 nursing home \$875

SAVINGS: \$2,345.87 - COMMUNITY VS. HOSPITAL SETTING \$525187 - COMMUNITY VS. NURSING HOME SETTING	

3. 89-year old female, totally blind, post-stroke

<u>160 days home maintenance care</u>	<u>comparable institutional care 160 days</u>
visits by nurse, social worker and home health aide totalling 42 visits	per diem costs only
Cost: \$399	Cost: hospital - \$12,320 nursing home - \$4,000

SAVINGS: \$11,921 - COMMUNITY VS. HOSPITAL SETTING \$ 3,601 - COMMUNITY VS. NURSING HOME SETTING	

4. The Rochester, New York Home Care Association studied the results of early release of patients from hospitals to home health programs. Results showed an estimated reduction of 13,713 patient days and a savings of \$1,055,000 in calendar year 1970; and an estimated reduction of 12,579 patient days and a savings of \$1,068,000 in calendar year 1971.
5. The Denver Department of Health and Hospitals studied the results of its Early Hospital Discharge Program and showed a savings of \$515,729 in Hospital costs for Medicare patients in 1970 as a result of early discharge of 292 patients from hospitals to home care programs.

The major portion of care rendered in the above cited examples was rendered by registered professional nurses. All care was coordinated by registered professional nurses. Similar cost effectiveness will be immediately implemented throughout the general population of New York State if utilization of reimbursement by third party payers for services of registered professional nurses is authorized through enactment of this legislation.

*Excerpted from NEWS, National League for Nursing, October 23, 1974.

