P U B L I C H E A R I N G

before

ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

To examine the problem of nursing staff shortages in this State

September 28, 1987
State Museum Auditorium
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Harold L. Colburn, Jr., Chairman
Assemblyman Rodney P. Frelinghuysen
Assemblyman Thomas J. Deverin
Assemblyman George J. Otlowski

ALSO PRESENT:

David Price
Office of Legislative Services
Aide, Assembly Health and Human
Resources Committee

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New Jersey State Legislature
ASSEMBLY HEALTH AND HUMAN
RESOURCES COMMITTEE
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September 17, 1987

NOTICE OF A PUBLIC HEARING

THE ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE ANNOUNCES A PUBLIC HEARING TO EXAMINE THE PROBLEM OF NURSING STAFF SHORTAGES IN NEW JERSEY

Monday, September 28, 1987
Beginning at 1:00 P.M.
State Museum Auditorium
Trenton, New Jersey

The Assembly Health and Human Resources Committee will hold a public hearing on Monday, September 28, 1987, beginning at 1:00 P.M., in the State Museum Auditorium, Trenton, New Jersey, to examine the problem of nursing staff shortages in this State. The purpose of this hearing is to receive testimony about problems relating to the hiring and retention of high quality nursing and allied health professionals in hospitals and other health care settings and the consequences for health care consumers, as well as possible legislative and administrative policy initiatives to address these problems.

Address any questions or requests to testify to David Price, Committee Aide (609-292-1646), State House Annex, Trenton, New Jersey 08625. Persons wishing to testify are asked to submit nine typed copies of their testimony on the day of the hearing. The chairman may find it necessary to limit the number of witnesses or the time available to each witness.

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ASSEMBLYMAN HAROLD L. COLBURN (Chairman): Good afternoon. For any of you who are not aware of it -- and perhaps all of you are -- there are lists of the expected witnesses in these boxes up front. I think there may have been some outside the door also. We are going to get going. I would like to call the public hearing to order. As you know, the purpose of this hearing is to find out as much as we can about the reasons for the shortage of nurses in New Jersey, and what the Legislature might reasonably do to help alleviate the problem.

We have quite a few people to speak today. We have been told by the folks who run the auditorium, that we are supposed to be out of here no later than five p.m. So, if we don't finish by then, we will probably be swept out. I will be deviating from the order of the people on the witness list. What I am trying to do-- First of all, we usually give courtesy to the legislative members who wish to testify, and secondly, I would like to get as many variations of opinion as I can. I think chances are we will pretty much agree on things, but I would like to give chances to people who have varying opinions. I would also like to weight the list, as much as I can, on the side of nurses themselves. So, you'll see this evolving we are going to have. We will have one or two people, and then we will have a couple of nurses, then we'll have another one, and that is the way it is going to work.

We are not going to try to get any kind of a biased sample here. We are here to learn, all of us. The members of the Committee have been on this Committee-- Two of them have been Chairmen of this Committee in the past, and they have a lot more experience than I. They are Mr. Deverin and Mr. Otlowski. Believe me, they, and we, are interested in the problem and in trying to solve it. Everyone is sincere about that on this Committee. Not only do we have Mr. Deverin and Mr. Otlowski here, but we also have Assemblyman Frelinghuysen,

who is sitting next to me. I am Harold Colburn. I am Chairman of the Assembly Health and Human Resources Committee. Dave Price is the nonpartisan aide to us all, the man we all trust. We don't have to worry about him zinging us in any way. Then, we have our own aides here and there, who will tend to zing a little bit, but everybody here is really very fair, very friendly, and highly intelligent, I might tell you. They are always a big help.

I think with that, I will call the first witness. Let me get a little run-down on the first witness. (Assemblyman Colburn peruses witness list) The first witness will be Assemblyman Jack Collins. He represents the Third District; that is Salem County and parts of Cumberland and Gloucester. He, himself, is from Elmer. He is the prime sponsor of A-4001, which establishes a Registered Professional Nurse Manpower Commission to study the nursing shortage in New Jersey. That bill passed the Assembly by a 72 to 1 vote in June of this year, and is awaiting action in the Senate. He is also the prime sponsor of A-4483, which provides for an increase in hospital nursing salaries. Mr. Collins?

A S S E M B L Y M A N J A C K C O L L I N S: Thank you, Mr. Chairman, members of the Committee. I am honored to come before your Committee today, though the honor is somewhat laid back because of the importance of why I come. I think all of us, over the last few months -- if not longer for those directly involved -- are very familiar with what is going on with our nursing shortage here in New Jersey. As you mentioned, Mr. Chairman, my bill -- A-4001 -- has left the Assembly and is now waiting in the Senate for a floor vote, a vote I would hope would take place soon; one that really has caused me to even think of calling on the Governor to act in his powers -- to use his powers -- in an executive order even, to maybe put this commission into action right now. I think it is something we have to think about. I don't know if today is

the day we have to make a decision like that, but I do know that that commission, which will give us much needed information far beyond just wage concerns for the nursing industry -- nursing profession -- is something we may well have to look very closely at, with great speed, in the upcoming days.

Today we come with the bill I am very proud to be the prime sponsor of in our house -- A-4483. That is a bill that will make permanent the recommendations that were made just a month ago by the Hospital Rate Setting Commission. As you well know, and members of the Committee know, that action took place, and brought into the pocketbooks of nurses much needed funds to keep them able to have a commitment to their profession.

We throw the word "profession" around quite easily. These days, everyone is a professional. But who can think at all of a profession that is more important to society than nursing -- not just in the past, but where we are now, as we move into the twenty-first century? All of us are part of an aging America, let alone an aging New Jersey. With so many of the changes in how we take care of our ill, we have to look at what is going on in hospitals. We have more nurses working now than we have ever had, but we still have a great, great shortage. Nationwide, 83% of the hospitals have vacancies, when it comes to their need for nurses. Why is this? The commission in A-4001, hopefully, will give us some of those answers. But this bill -- A-4483 -- will allow us to continue to meet this wage demand that is being forced upon our nurses here in New Jersey.

We know they can go right across the river -- be it the river to the north or the river to the south, be it New York or Philadelphia -- and make thousands and thousands of dollars more helping the citizens in those states, more so than helping our own citizens.

People in hospitals are more ill in comparison than people have been in years past, because of outpatient service, and so on. More nursing hours are spent directly with patients. We must respond to this challenge. Wages is but one way, and I want to make that very clear, but that is the way we are dealing with today. What this bill will do, is enable the temporary recommendations that were made a month ago to become permanent. Wages are a part of it. Starting wages are not really the major problem. The problem is, we have people -- and I am sure people in this audience -- who have labored, given their hearts and souls for years, and the starting salary goes from, once it begins, to a maximum increase of approximately $7000, in most places, over a lifetime. We have to look at the total picture. This is what this bill will enable us to do. It will enable the continuation of what the Hospital Rate Setting Commission did. It will also set up a committee to look into what would be proper wages, as we look at the eastern part of our country, where New Jersey is right at the hub.

When nursing started with Florence Nightingale, it was a voluntary profession. We can't ask our nurses to be volunteers in 1987. Things have changed. The profession is at its peak. People are growing all the time professionally, and we have to give them the proper compensation. If we don't, the reduction in future nurses -- and it is shown right now in our nursing schools -- is something we are just not going to be able to deal with as we move on into the twenty-first century. All of us, young and old, black and white, male and female, rich and poor -- all of us -- will some day, in all probability, need a nurse. Let's hope they will be there to help us.

Thank you, Mr. Chairman. (applause)

ASSEMBLYMAN COLBURN: Thank you. Theoretically, at these public hearings, I think we discourage applause. I know

it is merited, but one of the things is, if you applaud too long, that gives less time to the witnesses. So, you might give a quick response, and then have it be over with, because we are trying not to have arguments or shouting or screaming. if you don't agree with somebody, kindly be as courteous to him or her as you possibly can.

Does anyone have any questions of Mr. Collins?

ASSEMBLYMAN DEVERIN: Yes, I do. When did you introduce this bill, Assemblyman?

ASSEMBLYMAN COLLINS: Why?

ASSEMBLYMAN DEVERIN: When, when?

ASSEMBLYMAN COLLINS: When? This was introduced on the fourteenth, Assemblyman, at our last session.

ASSEMBLYMAN DEVERIN: Okay. Certainly everyone agrees that the salary is-- You don't think it is that important, but it is probably the most important thing in the problem. I met recently with the nun who is the head of nursing at St. Peter's and with the director of St. Peter's. I have three very large hospitals in Elizabeth, and one in Rahway, and I am very much aware of the problem.

I don't know how your bill is funded, though. That is the only thing that worries me. I think if we are really going to do something, the State has to put some money where its mouth is. The State has to start paying, one way or the other. It has to start paying for the salaries. It has to start granting some aid and tuition. It has to put some more money into the nursing schools; it has to make them stronger. It has to entice people into the industry. Does your bill do that? I am not sure what it does.

ASSEMBLYMAN COLLINS: No. This does not bring the State in as you just said. This bill will extend what happened, as I said, a month ago. But, A-4001, when that report comes out -- the 18-member commission -- if we can get it out of the Senate and get it signed by the Governor, will

really give us the perspective, Assemblyman, that I think you are looking for, and the schools are, and the hospitals are, and can really move us forward. This is stopgap at the present time. As many have said, even this increase, when it took place, was not enough. That is what we want to find out, but we don't want to slide back at the end of the period of this temporary rate increase -- back to where we were before.

But, your point is well taken. It is something I know you will be supportive of as we move forward.

ASSEMBLYMAN DEVERIN: The only problem with increasing the rates is, you muster up so much opposition. As you would know if you had been on this Committee as long as the Doctor, Rodney, George, and I have, every time there is an increase in rates, you have an audience full of people against you. You have the business people, the labor people, the clients, the insurance companies. I would rather see that bill, as it is written -- and I understand it is written pretty well -- have the State pick up the funding. There is no reason why we can't. If the teachers were entitled to it, certainly the nurses are entitled to it. (applause)

I think, Assemblyman, if you really take a good look at that bill, you can really change some of the funding and let the State put some kind of money in, particularly in the areas where there are shortages; and, you know, particularly where the nurses are needed. The funny part about it is, if you increase the rates in the hospitals, the opposition is murder. So, I think we ought to take a look, if that study commission is ever formed -- look at some way the State can put some money in, because if they have one obligation, it is to take care of the people who are sick, as you said. We have the obligation of taking care of the older people as they get sick, and nursing is probably the basis for good health care in America. So, we have to do that. I think you have to take a look at the refunding of that bill, and you will have much more success with it.

ASSEMBLYMAN COLLINS: Your point is well taken, Assemblyman. Not being here when the teachers' plan went through the Assembly, though being familiar with it, I think opposition arose there also. I think there will always be opposition to increases in wages, wherever the moneys will be coming from. As you just said, the State's obligation to take care of the sick is there. No one is more important in taking care of the sick than nurses, so I hope that logic and reason will win out. As we go through this process, there will be many ideas thrown into the discussion, such as you just did, and I am open to suggestions. I just want to make sure that where we are going is forward, not backward, or even stationary.

ASSEMBLYMAN COLBURN: Thank you. Any further questions? (no response) Thanks, Mr. Collins.

ASSEMBLYMAN COLLINS: Thank you, Mr. Chairman.

ASSEMBLYMAN COLBURN: The second witness will be Assemblywoman Joann Smith, who represents the Thirteenth District, which includes parts of Middlesex and Monmouth. She is from Old Bridge. She is a prime sponsor of A-4001, which establishes a Registered Professional Nurse Manpower Commission, as you know. She is also a co-sponsor of A-4483, which provides for an increase in salaries. Additionally, she has recently sponsored a $270,000 appropriation bill to expand the nursing scholarship program. Good afternoon.

A S S E M B L Y W O M A N J O A N N H. S M I T H: Good afternoon, and thank you, Mr. Chairman and members of the Committee.

Obviously, we are all here for one reason. The reason is, we recognize the fact that there are many inequities and many problems in the shortage in the one profession that is probably the most important of all to the people of this State and their health and well-being. As someone who got very involved long before I became an Assemblywoman in many things because of close family in the profession -- and in other areas

of the medical profession also -- I found out there were many inequities.

The hospitals in the area that sort of service the district I live in -- Old Bridge Regional and Bay Shore Hospital in South Amboy and Riverview -- have problems, just those hospitals alone in upper Monmouth and lower Middlesex Counties. I believe their quota is understaffed by about 120 personnel in the nursing profession.

After talking to many of the people, I realize it is not just a question of money. It is a question of conditions; it is a question of job classification, if you categorize it as that. Nurses are doing much more than just the nursing profession these days, because of the DRG factor. That seems to be the catchall -- the DRG factor. When there is no money to pay for services, they sort of say, "Well, let the night nurse do the administrative work, and let this one do that," and so forth. I think I owe a special debt to some in particular, because I know there is one special one out there who gave up a month's vacation to care for a daughter of mine who was critical for a long time. I feel I owe her, and I owe the whole profession probably, to make their lives a little bit easier, and to help them along the way.

The problem we face is not going to be solved overnight. Bottom-line salary and State-mandated State pay is fine to say, but what happens with the hospitals? Even when the moneys are allocated through their budgets-- The moneys seem to tend to get placed elsewhere. There is always enough for everything else, it seems, except for the nursing staff and the things they need. The L.P.N.s are probably in the same position. They are not being treated as fairly as they should be either. So, there is no incentive for a girl to come out of school and to have to have a degree any more, to even consider going into the profession. It is not classified with the high esteem it should be, and it had been for many, many years. In

fact, there are so many menial jobs now that are being done by the nursing profession that I think it is just downright-- It is just not fair, really, you know.

So, I am happy to be a prime co-sponsor for two of the pieces of legislation that are most important, which might help to brighten that light a little way to guide us to what to do. It is most important that these people are there. I know for a fact that a couple of weeks ago, part of a wing was closed off in a hospital because they didn't have the staff. But then you overload the personnel in another wing. That is not the way to do it.

I don't know what the answer is. This is one reason I am hoping this commission that I am prime sponsor on with Jack Collins will work as expeditiously as possible to help us to find another avenue. Through the input from the nurses and their profession, maybe we can come up with some of the solutions anyway.

I would like to thank you for allowing me to be here. I know it is going to be a long day for you.

ASSEMBLYMAN COLBURN: Thank you. Any questions on the part of the Committee? Assemblyman Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Assemblywoman, could you comment on your appropriations bill to expand the nursing scholarship program?

ASSEMBLYWOMAN SMITH: Well, basically it is an incentive bill, of course. The nurses will be eligible for scholarships so they can continue their training. It's simple, but very to the point.

ASSEMBLYMAN COLBURN: Are there any further questions? (no response) Thanks very much.

ASSEMBLYWOMAN SMITH: Thank you.

ASSEMBLYMAN COLBURN: The next witness will be Assemblyman Robert Singer, who represents the Tenth District -- Ocean County. He is the Deputy Mayor of Lakewood. He is

Secretary/Treasurer of the Ocean County Board of Health, which has the largest visiting nurse service in the State of New Jersey. He is on the Foundation of Ocean County Community College, which has an excellent nursing school. He is also on the Board of Kimball Medical Center. He is no stranger to the needs of nurses, and he is a prime sponsor of A-4483, which provides for an increase in hospital nursing salaries. Assemblyman?

A S S E M B L Y M A N R O B E R T W. S I N G E R: Good afternoon, Mr. Chairman. Thank you for the opportunity to share a few brief thoughts with you.

Ocean County, as you may or may not know, is the fastest growing county in the State of New Jersey, and the largest senior citizen county in the State of New Jersey. Certainly, with the increase of nursing homes being built in the county -- there are a number of them under construction -- with the increase of life care centers -- there are at least six or seven in various phases of construction in the county -- with the expansion of all of our hospitals in the last few years, we are starting to see a major crunch in the nursing shortage within our county. Certainly, this is becoming more acute to us in running the visiting nurse service throughout the county -- the service that cares for so many seniors who are home, and helps them along so finely.

We are concerned because the competitiveness in this field is driving our nurses out-of-state, and discouraging our young people from coming into this field. Certainly, as you have heard before, we did such a fine job with bringing up the salary scales of teachers throughout the State, and we must do the same thing with the nursing profession throughout the State of New Jersey.

It is essential that we are able to attract young people into the field knowing there is a potential for making money, and also, of course, that it is a fine profession to

come into. I think certainly the study commission that will look at salaries to be competitive -- and Tom certainly mentioned that-- We have to do something along those lines -- there is no question about it -- to see that we are competitive with surrounding states, to make sure we are not the follower, but that we are the pacesetter. I think that is something all of us in New Jersey always try to be -- the pacesetter. We should certainly strive to be on top, not just following along with everyone else. I hope that commission will come back with those kinds of answers for us.

I would just like to comment, though, on something Assemblyman Deverin said. I am concerned, too, about the cost to people. When you start raising fees, you know we all get the comment coming back, "Another hike! Another hike!" But, unfortunately, the State cannot always be everything to everybody. We are looking at our largest surplus ever, and certainly I would like to see full funding for community colleges throughout the State. Our nursing school in Ocean County could certainly use that, as could all of the other community colleges. Maybe if we looked at taking that large surplus and possibly using some for nursing, and using some for other things -- for instance, the Transportation Trust Fund, and things of that sort-- We certainly might want to take some of that surplus away.

I think presently we must deal with the fact that we are not using that surplus; we are using the money at hand. The money at hand requires a raise, and we are going to have to go along those lines. I would be more than willing, and offer at any time -- if we want to talk about separate moneys for nursing from the surplus -- to sponsor that, and work with you on that. That is certainly an avenue you want to look into.

But right now, we have to deal with the money at hand. I can say to you that, looking at the future of Ocean County, if something is not done now, or in the near future, we

are going to be at a standstill in our county. I would like to share with you just one brief thought: We have the first retirement community of its kind in the State of New Jersey, the original Leisure Village, which is in Lakewood. It houses some 3500 senior citizens. This development was opened 25 years ago. The medium age in Leisure Village today is the mid-'80s. That starts to tell you the kind of care that is going to be needed down the road in Ocean County to help these senior citizens. Certainly, nurses play a major part in that. If we don't prepare for that, and don't prepare for the future in our State, especially in Ocean County with its large senior population, we are going to have a serious problem.

I think the bill is a start, certainly not a finish, and certainly something we can be proud of, to say that we have contributed a major factor in bringing up the financial standards of nurses throughout the State of New Jersey.

ASSEMBLYMAN COLBURN: Thank you. Any questions? (no response) Thanks very much.

ASSEMBLYMAN SINGER: Thank you, Mr. Chairman.

ASSEMBLYMAN COLBURN: The last elected person to be a witness will be Senator James Hurley, from the First District. He is the Senate Minority Leader, and represents Cape May and Cumberland.

S E N A T O R J A M E S R. H U R L E Y: Thank you. Mr. Chairman, members of the Committee: I rode up with a bus load of people from Bridgeton and Millville who are concerned about this problem. I joined them, because we are worried about the severe shortage of nurses in our hospitals throughout the State.

The problem is apparent enough. New Jersey has a 17% vacancy rate in the area of nursing, compared with the usual 7% to 10%, and a 12.7% nursing vacancy rate nationwide. Many hospitals have been forced to reduce the number of available beds because of the shortage of registered nurses. The reasons for this shortage are easy to explain, if we look closely at

the problem, and we are all part of -- probably everybody in this room, and certainly members of the Legislature -- have in the past been part of efforts to try to contain the costs of hospital care. The problem is, the system is out of balance now, and because it is out of balance it has cost us this tremendous shortage in nurses. There are a lot of other factors, too, which will be testified upon by other speakers.

For too long now, nurses have been the neglected stepchildren of the health care industry. They have been asked to perform difficult duties and to work long hours, yet when the time comes to cut up the health care pie, they have been getting a sliver.

In our New Jersey hospitals, nurses are offered a lower starting salary than their counterparts in surrounding states. Nurses have been visiting me in my office and showing me the advertisements, from Philadelphia for example, which is just across the river from us. Since our hospitals are also competing with other health care providers that pay higher nursing salaries, they are losing the battle. The State bears some of the responsibility for the salaries, because we are so involved in the regulation of our hospitals. The temporary action by the State Hospital Rate Setting Commission to increase the labor economic factor by 2% is a good first step, but we need to make this permanent, and you have heard testimony about Assemblyman Jack Collins' bill today.

There are 2500 registered nurse vacancies throughout the State. We are also facing shortages in other areas, too, I am told. Hospital pharmacists, physical therapists, and allied health professionals are in high demand. Low salaries lead to fewer professionals in our hospitals, which causes an extra burden for the nurses on the job, which forces morale down. More nurses leave the profession, and hospitals are forced to reduce the number of available beds. It is a vicious circle. We are in that circle, and we have been there for some time.

To help to combat this cycle -- and you are considering Assembly Bill 4483 by Assemblyman Jack Collins, which provides for an increase-- Although I commend the Committee and Assemblyman Collins for this legislation, and vow to fight for it in the Senate, I know that much more needs to be done. I understand the sponsor of the bill in the Senate will be Senator Codey, and I have asked to sign on as a co-sponsor with him.

We in the Legislature must take a comprehensive look at the shortages and come up with some long-term answers. One plan of attack I ask to have explored -- and Senator Gagliano has also joined in this request -- is in the field of educating those who choose nursing and other health care professions. Surveys conducted between 1974 and 1986 by the American Council on Education and the UCLA Cooperative Institution Research Program, showed a 50% drop in the proportion of first-time, full-time freshmen women in all kinds of institutions of higher learning who plan to pursue careers in nursing.

I am proposing that we, the Legislature, through the Department of Education and the Department of Higher Education, formulate a program to increase interest and awareness in the health care fields among our high school students. We should, through a State effort, go into our high schools and promote the good work nurses do, and encourage others to pursue this worthwhile profession. And we should offer substantial financial assistance to those students studying nursing in New Jersey colleges and universities. We should offer our nursing students a deal: If they stay in New Jersey and work in one of our hospitals after graduation for five years, we will pay for their education, or a portion thereof.

Now, we are going to have to market this proposal if it is going to be successful. But my feeling is, when you have a problem like this, it needs to have the same kind of creative answers, and innovative answers, that we have given to other

problems of the same nature. One of those could be forgiveness of student loans, or actually paying for their education if they sign a contract to stay in New Jersey and work in our hospitals.

There are other things we can do, too. We can support the call for this blue-ribbon commission, or blue-ribbon panel, which will recommend ways to make hospital nursing more financially rewarding, appealing, and effective. We cannot solve this problem overnight, but by working together, we can begin to reverse the trend away from nursing and other health care professions.

Again, Mr. Chairman, I commend you and the members of this Committee for facing the problem head-on by having this hearing today. I will do all I can in the Senate to work for a better future for New Jersey's nurses.

Thank you.

ASSEMBLYMAN COLBURN: Thank you very much. Any questions? Mr. Deverin?

ASSEMBLYMAN DEVERIN: Senator, I noticed you almost tripped going up the stairs.

SENATOR HURLEY: Yes.

ASSEMBLYMAN DEVERIN: You couldn't pick a better day to do it, with all these nurses. (laughter)

SENATOR HURLEY: You always were one for the good one-liners, Tom. I was hoping you didn't notice that.

ASSEMBLYMAN DEVERIN: I agree with you, Jim. That is what I talked about before. We have to create some incentive for people to go into nursing. It has to be the State that does that. As Mr. Singer said, we are probably one of the wealthiest states in the nation. We have to find some way to encourage children coming out of the high schools who want to go to college to go to nursing schools and take nursing degrees in college, and to pay for it.

There is a very interesting statistic -- I am not sure you have the answer to it -- about the number of nurses we have a shortage of. Now, when I had those meetings with St. Elizabeth's and St. Peter's, one of the things one of the nurses told me was that there are plenty of nurses in New Jersey -- licensed nurses -- who are not practicing. I am not sure I know whether that is true or not. They are in some other field -- sales; they are in everything but nursing. Now there ought to be some incentive to get those people back, and that is where the salary comes in.

So, I agree with your testimony, Jim. We will do everything we can to help in that. You know, I have a lot of faith in study commissions, and I have no faith in study commissions. You and I have been here a long time, and so has George. If you want to kill something, and you want to delay something, you study it. (laughter) When I ask Mrs. Deverin to make a steak, she is going to study it, and I never get that steak. So I know that works that way. I am not sure the commission is even necessary, but it is something we should do.

The germ of an idea you have -- the incentive for getting the children coming out of high school to go into nursing -- and a reason to get the people who are in the profession but not working at the profession back into the profession, are two things we ought to work on.

SENATOR HURLEY: Thank you, Assemblyman. I heard your comments, and whether you do it by means of subsidizing the salaries or whether you do it by forgiveness of loans or whether you do it by actually paying at the time they sign a contract to go to work for five years -- however you do it -- we are in concurrence. I will be anxious to see how your Committee functions and what it reports out in the days and weeks ahead. I can assure you I will support that in the Senate.

Thank you, Mr. Chairman.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen, did you have a comment or a question?

ASSEMBLYMAN FRELINGHUYSEN: Yes. Mr. Chairman, I don't think we should interpret Mr. Deverin's comments, nor do I think he meant them, in any negative way. I personally feel that the commission is a good idea, because it will serve to focus public attention on the problem -- greater public attention. While there is often a tendency to study things to death and to set up commissions and not expect those commission reports to bring out a recommended product, I think in this case the recommendations have validity, because I think we will be able to build legislation, and you will be able to build support for your case.

I can say that over the last couple of weeks -- and I'm sure my colleagues here have felt the same way -- we have had more letters from nurses than we have ever had in the past. It is nice to be able to say -- and I think we mean it -- that we give full faith and credit to the notion of the study commission. I don't think in any way we meant anything negative about it. I think it has merit, and I think it will bring more public visibility to a critical problem not only in this State, but across the nation.

Thank you.

ASSEMBLYMAN COLBURN: Thank you. Thanks, Senator. The next two witnesses will represent the nursing profession. The first will be Andrea Aughenbaugh, from the New Jersey State Nurses Association. Just so you will know where the ax will fall next, Ruth Strickland will be after that.

A N D R E A A U G H E N B A U G H: Thank you, Mr. Chairman. My name is Andrea Aughenbaugh. I am the Associate Director for the New Jersey State Nurses Association. I am taking the place of Judy Brett, who is our Chairperson for the Legislation Committee, who has to teach a class this afternoon.

We want to thank you, Mr. Chairman, for this public hearing. We are here today to lend our support for A-4483, the bill to increase reimbursement to acute care hospitals for nurses. We appreciate the New Jersey Assembly's attention to this matter, and wish to thank Assemblypeople Jack Collins, Joann Smith, Robert Singer, and Joseph Azzolina, for their sensitivity to the profession on this issue. Jack Collins and Joann Smith are also the sponsors of a bill to create a commission to study the nursing shortage, which is a very necessary step if we are to address the shortage of nurses across all work settings. The bill we are here to discuss today specifically focuses on rate reimbursement in the acute care system, and it specifically focuses on adding 2% to a labor economic factor, referring to professional nurses as part of that factor.

The New Jersey State Nurses Association wishes to be on record as fully supporting this bill and its amendments, because we know this system is seriously underfunded for nursing costs, and every 2% helps.

We are here today, however, to also be on record as fully supporting nursing as a revenue producing center for hospitals, and to point out the astonishing fact that nowhere in the rate reimbursement system does the Department of Health cost out nursing service.

Over a year ago, this Committee held another public hearing to examine the effects of the DRG system on hospital costs and quality of care. Your focus at that meeting was the study by researchers at Harvard and MIT published in "Health Affairs," Summer 1986.

The major conclusion of that study was that the DRG system had not significantly altered the behavior of physicians or hospital administrators. This three-year study, funded by the Robert Wood Johnson Foundation, not only failed to address how the DRGs had affected the behavior of nurses, it did not even perceive that nurses needed to be a subject for the study.

I think you are going to hear testimony today that is going to make you understand that the DRGs have drastically changed the practice of nursing. Nurses today have called on all their reserves to come forth with good care in a system that has caused them a great change in practice.

In addition, the study came to the conclusion that in New Jersey, as in the rest of the country, new technology is the heart of the modern hospital and, therefore, the grand struggle for planners is how to allocate that technology. I want to affirm that; that is the great struggle. Everybody wants to have new technology in their hospital, and they completely forget about the one piece of health care that is essential for the modern hospital.

So, here we are one year later, in the depths of the worst nursing shortage yet, and the reimbursement system has been caught by surprise and is totally ill-equipped to cope. Short of the Department throwing more money into the total system and individual managers shifting their resources, no solutions are presented. In fact, historically that is the traditional response to all past nursing shortages. According to Linda Aiken, a Robert Wood Johnson researcher, the 1987 nursing shortage follows an equally severe 1979 shortage that was the result of wages lagging behind other women's occupations. The 1979 shortage had been preceded by the 1961 shortage that had the same cause. All nursing crises in the past 20 years have been solved by raising salaries. Nurses respond to wage increases by inactive nurses returning to active employment, and part-time nurses increasing their hours.

What the New Jersey State Nurses Association is suggesting today, is that health care planning can avoid these periodic shortages that endanger patients and exasperate nurses. Relying on a slow-to-respond captured labor market to provide full staffing is unnecessary, if the planners would only cost out nursing services as a first step to acknowledge

the profession as a resource center and revenue producing department.

The New Jersey State Nurses Association maintains that 24-hour nursing care is the real heart of the modern hospital. Patients are admitted to hospitals to receive 24-hour nursing care. They can get their tests as an outpatient; they can get their surgery as an outpatient; and they can visit their physician as an outpatient, but if at any time they need to be monitored and cared for, they are admitted to receive 24-hour nursing care.

Payers should understand that while the physician admits patients to the hospital, it is the nursing care that gets them discharged.

You cannot stabilize nursing staff without a reimbursement system that understands what nurses do. Costing them out is a first step. Acuity systems that are being written into the regulations are a management tool, not a reimbursement tool. To have your case mix data be able to tell you your nursing costs would be invaluable.

All the research is done. New Jersey's Department of Health is way ahead of its time. Nursing can be costed out and nurse staffing can be stabilized. New Jersey does not have to experience another shortage, but more importantly, New Jersey nurses do not have to be anonymous, invisible, and only missed when they are gone.

With a costing out system, New Jersey nurses would not have to hit bottom before the so-called marketplace, which is regulated and captured, responds. The Department has not yet moved on this issue. We are asking the Legislature to take the lead for nursing's future, and to cost out nursing.

I have copies of my testimony, and also of a couple of articles by Linda Aiken, which I referred to.

ASSEMBLYMAN COLBURN: Fine, thank you. Any questions on the part of the Committee?

ASSEMBLYMAN DEVERIN: Andrea, do you know how many nurses there are in New Jersey who are not practicing, but who are in the labor market?

MS. AUGHENBAUGH: We are going--

ASSEMBLYMAN DEVERIN: That question just bugs me. I just want to know if anyone knows the answer.

MS. AUGHENBAUGH: It is not very high any more. There are more nurses working today than ever before. That is one of the things that is a little frightening about this shortage, although we are sure that when the wages go up, more part-timers will work full-time, and some will come out of inactivity. But nursing as a woman's occupation has the highest percentage of women working, so it may be 20% to 25%.

ASSEMBLYMAN DEVERIN: One of the conversations I had with the nun from St. Peter's, was that they are sometimes so short that they have to go to an agency for the private nurses, and pay them the $18 an hour, as compared to their floor nurses, who are getting $10.80 an hour, or something. That is how short they are. That is the market they say they hope we can get back into the nursing profession.

MS. AUGHENBAUGH: But, there are other reasons why nurses go to agencies. That is what a commission would address, as all commissions have addressed in the past. There are certain basics--

ASSEMBLYMAN DEVERIN: I have no objection to a commission, Andrea, and you know that--

MS. AUGHENBAUGH: --to the word "commission."

ASSEMBLYMAN DEVERIN: --except I have a room full of commission reports. You have been around here, too, and you know what I am talking about. Unless they set a deadline, a date, an end, a beginning, forget it. You are not going to get anything from it. Unless they set a date for the appointments -- a date when one-year appointments must be finished -- and when the commission starts, you know-- I just want to make

sure we don't promise something that isn't going to work, that's all. But I have no objection to a commission.

What would the commission bring out? I'm sorry. What would it show us, as far as the market?

MS. AUGHENBAUGH: It again will point out the working conditions that are so frustrating to nurses, which are part of the reason why they drop out. Wages is number one, and always has been. It will bring them back if you bring the wages up. But there is a lot more for nurses out there than just the wages. That is what we think costing out will do. At least everybody will pay attention that there is a nurse. It was incredible that you could do a study and come to the conclusion that new technology is the heart of the hospital. It is not the heart. Nurses are the heart of the hospital.

ASSEMBLYMAN DEVERIN: Absolutely, I buy that; I agree with that. My brother just went through a very serious operation. When he came home from the hospital, I never heard him mention his physician. Excuse me, Doc. I never heard him say whether he was good or bad. I never heard him say whether the food was good or bad. All he talked about were the great nurses he had, and I mean that. That is why-- Most of us have known nurses, and it bugs us that we can't get this shortage over with. Whatever we have to do, I'm sure we are going to do one way or another.

MS. AUGHENBAUGH: Yeah, I think New Jersey is responding.

ASSEMBLYMAN COLBURN: Do you want to ask any questions, Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Yes, Mr. Chairman. What about the whole issue of promotion and frustration with going up the ladder, so to speak? Isn't there a feeling among nurses that they can only go so far and then they are turned into paperwork nurses?

MS. AUGHENBAUGH: Yes, there is.

ASSEMBLYMAN FRELINGHUYSEN: Could you comment on that? I must say that I, for the first time in my six or seven years of being on the Board of Trustees of a hospital, at a full presentation last week from one of your colleagues, you know, up in my neck of the woods, who reviewed a lot of what we are going to be hearing today, which I have already heard-- One of the things she pointed out was the frustration with the whole ability to be a fine nurse, and when you get the experience behind you after five or ten or fifteen years, you are held down by the salary. And, if you get a higher position, it is purely paperwork. It takes you away from the bedside. Can you comment on that?

S U S A N R E I N H A R D: I can. I am Susan Reinhard, a lobbyist with the State Nurses Association. Assemblyman Frelinghuysen, I know you have Morristown Memorial nurses calling you all the time. They call us and tell us how well you respond to them.

What you are pointing out, too, is a problem in the system that goes beyond salaries, but does include the salary issue. One of the points of the commission is to address the working practice setting for nurses, and part of that is management. Andrea's point was that until we really look at what nurses do and cost that out, we really won't have a grip on any part of the solution to the problem.

One of the things is, in the regulations for Chapter 83, the specifications of the cost centers for each unit -- med-surg, OB, psyc, etc. -- list the functions of that unit. It is inferred that the functions of the unit are identical to the functions of the nurse. Those functions are very task oriented. Basically, it says that nurses collect urine and sputum specimens and keep the room neat and report and observe, and those kinds of things. It does not even identify in the regulations an expectation that professional nurses have a practice that is unique and that makes a complete difference in

each client's length of stay and discharge status. That is what the experienced nurse can do. The more experienced that nurse is, the more able he or she is to expedite the actual care plan and discharge of the patient.

Hospitals right now -- and it will be different for each hospial you talk to -- have a salary structure that will identify different salaries for nurses, at the entry level and perhaps up to two, three, four, five years. Maybe some of the nurses here can confirm what I'm saying. Many of them do not really make a difference. It does not make a difference in them if you have more than six or eight years of experience. The reason that is so is because they don't see in the system that a nurse can do anything different after those eight years. You have sort of maxed out on what you can contribute. Now, the nurses here know that that is not so. They have that intuitive sense. They have a wealth of scientific knowledge, as well as experience. (applause) What has to happen is a system that allows them to apply that knowledge and experience in a meaningful way, and for them to be recognized for the application of that knowledge and those skills, and to be reimbursed appropriately.

ASSEMBLYMAN FRELINGHUYSEN: Thank you. I'm glad your remarks are being recorded. I will be able to see them in print as well. Thank you.

ASSEMBLYMAN COLBURN: I was going to ask you -- either of you -- the amount of money the commission is allowing now to go into the labor factor-- Will that go to nurses specifically?

MS. AUGHENBAUGH: Not the way the bill is written.

ASSEMBLYMAN COLBURN: Well, I mean what the commission just did -- the Hospital Rate Setting Commission. They just allowed a certain, what, 2% into the labor thing. Now, that is not specifically directed to nurses, or is it?

MS. AUGHENBAUGH: They allowed the 2%, yes, for nurses.

MS. REINHARD: Each hospital was to make its own decision. It was a cash flow release, I think. They were really up against it.

ASSEMBLYMAN COLBURN: So they could use it for things other than nurses, I guess.

MS. AUGHENBAUGH: They could, yeah.

MS. REINHARD: That has been our problem all along.

ASSEMBLYMAN COLBURN: Okay. Now, the bill itself, how do you interpret the bill? Does that specify nurses?

MS. AUGHENBAUGH: No.

ASSEMBLYMAN COLBURN: I thought it did.

ASSEMBLYMAN DEVERIN: No, it doesn't. (inaudible response here from audience)

ASSEMBLYMAN COLBURN: The bill that we are--

UNIDENTIFIED SPEAKER FROM AUDIENCE: Right.

MR. PRICE (Committee Aide): It does.

ASSEMBLYMAN COLBURN: It does? David Price thinks it does. (indiscernible discussion among Committee members and aide at this point)

ASSEMBLYMAN DEVERIN: If it doesn't, it certainly should. You know, what is the sense of putting in a bill to give the hospital more money?

ASSEMBLYMAN COLBURN: See, my feeling is that if we do it, it should be specified, because that is the problem we are trying to solve. (applause)

MS. REINHARD: You should be aware that the labor economic factor -- and I believe Pamela Dickson will most appropriately address this issue-- But the labor economic factor does not specify nursing. There is no nurse proxy as part of the labor economic factor. It is for hospital workers per se. But I'm sure Ms. Dickson can address that.

ASSEMBLYMAN COLBURN: The other question I had was-- Let's assume that the 2% were directed only at nursing salaries. Would that be sufficient, do you think, to meet the

problem? (negative response from audience) I am only asking. (laughter)

MS. AUGHENBAUGH: No. They have a gap like this, and that is going to take care of this. We're for it, because at least it takes care of that.

ASSEMBLYMAN COLBURN: It's a step in the right direction.

MS. AUGHENBAUGH: Yes.

ASSEMBLYMAN COLBURN: Okay. Thanks a lot.

ASSEMBLYMAN OTLOWSKI: Doctor, may I--

ASSEMBLYMAN COLBURN: Sure, Mr. Otlowski.

ASSEMBLYMAN OTLOWSKI: I just want to make you feel comfortable. I am so different from Tommy's brother. You know, I like nurses, but I like doctors, too. I just wanted to make you feel comfortable after--

ASSEMBLYMAN COLBURN: His brother took a turn for the nurse, you know that. (laughter)

ASSEMBLYMAN OTLOWSKI: --Tommy's statement. The observation I want to make at this point is, I think this Committee, of course, has an important task before it. It is not just looking at a commission. I think we have to look at the whole picture, and hopefully the testimony will develop a very, very broad picture, with some of the problems that exist as far as nurses are concerned.

I just want to point this out to you: For the past 30 years that I have sat on panels, all that I have heard is the fact about the nurse shortage -- for the past 30 years. And we have been talking about it for the past 30 years. As a matter of fact, it has gotten more intense, rather than less intense, in those 30 years, with all of the talk, all of the attention that we have given to it. I hope that by the testimony that is going to be given here today, we are going to get something that will give us some sense of direction; that will give us some ideas; that will give us a better look at the total picture.

Are we just talking about wages? Is this something that should be negotiated with hospitals? Or are we talking about conditions of nurses? Are we talking about what is going to attract nurses to the field of nursing? I think we have to get that specific about what we are talking about, and what we expect to come out of this hearing. If we are just going to be limiting this hearing to the commission, you know, I think it is going to be very circumspect and circumscribed. Frankly, I hope I am not going to be sitting here for the next couple of hours and just hearing something that I have heard for the past 30 years. I hope, you know-- I am not apologizing for my age, but I just want to-- I hope there is going to be something new, something that is going to be attractive, something that is possible, and something that is going to answer the question, and not the same jargon that I have been hearing for the past 30 years.

I just wanted to make that observation, Mr. Chairman.

ASSEMBLYMAN COLBURN: Thank you.

MS. AUGHENBAUGH: I would like to respond, if I might. We think that costing out nursing services is the new thought. Many of the things you just mentioned are management problems, to be solved at the management level. But costing out will begin to recognize nurses for what they do. (applause)

ASSEMBLYMAN COLBURN: Thanks a lot.

I looked over this witness list, and I thought we ought to find some staff nurses who actually treat the patients. That is the way I feel as a physician, that those of us who treat patients probably know a lot, even though we might give these anecdotes. They always criticize us for anecdotal evidence. I have decided that anecdotal evidence is often the beginning of the truth, and the beginning of the solution of a problem. Do you have some anecdotes, or do you have some other stuff?

R U T H S T R I C K L A N D: I guess we will find out.

Chairman Colburn and Committee members: My name is Ruth Strickland, staff nurse at Riverview Medical Center in Red Bank. I appreciate the opportunity to speak and to represent my colleagues. I gave testimony before you in July, 1986, when you held a public hearing to examine the effects of the DRG system. If and when Assembly Bill 3438 -- which, Chairman Colburn, you are sponsor of -- is passed by the Senate and signed by Governor Kean, I plan to apply for appointment to the commission that it will establish.

I realize you have been, or will be, inundated with reams of data and statistics as to nurse vacancy rates, declining nursing school enrollments, and many other objective and measurable items. I wish to address you from a purely subjective and personal level, and I know that I speak for a great number of my peers.

I've worked as a staff nurse on a med-surg unit at Riverview for 11 years. I've been in nursing practice for 21 years, with 90% of that time spent in acute care hospital settings, involved with daily bedside nursing care.

Traditionally in the nursing profession, those of us who chose to remain at the bedside have done so with an altruistic understanding and acceptance. This self-sacrifice will no longer be the norm, but the exception. In addition to the satisfaction we derive from patient care, we "modern day" nurses need and expect other things -- a few of which are upward mobility, control of our practice, social status and acceptance, less pressure, better hours, more recognition, improved staffing, and more money.

Yes, at the risk of sounding cold and mercenary, I say more money. I am not foolish enough to think that money is the total solution to the nursing shortage, but I think it can help make a difference.

The prospect of higher base salaries would stimulate an increase in nursing school enrollment and attract more and better qualified new graduates, as opposed to young people being lured into business, industry, or other fields which offer much better prospects for upward mobility and financial incentives.

The long-term nurse experiences salary compression. Her experience and knowledge should be compensated at a higher salary, but she often earns only a small amount more than the newly hired inexperienced nurse, due to diminishing health care dollars.

Increased funding for nursing salaries would augment job dignity and satisfaction. Professional recognition by clinical ladders, clinical certifications, and merit raises requires money to finance. These vastly improve professionalism and nursing performance, which ultimately result in better patient care.

Speaking from a personal standpoint, I was very disappointed with own my hospital's inability to implement a clinical ladder. The detailed criteria for this program have been established and are ready to be activated, but due to funding problems, this program has been placed on the back burner.

In the nursing profession, if one does not go into administration or academia, there is little room for advancement, and there is little recognition for bedside nursing. The clinical ladder helps address this by granting professional status, a title other than just "staff nurse," and financial remuneration.

Over the years, I have seen many changes. Today's patients are admitted to the hospital much sicker and in need of more complex care. In addition, due to high utilization and demand for ICU beds, patients are often transferred to med-surg units from ICU while still requiring intensive nursing care.

This has required med-surg nurses to learn and implement technology and care that prior to this was available only in an ICU setting. This greatly increases job-related stress.

This increased complexity and acuity of patients requires more nursing care hours per patient. For quality nursing care to be provided, this would translate into more nurses to care for the same number of patients. In reality, however, we have fewer nurses, because nurses are leaving the profession, and new people are choosing other more attractive fields. We who remain, must assume this extra burden. This is a large contributing factor to nursing burnout.

An additional stress is the expanded teaching role nurses have had to assume. We must teach the patient and family general health restoration and maintenance, and explain detailed, often complex, discharge plans for home care. If done effectively, it has been shown to reduce readmission for the same problem. For patient education to be effective, the patient and family must feel physically and emotionally ready. With the burden of much shortened hospital stays, we must often begin teaching before the patient and family are "ready."

The nursing shortage also means that those of us who remain, must work harder and harder. Patients come to the hospital to be "nursed." Physicians send patients to the hospital to be "nursed." Patients, physicians, and the courts demand that patients receive adequate nursing care. What will happen to hospitals, and more importantly, patients, as fewer nurses choose to "nurse"?

Who is going to be available to "nurse" our rapidly enlarging elderly population and the increasing numbers of AIDS patients? These very special groups, at various times in their life span and disease process, in addition to requiring hospital care, will need complex home care, and many will eventually need extended care placement. More nurses will be needed for these alternate health care settings, but where will they come from?

As I said before, money is not the complete answer to the nursing shortage, but would certainly be a motivating factor to encourage more nurses to enter the profession, to keep those of us already in the profession working, and to encourage inactive nurses to reenter the work force. Increased salaries are also able to support a host of intangibles that support a general feeling of professional satisfaction.

I appreciate your interest and concern about the nursing shortage and your desire to attempt to find a solution to it. (applause)

ASSEMBLYMAN COLBURN: Thank you. Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: Thank you, Mr. Chairman. you mentioned several things you thought would attract and keep nurses in the field. You mentioned wages.

MS. STRICKLAND: Right.

ASSEMBLYMAN OTLOWSKI: You mentioned better management, and with the management better recognition of the nurse's role. Am I correct about that?

MS. STRICKLAND: Yes.

ASSEMBLYMAN OTLOWSKI: You also mentioned promotions for the kind of work nurses do, so there would be recognition.

MS. STRICKLAND: I think you are referring to the clinical ladder.

ASSEMBLYMAN OTLOWSKI: Right.

MS. STRICKLAND: Yes. That is for bedside nurses to be recognized for being experienced and knowledgeable. Rather than going into management or administration, some of us prefer to remain at bedside to do bedside nursing. In the past, we did not receive much recognition for that, whereas with clinical ladders, you receive higher status, and also a higher salary to compensate for your experience and knowledge.

ASSEMBLYMAN OTLOWSKI: Let me ask this question. I am merely probing, because I just want to have some questions answered in my own mind. Are you saying that hospitals

themselves do not have the kind of approach that is necessary to provide this kind of a program you are talking about for nurses?

MS. STRICKLAND: Well, hospitals have to have money to fund it. It requires money. You have people who, after they pass the criteria and they move up the clinical ladder, receive more money. If they don't have the money--

ASSEMBLYMAN OTLOWSKI: All right, let's just stay with that for a moment. I guess that is one of the things that has been bugging all of us, you know, where is the money going to come from, without upsetting the balance -- the supposed balance -- you have now with hospital costs?

Are you saying then that if you are going to get the nurse who is going to be everything you hope she will be, and if you are going to get the nurse who will stay in the hospital, be attracted to a hospital-- Are you saying then that there is money that has to come from-- There is only one way the money will come. It will either come from the patient, it will come from a subsidy from the government -- when I say "the government," I mean the Federal government or the State -- or some other general funds that are very, very limited. Private charity today is very limited because of the kind of costs we are facing. As someone said a moment ago, the day of the volunteer is over.

Have you any ideas? Have you been talking -- in the process of what you are saying now -- about how this would be funded, other than placing the cost on the patient? What would the role of the State be? How much money would the State be expected to spend to bring about the kind of conditions you are talking about?

MS. STRICKLAND: I really have no idea, in terms of a set number of dollars. That is not my field of expertise. Some of the previous speakers have already suggested several places money could come from -- the surplus State funds. There

are also gambling profits. There are also Lottery moneys. (applause) A previous speaker talked about costing out (a few words here inaudible due to applause) so that nurses can be paid separately.

ASSEMBLYMAN OTLOWSKI: Excuse me, I didn't hear the last part of your sentence because the applause destroyed it. Would you repeat that?

MS. STRICKLAND: The last speaker talked about costing out nursing service, so that nursing service would be distinct from the rest of the services the hospital would provide to the patient.

ASSEMBLYMAN OTLOWSKI: So, are you saying then that in the total hospital approach, and the total medical approach, that you are going to look for a solution for the nurses; that that has to be looked at separately, divorced from the hospital, divorced from the medical treatment; that the nurse has to be looked upon separately, if we are going to treat her fairly and adequately?

MS. STRICKLAND: Yes. Let me tell you, in the hospital, if there is not a housekeeper around, who does the housekeeping? A nurse picks up that responsibility. If there is not a unit secretary on the unit for that day, for whatever reason, who picks up the additional burden of doing the charting, in terms of the things the secretary usually does? If there is not a transporter around to transport patients to x-ray, who do you think does that? The nurse picks up the slack in almost every department in the hospital when they are short.

ASSEMBLYMAN OTLOWSKI: What you are saying then is, if we are going to look at this presentation, particularly the nurse's condition, we have to look at the nurse separately and distinctly from the whole medical approach. Isn't that what you're saying?

MS. STRICKLAND: Yes, yes. (applause)

ASSEMBLYMAN COLBURN: Thanks. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: No, thank you.

ASSEMBLYMAN COLBURN: Mr. Deverin? (no response) I wanted to ask you a couple of things.

MS. STRICKLAND: Yes?

ASSEMBLYMAN COLBURN: You mentioned the pressure. Now, I think in my own practice, the times I have performed most poorly have been when I have either been overworked or overtired.

MS. STRICKLAND: Right. That is a very common thing.

ASSEMBLYMAN COLBURN: I have told people that it is a little deadly to come to me either first in the morning or last at night. I guess I have a lot of witnesses to these statements. But, what do you think would relieve the pressure on you? What kind of pressure are you talking about? Are you talking about a lot of surveillance or a lot of paperwork or a lot of other people, too many patients, or, you know--

MS. STRICKLAND: Well, we are talking about increased patient assignments. Even if it is not an increased number of patients per assignment, the actual number of patients that you are taking care of are much sicker, and they require much more complex care. They need a lot of close observation, in terms of picking up symptoms that could show a change for the worse.

ASSEMBLYMAN COLBURN: What are the motivations for people to go to work for the agencies -- the agency nurses?

MS. STRICKLAND: They get paid much more money.

ASSEMBLYMAN COLBURN: How about hours, or ability to say, "No, I don't want to go today," or something?

MS. STRICKLAND: Well, I don't know what their contracts are with the agencies--

ASSEMBLYMAN COLBURN: No, I don't either.

MS. STRICKLAND: --but my understanding is that they can more or less set their own hours for, you know, which days they want to work, and where they want to work, too, and they get paid much higher salaries.

ASSEMBLYMAN COLBURN: Do they have fringe benefits with those agencies?

ASSEMBLYMAN DEVERIN: No.

MS. STRICKLAND: I have no idea. I think that would vary from agency to agency.

ASSEMBLYMAN COLBURN: Okay. Mr. Deverin?

ASSEMBLYMAN DEVERIN: One of the things I remember from that conversation is, the difference in pay, I think, was $10.80 against $18 an hour, but there were no fringes.

MS. STRICKLAND: I think it varies from agency to agency.

ASSEMBLYMAN DEVERIN: Yeah, yeah, and that is one of the advantages of being in an agency. You can either work the afternoons or the weekends, or you can do whatever you want.

MS. STRICKLAND: Right. Well, if you work for an agency, you can elect to not work any weekends and no holidays and no evenings or nights.

ASSEMBLYMAN DEVERIN: I'm saying the same thing you are.

MS. STRICKLAND: Right.

ASSEMBLYMAN COLBURN: I wanted to ask you one final thing, and that is-- I might tell you that physicians, as far as I know, are basically against the DRG system. I guess we viewed it with suspicion, and now we wonder if it is any good. I guess we are probably in agreement on that.

How has it changed the practice of nursing in the hospital? Can you give me some ideas?

MS. STRICKLAND: Well, in the past, patients came to the hospital before they got as sick as they are now. Now they stay at home much longer than they did before. They come into the hospital much sicker. They are discharged much quicker and, in essence, are still quite sick, in a lot of cases.

ASSEMBLYMAN COLBURN: So, the pressure under the DRG system is to get them out--

MS. STRICKLAND: Right.

ASSEMBLYMAN COLBURN: --because the hospital gets the same payment whether they are in there five days or ten, depending upon the diagnosis. Okay, I see what you mean.

ASSEMBLYMAN DEVERIN: Just on a personal matter-- You know, that's one thing-- I have a terrible hang-up about the DRG. It's not so much the DRG regulations; it's the PRO regulations.

UNIDENTIFIED SPEAKER FROM AUDIENCE: Right.

ASSEMBLYMAN DEVERIN: Whenever I hear a complaint, it is about somebody sitting in Trenton reading doctors' reports, and sending the patient home two days ahead of time. That is the problem, isn't it, really? That is part of the problem.

ASSEMBLYMAN COLBURN: That is the review part of it.

MS. STRICKLAND: Right, right.

ASSEMBLYMAN DEVERIN: He's right. DRG is no good. I agree with him.

ASSEMBLYMAN COLBURN: But Mr. Deverin points up another part of this whole complicated thing -- the PRO. So, do you have any feelings about that mechanism?

MS. STRICKLAND: No, not really. I know of the system, but I am not familiar enough to make any sort of statements about it.

ASSEMBLYMAN COLBURN: I know sometimes when I go to see a patient and I'm looking around for the record, guess what? It's two floors down with the darned PRO, and you can't get the chart.

MS. STRICKLAND: The reviewer has the chart, right.

ASSEMBLYMAN DEVERIN: Or, if you are on Medicare, the record is in Trenton or in Newark somewhere, and you're in Jersey City.

ASSEMBLYMAN COLBURN: It might be.

ASSEMBLYMAN OTLOWSKI: Doctor, may I just follow this up?

ASSEMBLYMAN COLBURN: Yes, Mr. Otlowski.

ASSEMBLYMAN OTLOWSKI: I got the impression, in the final stages of your testimony, that really if you are going to make the nurse happy, you have to make her happy with money. Isn't that basically the question?

MS. STRICKLAND: Well, that is part of it. Money will cetainly go a long way toward helping you to buy a decent house, a nice car, and feeding your family, if you happen to be a single nurse supporting a family.

ASSEMBLYMAN OTLOWSKI: So, what we are talking about then-- I want to get at the nub of this thing, so I will have some idea of what you are talking about. There will be a lot of verbiage, and I just want to get to the nub of this. You are really talking about money, aren't you really?

MS. STRICKLAND: Basically, yes. (applause) But the money also supports a lot of intangible things.

ASSEMBLYMAN OTLOWSKI: Let's stay with that just for a moment. If you are going to be talking money, and if that is going to solve the shortage, if that is going to make a better nurse, I have no argument about that, you know. The next thing you have to give some thought to, at least as far as I am concerned-- I am getting some idea of your problem. If you are going to do that, the next thing is, you've got to tell us, and you've got to show us -- or at least give us some ideas, you know, how this money is going to be generated, because everybody-- (loud reaction from audience) Don't worry about it.

MS. STRICKLAND: I wish I could give you an answer about where the money would come from.

ASSEMBLYMAN OTLOWSKI: Don't worry about it. They're getting a new, faster printing press. No, what I wanted to ask you-- Obviously, if you are going to bring it down to money, and I am not finding any fault with that-- I am not finding any fault with your testimony, I just want you to feel

comfortable about that. If it is money, then we have to stop kidding ourselves. This is what I'm saying. We've got to stop kidding ourselves, and we've got to find out how we are going to do this; how we are going to single out the nurse.

MS. STRICKLAND: Well, it has already been suggested that we cost out nursing service.

ASSEMBLYMAN OTLOWSKI: What was that?

MS. STRICKLAND: Costing out nursing service from the other costs of the hospital stay.

ASSEMBLYMAN OTLOWSKI: Excuse me, did you want to ask something? (addressed to Assemblyman Deverin) Mr. Chairman, maybe he can be of a little help.

ASSEMBLYMAN COLBURN: Go ahead.

ASSEMBLYMAN DEVERIN: When you talk about money, I agree with you, but you know as well as I know that if you keep hanging it on the individual patient, you run into a lot of opposition. There is no reason-- You know, the Doctor was the sponsor on uncompensated health care, which helped the city hospitals that I represent a great deal.

MS. STRICKLAND: Right.

ASSEMBLYMAN DEVERIN: Kept them from going bankrupt in some of the towns. We would have lost a couple of hospitals. What George and I are trying to say is, money is the problem -- the basis of the problem. You can't improve the lot of the nurse in promotion, technology, or anything else, unless you get some money. The State has to pick it up. If we don't do it one way, we are going to do it some other way. If we don't give it directly as a grant for nurses' service, it is going to wind up -- when the paying patient goes in -- with an increase in the uncompensated care.

So, we might as well come up with a solution as to which way the State can pick up the salaries, the grants, the tuitions, and the incentives, to make the nursing service a place you want to be, and want to stay in. That is what we are both trying to say, I think.

MS. STRICKLAND: Right.

ASSEMBLYMAN DEVERIN: That is what we ought to get down to doing. (applause)

ASSEMBLYMAN COLBURN: I just thought of another question: Don't you get the feeling, as a health professional, that the health care professionals in general are being -- are having more expected of them all the time?

MS. STRICKLAND: Oh, definitely.

ASSEMBLYMAN COLBURN: I think you share that with all the others. I don't think you are different in that respect. There are more people looking over your shoulder, demanding this, and criticizing you for that, and really it has gotten to be, I think, less pleasurable to most health professionals than it used to be. That is something for us to think about.

Thanks very much.

MS. STRICKLAND: Thank you. I have copies of my speech. Let me give them to you. (much applause)

ASSEMBLYMAN COLBURN: I was waiting to see if that was a standing ovation. (laughter)

The next person to testify will be Penny Wild, representing the New Jersey Association of Health Care Facilities.

P E N N Y W I L D: Good afternoon, Mr. Chairman and Committee members. My name is Penny Wild, of the Joseph Katz Company. I am pleased to appear before this Committee today on behalf of James Cunningham, President of the New Jersey Association of Health Care Facilities.

The Association represents more than 200 nursing homes which provide a majority of the State's long-term care beds. I appreciate the opportunity to present to you the nursing shortages we have in our industry.

In 1981, a survey conducted by the Central Jersey Health Planning Council showed that there already was a nurse shortage in all health areas. Nurses who were frustrated with

shift work and inadequate wages were changing careers. Now, as career opportunities abound, it is easier than ever for nurses to leave medicine in favor of other professions that offer better hours and higher salaries. And, naturally, the shortage of nurses is deeper and more troubling than ever before in the modern history of our State and nation.

Earlier this year, our Association formed a task force to address shortages in our facilities and develop strategies that would protect the high quality of care which we provide and which New Jersey requires.

We first surveyed all our members to determine how many facilities had been cited and fined for nurse shortages. Almost half of those responding had been cited. Fortunately, the Department of Health did not levy fines on the majority of these facilities because the Department determined that quality of care had not suffered.

We have also learned that facilities -- when lacking nursing staff -- have imposed voluntary admission bans in order to avoid State violations. Worse, despite the need for increased elderly care, we are seeing more and more new facilities unable to fully open to capacity because they can't find R.N.s.

Obviously, we need to find solutions to fully utilize our much needed facilities and, of course, to avert damage to the quality of care in all health areas.

We understand that Congress is considering legislation which would increase recruitment and retention of nurses in hospitals and long-term and home health care settings, and that it is examining the establishment of special tuition assistance programs for nursing schools.

But we need help on the State level now. Our Association has requested an urgent meeting with Commissioner of Human Services Drew Altman and Medicaid Director Thomas Russo, not only to discuss the severe staffing crisis in

long-term care facilities, but also to request an immediate, across-the-board Medicaid increase of not less than $5 per patient per day. This increase is necessary to help offset the costs of increased nursing salaries which we must pay in order to attract help.

We realize that legislation may be necessary to finance an increase and, if so, we would look to this Committee to help speed the process. In the meantime, we would like to propose other possible remedies.

One solution would be greater use of foreign-trained registered nurses -- a method employed to offset past shortages. Unfortunately, our recruitment efforts are hindered by a federally developed test which could be omitted. The exam is prepared by the Commission on Graduates of Foreign Nursing Schools, a national group of nurses and other professionals. States, however, may opt to waive the exam. Florida, Massachusetts, and California never required it; Pennsylvania waived it recently. Our State Board of Nursing has the power to waive it.

The Board mandates passage of the test before a foreign R.N. can work in New Jersey. With the preliminary test requirement dropped, foreign-trained nurses who graduate from a four-year nursing program with an average score of 80 or above, could enter the State and work immediately under the supervision of a State-licensed nurse. They could not be charge nurses or supervise a nursing staff until they pass the New Jersey licensing exam.

Another concept which you may want to explore is a State tax credit or free tuition program for nurses who commit to practice their profession in New Jersey for a specified number of years.

Another solution could be modeled after legislation recently passed in Maryland that requires nurses to work a total of 1000 hours during a five-year period, undergo

continuing education, or surrender their license. We realize that this could deepen the shortage, but the relatively modest work requirement -- less than four hours a week -- would, we think, expand the pool of qualified R.N.s by drawing from the large group of trained professionals who now rarely work at nursing.

We also suggest that you examine the proliferation of temporary nurse personnel pools, which in recent years have seriously diluted long-term care facilities' permanent nursing staffs. In an effort to control health care costs and improve training and dependability, regulation of nursing personnel pools could be transferred to the Department of Health from the Department of Law and Public Safety.

We appreciate the opportunity to present these comments and stand ready to assist the Committee in developing solutions to this very critical problem.

ASSEMBLYMAN COLBURN: Thank you.

ASSEMBLYMAN OTLOWSKI: Mr. Chairman--

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: --just one question. You're saying that if we are going to provide a means of nurses getting more money, you would increase the Medicaid payments, and you would specifically say that that increase would be used for nurses. Is that what you're saying?

MS. WILD: The money would be used for nurse salaries before it would be used for anything else, yes.

ASSEMBLYMAN OTLOWSKI: I just wanted to know. That would be the one source, but you also know that at the present time, there are other people in the field who also feel that Medicaid is inadequately compensating them, and they want an increase. You are aware of that?

MS. WILD: Yes.

ASSEMBLYMAN OTLOWSKI: So, again, with Medicaid, that could be a possibility. I just wanted to reiterate the

observation that Assemblyman Deverin and I have made here. You know, there was a suggestion about casino and Lottery money. We couldn't do that -- you know that -- because we are constitutionally prohibited from doing that.

One of the possibilities that I have heard so far, is with Medicaid. That is the only possibility I have heard so far that has legislative possibilities.

ASSEMBLYMAN COLBURN: Mr. Deverin?

ASSEMBLYMAN DEVERIN: I am not sure I understood what you meant about the foreign nurses. They have to take a test to work in New Jersey?

MS. WILD: Right. They have to take a test before they can even come into New Jersey to practice.

ASSEMBLYMAN DEVERIN: Do you think we ought to waive that test?

MS. WILD: If it were waived, those nurses could come in and practice as a general nurse.

ASSEMBLYMAN DEVERIN: There is a hospital near me, where if you go there it is like being in Dublin, Ireland. They're all Irish. I'm sure you girls know where it is, too. So, they have a recruiter over there bringing nurses over here.

MS. WILD: Oh.

ASSEMBLYMAN COLBURN: I guess, on my part, I would view with some, I don't know, reluctance, the idea of what would appear to be lowering our standards. (applause) Please don't stand up for that ovation. (laughter) I didn't know how you felt about that, but I had a good guess.

MS. WILD: Ideally, we will get the nurses from New Jersey first.

ASSEMBLYMAN COLBURN: I think we have to try to encourage our nurses who were educated in the United States. I think that other is a last-ditch resort.

MS. WILD: We are all for getting the State nurses to come on in.

ASSEMBLYMAN COLBURN: Yeah, okay. Are there any other questions? (no response) Thanks a lot.

Mr. Nicholas -- Mr. Robert Nicholas -- Deputy Commissioner, Department of Human Services.

D E P U T Y C O M M. R O B E R T N I C H O L A S: Good afternoon. My name is Bob Nicholas. I am the Deputy Commissioner of the State Department of Human Services. I would also like to introduce Dr. Michael Ross, who is Chairperson of our Management Team at Marlboro Psychiatric Hospital.

I would like to briefly -- very briefly -- this afternoon alert you to the impact which New Jersey's nursing shortage has on our State facilities. The Department currently has more than 1000 positions which require a registered nurse. Nearly 700 of these positions are direct care nursing positions at our seven State psychiatric hospitals. At the present time, overall, we have a vacancy rate of approximately 25% for direct care nurses at these facilities. At some facilities, this rate exceeds 30%. What is more troubling is that it is becoming increasingly difficult to recruit registered nurses for jobs at these facilities. Aside from negatively impacting on patient care, this problem is jeopardizing our Federal certification of these facilities and $13.5 million in Federal funds for their operation.

A case in point is the recent Federal survey of Marlboro Psychiatric Hospital. While highlighting positive patient care and conditions at the hospital, the Federal report recommends decertification of the hospital largely due to a shortage of nurses. The Department, based on a recommendation of the Management Team at Marlboro, had already added 73 registered nurse positions to the facility. Unfortunately, a major advertising campaign to recruit nurses for positions resulted in only three nurses being hired to date. We must correct this problem in the immediate future, or our

certification at Marlboro will be lost, in addition to more than $5 million in Federal reimbursement.

The Department is now considering both short- and long-term strategies to make nursing positions at the State psychiatric facilities more attractive. We will be announcing a short-term package of incentives within the week, and using this package in our continuing advertising campaign. It is obvious, however, that these and further economic enhancements of our nursing positions will require further funding.

In conclusion, I would like to reenforce that our State psychiatric facilities must compete in the health care market for nurses. Your deliberations here and the measures you develop will impact on our competitiveness and our need for additional resources.

Thank you.

ASSEMBLYMAN COLBURN: Thank you.

ASSEMBLYMAN OTLOWSKI: Doctor, may I ask a question?

ASSEMBLYMAN COLBURN: Sure, Mr. Otlowski.

ASSEMBLYMAN OTLOWSKI: You heard the testimony here, and in my own mind it has been reduced now to money. How would you provide the money? If we are going to answer the question that is now being brought into focus, how would you provide the money for the incentive to get the nurses? Obviously, you point out that you are advertising -- doing extensive advertising. That didn't work. How would you provide the money as an incentive? Have you any scheme, any ideas, on how that money would be provided; where it would come from? How would you treat the nurse separately, you know, from your other problems?

DEPUTY COMMISSIONER NICHOLAS: Well, we're looking at it in a little different way perhaps than the overall health care field, but I think we are dealing with many of the issues the previous speakers have raised; that is, is it our salaries? Our starting salaries are not competitive at this

point. That is one reason why we are not getting the people to work. The other reason is, even to pay the salaries we are paying, there is a lot of compression. We are starting people at the seventh and eighth steps of the ranges, which means that once they are hired, they have no place to go, and our retention rate is not very high either.

Based on this Federal reimbursement issue, however, clearly we need to come to the Legislature if we need further funding in our budget, or whatnot, because our risk of losing the volume of Federal reimbursement that is at risk at this point on this issue-- If we lose $13 million, we have to figure out a way to get $13 million in State funds just to fund the level of service we have now, which we all agree is inadequate.

So, I think with our facilities, they are State facilities, they are funded under the budget that the Legislature gives us each year--

ASSEMBLYMAN OTLOWSKI: If you were able to attract nurses to your institutions, what kind of money are you talking about -- $10 million, $20 million, $30 million, $50 million? What are you talking about?

DEPUTY COMMISSIONER NICHOLAS: Well, we have a short-term package, as I mentioned in my comments. I can't go into detail here today, because we are still in the process of finalizing it. It will cost approximately $1.5 million right now, in terms of the remainder of the year. We don't know how that will stack up competitively.

ASSEMBLYMAN OTLOWSKI: Do you think that $1.5 million is going to bring you the nurses you are looking for?

DEPUTY COMMISSIONER NICHOLAS: Well, our best guess at this point is that it will help. We think it will bring additional nurses into the system. But, whether it will be adequate in terms of across the system -- we're talking about a large system to maintain the accreditation throughout the

system -- we frankly don't know. It is a changing market out there; it changes by the week.

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Yes. Commissioner, I think your job-- I wouldn't want to compare it in toughness to the job of nurses in acute care hospitals, but I must say that one of the things I have always heard is, how do you provide incentives to recruit nurses to work with psychiatric or geriatric patients? I have heard some rather imaginative methods of recruiting for acute care hospitals -- incredible incentives. In competition between them, what are you doing, working with the Department of Human Services, to attract nurses?

DEPUTY COMMISSIONER NICHOLAS: Well, we obviously follow the advertising of the general hospitals. Once again, we are in that market. We need to do things-- Right now, we are up-to-date. We have been using primarily the somewhat rigid Civil Service system and Civil Service positions. We need more flexibility. We need to have more flexibility on hours when people want to work, or part-time types of positions. We need to have incentives to work undesirable times, as someone mentioned earlier. The issues of weekends, night shifts, holidays, and whatnot make it more difficult for us to staff the facilities than a weekday during nine to five.

So, we have to build in what our needs are, and have the flexibility to pay more in situations where we have to. We are looking at all those types of incentives. We have been working with the Department of Personnel now for a couple of months, and OMB, in terms of, you know, can we provide cars? I mean, that is one of the things to induce people to show up, that they get a car. I don't know. Issues such as housing. We are looking to recruit-- At this point, we are looking to expand our recruitment and look toward the Midwest and the south, where the salaries are not anywhere near approaching

what they are in New Jersey, to see if we can get some American-trained, English-speaking nurses to come to New Jersey. But clearly the housing market is such that we would have to assist them in terms of finding appropriate housing, or even providing it.

We are not anywhere near as far down the road as we need to be in terms of what we may have to do six months from now to keep our hospitals adequately staffed.

ASSEMBLYMAN DEVERIN: You have a different problem than the regular general hospitals in recruiting, because your salaries are a little lower, too, aren't they?

DEPUTY COMMISSIONER NICHOLAS: Well, actually, what we are bringing people on at right now is right at about the mean for the State, but, once again, it is highly compressed, so that once you start working, you don't go very far above that. Someone mentioned that as a problem before. We need to build an upgrade into the range, so we will have more latitude to get salary increases over two or three or four years, which is impossible now.

ASSEMBLYMAN COLBURN: Dr. Ross, do you have anything to add to what has been said?

D R. M I C H A E L R O S S: Well, the only thing I would add, for those of you who follow the costs of salaries and benefits in the health care field, is, what one actor does in a competitive marketplace, another will do the following week, and then the week after that, somebody will do a bit more, and so on and so forth. In the last six months, we have had a push-pull situation that has driven salaries up, benefits up. Our concern is, not only do we have to keep competitive in the short run, but there need to be long-run strategies that address not only compensation, but available supply. I think the Committee, and if there is to be a commission, need to address the long-run supply issue.

We have some opportunities within the public sector to offer nursing careers to those who are not now nurses, but that will take a dramatic increase in dollars for training opportunities, and things of that sort.

Generally, the market needs to expand. The supply has to go up, if we are ever to get out of this push-pull situation. If we don't do that, and you grant increases in the general industry, that will force us to come back three months later for yet higher increases, and all we will be doing is stealing nurses from each other -- from one institution to another. That is simply not going to solve the problem.

ASSEMBLYMAN DEVERIN: That is like the football players in a free agency, Doctor. You ought to go into that, or something.

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: A lot of what we have been talking about here this afternoon is obviously the bottom line in monetary -- in economics. What about the State of New Jersey and its attitude in terms of the equivocal role of nurses in our psychiatric institutions, those who work with developmentally disabled? In other words, one may point a finger, perhaps rightly, at the general hospitals, but I wonder how well our own house is in order in terms of giving nurses the recognition they need, in your overall operation.

DEPUTY COMMISSIONER NICHOLAS: I think we have, certainly, a lot of work to do in that area. I would not want to sit here and tell you that that has been the case in every situation, because I think that obviously it is a very, very difficult job in our hospitals dealing with very seriously disturbed people, who have violent behaviors and a multitude of kinds of problems. The kind of support we give them, and the kind of recognition we give them, clearly needs to improve.

Just to complete my answer from before in terms of your question, we are looking at all different avenues of what

it is like to be employed as a State nurse. That is not just financial. It is also training; it is also benefits; it's the environment. I was told that many general hospitals have nice lounges, have food programs, and other kinds of things that we don't have. We certainly need to look at that kind of thing, as well as the kind of recognition that these individuals ought to have, given the difficulties of their job.

I think it is important to note that we have had a scholarship program -- to follow up on what Dr. Ross said -- where people who are not registered people -- either human services assistants or licensed practical nurses -- can become registered nurses. To date, it has been about 25 people a year. We have had a very high retention rate of people who have graduated from that program. Next year we plan on tripling that, and actually going as high as we can, because as Dr. Ross indicates, a lot of those staff are committed to our facilities, and this is a way of reenforcing and creating a career ladder and meeting the tremendous problem at the same time.

DR. ROSS: I think it needs to be--

ASSEMBLYMAN OTLOWSKI: Doctor, may I just try something for size here?

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: Obviously, your role is more difficult in trying to recruit nurses because of the nature of the work. The same thing with a geriatric hospital. It is a tremendous thing to be able to recruit and keep nurses. The general hospital is more exciting for the nurse and, as a matter of fact, I suppose even more rewarding because she sees immediate results. In the long-term hospitals, she doesn't get that satisfaction.

Obviously, if you are going to be competitive, you are going to have to pay more. You are going to have to pay your nurses more than they are getting in the general hospitals. (applause)

ASSEMBLYMAN COLBURN: Is that the end of your statement, sir?

ASSEMBLYMAN OTLOWSKI: No, no. The other thing I wanted to follow-up -- which Deverin, of course, is a bug on-- Let me ask you if this is practical, because this is something for this Committee to think about, particularly in your case. Would it be practical, for example, that scholarships would be given to nurses who would sign a contract, or a pledge, that after they completed their nursing training, that for that total scholarship, they would be willing to work for at least three years in a State hospial or in a geriatric hospital? Is that practical, in your opinion?

DEPUTY COMMISSIONER NICHOLAS: That is what we are doing inside the hospitals right now in terms of our scholarship program, but to expand it statewide, I think, would be a practical thing to look at.

ASSEMBLYMAN OTLOWSKI: It would be practical?

DEPUTY COMMISSIONER NICHOLAS: Would be, yes.

ASSEMBLYMAN COLBURN: Dr. Ross, do you have a quick addition?

DR. ROSS: I just want to say, you need to bear in mind the context of this is that in a declining enrollment situation for all nurses, the portion of those who go into psyc is traditionally small and, therefore, is declining at an even greater rate. The people we hire are principally non-psychiatric by background, who we persuade to go into psychiatry.

ASSEMBLYMAN COLBURN: Okay. Thanks very much, gentlemen.

I am going to ask Maureen Hreha to come up. She represents nursing education at Muhlenberg Regional Medical Center. Then following that, I am going to ask for the contingent from the Hospital Association, led by Craig Becker.

Maureen, we are going to pick up your statement right at the start so we can look at it as you speak, since you have it right there. Did I pronounce your name properly?

M A U R E E N S I M K O H R E H A: It's Hreha (correcting Chairman's pronunciation).

ASSEMBLYMAN COLBURN: Hreha, excuse me.

MS. HREHA: I'm sure Mr. Otlowski could pronounce it correctly.

ASSEMBLYMAN COLBURN: Yes, okay.

MS. HREHA: Taking me out of order kind of caught me by surprise, but I'm certainly happy to know--

ASSEMBLYMAN COLBURN: I'm sorry. I did announce at the start that we would be taking people out of order, because we want to get a mix here. This order was not established by the Chairman, so the Chairman is now establishing the order. I realize I surprised you.

MS. HREHA: No, I certainly understand. I am just making sure I have the right preparation in front of me.

ASSEMBLYMAN COLBURN: Okay, catch your breath.

MS. HREHA: Mr. Chairman and members of the Committee: I am Maureen Simko Hreha, Nursing Instructor at the Muhlenberg Regional Medical Center School of Nursing. I have practiced nursing for 17 years. For the past 13 of those years, I have been a nurse educator.

As a nurse educator, I am keenly in touch with the reality of declining nursing school enrollments. I see firsthand the continuous drop in the number of students entering the nursing profession. National figures indicate that since 1983, enrollments in nursing school programs have dropped by 20%. Predictions are that this trend will continue, or accelerate.

A recent study from UCLA of American college freshmen found that in 1986 -- for the first time ever -- more college freshman women planned to enter medicine than nursing. The

UCLA survey also showed us that since 1974, the number of full-time women students entering nursing as a major has declined by 50%. That was pointed out before by Senator Hurley. In contrast to that, there has been an almost threefold increase in the in the proportion of full-time women students interested in business as a career.

Why are fewer and fewer students choosing to enter nursing? I am the mother of a 10-year-old and a 12-year-old, and I thought I would try to answer that question by explaining to you what I would tell them. If they were to ask me if they should enter nursing, I would like to give them the facts so that they could then make an informed decision.

First, I would tell them that they might find the starting salaries in nursing attractive and competitive with other professions at the entry level. However, nurses quickly reach their salary range maximums. An American Hospital Association survey reported, in August, 1987, that on average in this country, a staff nurse can expect to make a maximum salary that is just 30% more than her entry level amount. My current salary of $29,500 is an average of just 20% higher than what my students can earn upon graduation.

After a few years in practice, nurses' find their salaries are no longer competitive. A University of Texas survey reported that in 1985, on average, teachers earned 19% higher than nurses. And, despite the nursing shortage, nurses' wages have only increased approximately 4% in 1986.

The second thing I would tell my children, is that for those nurses who obtained advanced degrees, an economic return on the cost of education is poor in comparison to alternative professions. I hold two master's degrees, one in nursing and one in education. Since 1966, I have invested approximately $36,000 in my education. That education would be well beyond $50,000 in today's terms. It is difficult to estimate when, if ever, such an investment will pay off financially.

Had I gone across the University of Pennsylvania campus for a Wharton School Master's in Business Administration -- instead of the Nursing Master's Program I chose -- I would be earning substantially more today. I find it necessary to supplement my income with alternative activities in the field of nursing.

Third, I would tell my children that since 68% of all employed nurses work in hospitals -- I want to emphasize that, because they are working -- they need to understand the realities of hospital nursing. The hospital must provide patient care 24 hours a day, and as a nurse, you work days, evenings, nights, weekends, and holidays. Shift rotation is a requirement of employment, in most cases. Most people view working evenings, nights, weekends, and holidays as less desirable, and industry has rewarded its people who work those hours with substantial shift differentials. This has not been the case in hospitals, and it is on these shifts -- with no surprise -- that we find the shortage to be at its greatest. Because of the shortage, the nurses who continue to work in hospitals are often called upon to work overtime and continually rotate shifts. In other words, within the same week, they might work a night, a day, an evening -- within the same week. I don't know how they do it, really. This continued demand -- the combination of rotating shifts and working overtime -- has just caused my colleagues to become exhausted.

The fourth thing I would tell my children is about the working conditions they would find on the job. Again, nearly two-thirds of the nurses work in hospitals. Labor economists have described nursing as "a captured labor market." Hospitals traditionally have set the terms for both nurses' salaries and nursing practice. For example, on the undesirable shift, we often find nurses doing a wide range of functions that are outside of their job duties. In the absence of pharmacists,

housekeepers, secretaries, lab technicians -- endless numbers of support services -- nurses are expected to provide those services. With all of that going on, we find that patients are sicker, on average, than they had been, and with their increased caseloads due to the shortage, nurses need to be well-educated athletes just to survive a shift. (laughter and applause) The ones with sneakers on.

Finally, I would tell my children that the advancements in health care procedures and technologies place a continual challenge to the nurse today, to stay up-to-date with the knowledge in the field. One of my colleagues recently noted to me that we are now spending more time nursing machinery, than we do nursing the patient. I find this fact most distressing, because I know of no one who entered nursing to care for a machine. We all entered nursing to take care of patients.

In talking to my children, I would go on to tell them why I chose to enter nursing; why I continue to stay in nursing; and why I continued my career in educating others to enter the profession. Quite simply, I am a nurse because I believe that every patient needs the knowledge, the comfort, the caring, and the expertise that nursing can uniquely provide. I also believe that nursing makes the difference in quality hospital care. Hospitalization is, in fact, a nursing consultation, because when a surgeon puts his knife away, it is the nurse who takes over to help the patient's body heal. And when a premature baby is hooked up to countless tubes and machines to maintain life, it is the nurse's gentle hands that comfort and swaddle the infant into thriving in spite of all those odds. And because after a heart attack, it is the knowledge and experience of the nurse who constantly monitors and protects the patient with the weak heart.

A recent George Washington University study reported that the most critical factor found to influence the survival

rate of patients admitted to an intensive care unit, is the quality of the nursing care. This is sublime testimony to my commitment to the profession. (applause) I continue to practice nursing because I believe I can make a difference.

Now I have laid out the facts for my children -- and for your children, too. What will they choose? What would you encourage your children to choose?

You now, as members of this Committee, have to make choices. How can you help nursing bolster its profession so that more and more students will choose this profession? You need to find more and better ways of providing financial support for students interested in enrolling in schools of nursing. And you will need to find ways to enable hospitals to significantly increase nurses' salaries, so that the nursing practice can become more desirable.

Your support of Assembly Bill 4483 to increase nursing salaries will just begin to rectify the serious problems of inadequate wages. The question is, will these salary hikes solve the problem?

Mary Mallison, editor of the "American Journal of Nursing," recently wrote in her August editorial, that a lot of decision-makers still don't believe that nurses will respond to market incentives just like everybody else does. Linda Aiken adds that they do respond. She has documented through her research as a sociologist that if nursing salaries rise, the number of vacant R.N. positions will fall. Therefore, as more and more people enter nursing, and as more nurses return to hospital practice, it will become easier to address the other problems that I have laid out before you -- the 24-hour coverage, the job stress, maximizing the utilization of each nurse's expertise. We can work together to make nursing a more appealing career.

I would like to also add my support to the New Jersey State Nurses Association's proposal that we try to cost out

nursing. I think that if we don't know what we are paying for-- I mean, if I go to a mechanic, he gives me a flat rate of $14 an hour. I don't know where he got that from, but he can sure tell me if I ask him, I'm sure. I think we need to look at that issue, and start to put a dollar value on our practice. This would solve the problem, perhaps, of, what do we do?

Thank you for your time. (applause)

ASSEMBLYMAN COLBURN: Thank you. Any questions?

ASSEMBLYMAN DEVERIN: What article said that nurses won't respond to incentives? I'm sorry, you said--

MS. HREHA: I can show that to you. That was an article by Linda Aiken. In fact, I think Andrea gave you a copy. It was recently in the "New England Journal of Medicine." I believe it was September 7.

ASSEMBLYMAN DEVERIN: The third.

MS. HREHA: Thank you. I was close -- very close.

ASSEMBLYMAN DEVERIN: I don't believe that. As a matter of fact, I can tell you why. Back in the early '70s, sometime around '75, I was the sponsor of a bill to put school nurses with a degree on the same level as a teacher. If you remember, that raised a lot of hell with all of the school boards. But it worked, and since that time most of the nurses who didn't have degrees in the schools have gone out to get degrees. Incentives will work, so that article doesn't mean anything.

MS. HREHA: I guess I am kind of confused. The incentives to get future degrees, or the incentive to raise salaries?

ASSEMBLYMAN DEVERIN: Well, it was a combination of both. You said the nurses would not react to an incentive if you made the money higher.

MS. HREHA: Oh, no, I think they will. My point-- I'm saying--

ASSEMBLYMAN DEVERIN: What does the article say?

MS. HREHA: The article says that nurses do, in fact, respond to an economic incentive. I guess it is a point of clarification. Yes, they do respond.

ASSEMBLYMAN DEVERIN: Okay, fine. Good.

ASSEMBLYMAN COLBURN: Anyone else? (no response) May I ask now -- I meant to ask before -- do most nurses going through their education take out loans? It probably sounds like a dumb question.

MS. HREHA: Well, that is a very common way to do it, if you can find a loan. The moneys -- the Nurse Training Act moneys and whatnot -- are not as available as they had been. Very often you will find that one of the benefits that nurses receive from a hospital is a tuition incentive, or a tuition reimbursement policy, and that varies from hospital to hospital.

ASSEMBLYMAN COLBURN: I want to get a little more into that now. When they finish their education, do they usually have outstanding loans? If so, what would be the average? Is there any kind of an average? I suppose it would be highly variable.

MS. HREHA: It would depend, first of all, on what degree they are going for. If they are going for a--

ASSEMBLYMAN COLBURN: Let's say it is a B.S.

MS. HREHA: If they are going to a private college or a private university for a bachelor of science degree, it would be quite expensive. Some of you with people going off to college these days know that it is very expensive. If they are going for a master's, it is the same situation.

ASSEMBLYMAN COLBURN: How about an associate? We have some of them.

MS. HREHA: Associate degree programs are fairly economically affordable, at this point in time.

ASSEMBLYMAN COLBURN: I am not sure of this, are there any more R.N. programs in New Jersey -- any remaining?

ASSEMBLYMAN DEVERIN: They call them diploma schools.

ASSEMBLYMAN COLBURN: Excuse me, diploma.

MS. HREHA: There are still hospital-based programs of nursing; that is correct.

ASSEMBLYMAN COLBURN: There are some?

MS. HREHA: Yes.

ASSEMBLYMAN COLBURN: Now, do they have to take out loans?

MS. HREHA: Well, I suppose that would depend-- All of our schools of nursing have, in fact, gotten very heavily involved in investigating any kind of financial reimbursement that would be available for any student. Some students, in fact, get Economic Opportunity moneys; some students, in fact, take guaranteed student loans, which is a loan from the government. There are a variety of ways of doing it. So, yes, in fact, many students graduating-- Some of the graduating class I spoke to are talking about having maybe $4000 or $5000 to pay back, which is--

ASSEMBLYMAN COLBURN: The reason I am asking all this -- and obviously I don't know the answers to these questions -- is because it has been suggested that we have more scholarships. I just wondered, you know, just where they are needed.

MS. HREHA: Scholarships are a wonderful idea. This has been discussed, and certainly many hospitals are offering this as an induction to try to get graduates into their employment. However, you can't get them to do something they don't want to do. If they are terrified of the situation they see-- You can imagine what a young graduate feels like-- If someone says to you, "You are going to take your 16 patients tonight. I am the supervisor, and if I get a chance to see you later, well, you'll be lucky, because I have to run the pharmacy and I have to run to the medical records department and I have to transport, and God knows what else I might be

doing. But, if you break down in tears, beep me, and maybe I can get there for you." It is no wonder they leave in three months. I mean, it really-- Come with me. (laughter)

ASSEMBLYMAN COLBURN: One of the nurses I spoke to who had been out of practice for a while and thought of going back, felt that all this machinery you talked about was pretty foreboding and, frankly, I know it would be for me. One thing that occurred to me, too, was, I think they might change the machinery. You know, they start with one installation, and then they go to another model because-- I don't know whether it costs less, or works better. Then there is this constant changing of the apparatus.

MS. HREHA: Even to do something as simple as take a temperature or take a blood pressure, I can't be guaranteed that if I go from hospital to hospital, whether I am going to have the same piece of equipment to do that simple task any more.

ASSEMBLYMAN COLBURN: So you have to relearn that.

MS. HREHA: Read the manual. If you are by yourself, you have to read the manual, because there is no one around to teach you.

ASSEMBLYMAN COLBURN: Yeah, okay. Thanks very much.

MS. HREHA: Thank you. (applause)

ASSEMBLYMAN COLBURN: Mr. Becker and his contingent. I might say that the Department of Health, if they have survived the hearing thus far, will be next after the hospital group.

C R A I G A. B E C K E R: Mr. Chairman, thank you for taking us as a panel. I think it will perhaps save some time. We were all listed as speakers.

Quickly, I will introduce myself. I am Craig Becker. I am with the New Jersey Hospital Association. With me today I have: Ann Budde, Vice President for Administration from Bridgeton Hospital. She is taking the place of Pat Lynch, who

is out of town today. To my right is Lou Ditzel, President and CEO of Irvington General, but perhaps most importantly to us, he is Chairman of the Committee on Nursing, which is looking at some of the long-range goals, or solutions to the nursing problems. Finally, Jack DeCerce, President of the Freehold Area Hospital, who is representing the Council on Government Relations from the Hospital Association.

If I may start out, I would like to give you an overview, at least as we see it at the Association. Clearly, the health care system in New Jersey is in crisis. We are losing our most precious commodity -- our professional workers, our professional nurses. They are going across the river. They are going into New York, and they are leaving the hospital field -- the health care field -- altogether, and going into other professions. In nursing alone in this State, we have 2500 vacancies. That equates to about a 17% vacancy rate, which compares to 13% -- around 13% -- nationwide. So clearly, New Jersey is in a special category in our vacancy rates.

There are long-term and short-term solutions to this problem. We believe that money is the first order of business. A starting salary for a nurse in this State is $23,000. If you go across the river, it runs anywhere -- in Philadelphia -- from $28,000 to $32,000. You can justify, perhaps, a 5% or 6% differential, but when you start talking about a 20%, 25% differential, the river becomes no barrier for a nurse to go across. Perhaps even more damaging is the maximum salary rates they are paid. In New Jersey, it maxes out around $28,000. This is just totally unacceptable at this particular point.

Part of the problem we face as an industry is, our reimbursement system is such that in the beginning of the year we are given a set amount of dollars we are allowed to give out to our nurses -- to all of our personnel. Unfortunately, that

system and those dollars do not reflect what is happening in the marketplace. Hospitals have been giving out increases all this year just to try to keep pace with what is going on in Philadelphia and New York and, frankly, we haven't come close to being able to keep up.

Other factors you have heard about today are the higher acuity levels that are occurring in our hospitals; the fact that we have the second oldest median age population in the country; some unrealistic regulations, whether they be hospital generated or State bureaucracy-generated; plus what I call the "curse of full employment," again where we are losing many of our health care personnel to other higher paying professions which are a lot less stressful.

You should also understand that the shortage is not regional. I think the Hospital Rate Setting Commission attempted to paint it as a regional problem, but we have seen the shortages not only in Camden and up in Bergen County, but we are seeing them in Cape May Court House and in the Freehold area, up in Warren County, and all over. It is truly a statewide problem.

In addition, it is not only a nursing shortage, but we are seeing a critical shortage in physical therapists, respiratory therapists, x-rays techs, and pharmacists. They are just some of the more critical areas where we are seeing shortages.

One point I would like to make is, I think the quality of care we are giving in this State is still good. However, let's face it, it is starting to collapse under the burden of the shortages we are seeing. Unless something is done quickly, I think we are really going to see the quality of care go down in the State, to a point where it is going to be totally unacceptable to all of our residents.

Hospital administrators are doing some inventive things, but they end up hurting themselves by closing units and

delaying elective surgery, which in some cases is going up to six or eight weeks now. This obviously plays into the hands of the hospitals in Philadelphia and New York, which gladly take our patients in this age of declining admissions.

The payment system clearly has not been able to move quickly enough to keep up to it. The $50 million increase we had was a start, but I think what you are going to hear -- probably in testimony later on -- is that it certainly is not going to be enough. The system needs to be more flexible. We have been very good at holding down hospital costs, but not too good at pumping it in. You should also know that New Jersey, in terms of overall costs, has been around $437 a day, versus a national average of $600. Clearly that cost savings has come not on technology, but on the backs of our workers. We just feel strongly that this is not acceptable any more. The time clearly has passed.

How can we pay for this? This is a question that has been going around and around. One suggestion I would like to offer to you, is that there is currently the $350 million uncompensated care budget that is paid for by the payers. It is my belief that if we can come up with an innovative system which would include certainly State participation to a significant level -- whether it be through expansion of the Medicaid Program or the Medically Needy Program -- that this could certainly cut into some of the uncompensated care, and perhaps the payers would not mind paying for nursing care. In fact, this is what they have said. They will pay for nursing care; they will pay for technology; but they do not want to pay for uncompensated care. Perhaps if the State can kick in where maybe it should be considered it would be more its social responsibility in the uncompensated care, it would leave more dollars to fund nursing salaries and other salaries.

At this point, with your permission, Mr. Chairman, I would like to turn it over to Jack DeCerce, who is President of the Freehold Area Hospital, for his comments.

ASSEMBLYMAN COLBURN: Fine. Excuse me, though. Did you want to ask any questions of Mr. Becker, Mr. Frelinghuysen, or do you want to wait?

ASSEMBLYMAN FRELINGHUYSEN: Maybe I'll wait until I hear all of the testimony.

ASSEMBLYMAN COLBURN: Okay. Please go ahead, Mr. DeCerce.

J A C K D e C E R C E: Thank you. I have an outline here I will share with you, but from a hospital administrator's perspective, I would like to share some views on how we see the nursing problem.

We have been dialoguing with our nurses for many years and have tried many of the solutions you have heard today. There are some fundamental issues, though. We see New Jersey economics. We are in boom times, with full employment, record per capita income, high housing prices and, as Craig said, we have had a decade of very severe reimbursement control. We are offering a bargain in health care to the people in New Jersey. Everybody moans about the cost of things, but New Jersey ranks among the lowest states in the nation in terms of the rate of increase in health care costs. That is very commendable, but I think to some degree it represents a subsidy. We have to think about, who is paying the cost of that?

The nurses and the clinical and support staffs in hospitals have been limited to very, very severe and very conservative cost of living increases for well over a decade, and the bulk of it was done under Chapter 83. It is an appropriate law, and we have all supported it. It has many good elements, like the charity care portion. But I think there are some areas here where we are seeing that regulation -- as the Russians are finding out -- has its limits. I think central planning and central control need to be examined in terms of their ability to respond to things like market incentives or competing for manpower.

New Jersey's hospital patients are more acutely ill, and it is not only the PRO. The DRGs obviously have an effect on that. We see more and more sicker and sicker patients, and much stress on the floors. The acuity issue is very severe. Frankly, although Merrill Lynch is a little bit attractive, there is nowhere near the challenge and life style and support and satisfaction nursing offers. But the stress, what the young ladies have been telling you about, is most severe, and very real. With the technology and the sicker patient, the pressure, the liability, the insurance, the litigation-- All of that brings to bear a lot of pressures which make it relatively unattractive. And life style -- people who want to have a reasonable life style, who want to be with their families like the rest of America, but find themselves working weekends and nights. The burnout is very severe, and the enrollment is going down.

I would suggest that we have to countervail a little bit, the regulation. It has been very appropriate, and we certainly have gotten health care costs under control. I must tell you, my hospital, and most of the hospitals I am aware of, have exceeded the economic factors allowed for salaries, every year for the last several. We have taken from Peter to pay Paul. We try to argue the best we can, but there are limits to that. I keep hearing from regulators; I hear it from the insurance companies; I hear it from the Public Advocate: "Let's go slow on this. Let's be careful. We don't want to have too-excessive payments made." If you want to focus on nursing, that's fine, but there are other areas I think you need to consider as well.

There needs to be a broad public and political consensus and, frankly, maybe it is on the political level now -- maybe in the arena. I think the regulators themselves have a job to do. Their job is to control costs, as Craig said. I think we need to get a broad mandate from the public, and

perhaps from the Assembly, and the legislators in the Senate, that it is time, like the teachers, to establish a minimum wage for nurses. I recommend that maybe in 1987 it be $25,000 in the first phase, and in the second phase, perhaps up to $30,000. That would renew a base. Allow the control and the regulation to proceed from there.

There are several pieces of information I copied to bring to you. One is an ad the Monmouth-Ocean Hospital Service Corporation put in every newspaper in the State yesterday -- "The Latest Addition to Our List of Endangered Species." We are very concerned about that. We don't believe we have control over this. We believe the Hospital Rate Setting Commission has control over it. We get a limited amount of dollars to spend as best we can.

In July, we enacted a $1 million increase specifically for our nurses. We were at about the bottom of the pack in Monmouth-Ocean County, and we got about to the middle. We examined it this month, and we found that we were at the bottom again. We are going to our Board next week for another million dollars. We are only a little hospital, with a $40 million budget, 250 beds. We service just a small town in the back end of Monmouth County away from the beach. But $2 million for us is an enormous amount of money, and we are not being reimbursed for that. The 2% mentioned, for us is a rather modest sum, and we are afraid we are not going to catch up.

There needs to be some dramatic statement made. You have heard from the nurses that they need help and assistance, and we need to support them. But it has to be in dollar terms.

There was a marvelous editorial in the Asbury Park Press just a few weeks ago -- just last week -- and I recommend it for your reading. Also, very coincidentally, there was a very interesting article about education in The Wall Street Journal last Monday. It talked about the fact that there was a concern about education and teachers just a few years ago, and

now they have liberalized and supported and generally come out in favor of enhancing education and teaching as a profession. There have been some marvelous results, both on the entry level and on the experienced level. The most important job we can do perhaps is to educate our young, and I think also take care of the sick who need it in our communities.

Thank you. (applause)

ASSEMBLYMAN COLBURN: I was just going to ask, if you have any list of things that ought to be deregulated, will you let us know? I think you mentioned regulation. That is kind of a pet peeve of mine, but when it comes time to get down to specifics on getting rid of regulations, I would like to see what you have in mind.

MR. DeCERCE: Well, the total hospital budget -- 100% now -- is governed by the Hospital Rate Setting Commission under Chapter 83. We are essentially mailed our rates.

ASSEMBLYMAN COLBURN: So, you were speaking of that?

MR. DeCERCE: Yes.

ASSEMBLYMAN COLBURN: Okay. Not individual little regulations, okay.

A N N M. B U D D E: I am Ann Budde, Vice President of Administration for Bridgeton Hospital. I also serve on the New Jersey Hospital Association Committee on Nursing, and have done so since its inception about six years ago. I have been employed in the health care field for over 25 years, initially as a registered nurse, and now as Vice President of a 252-bed acute care hospital. I speak to you today because of this background.

As a registered nurse, although not actively practicing right now, and as the Vice President of Bridgeton Hospital, I can speak with some authority about the evolution of health care over the past 25 years. I graduated from a school of nursing -- a diploma school of nursing -- in 1960. Since that time, the facilities, the technology, the members of

the health care team, the patient, and the social pressures have all changed.

When I graduated from high school, young ladies who wished to pursue a professional education selected basically either nursing or teaching. Fortunately, in the 1980s, opportunities exist in all areas of life, and the female high school graduate of today, who is motivated to further her education, can choose from a multitude of challenging opportunities.

One factor which plays a large part in making a career choice, is the potential earnings after graduation and throughout a career-oriented life. As it relates to nursing, this factor alone discourages people from pursuing a nursing education, and it also lures the practicing nurse away from the acute care hospital. Generally speaking, the practicing nurse who leaves an acute care hospital leaves because of the stress, because of the hours, and because of the pay. The hospital worker who is an excellent patient care giver, finds that after a few years they have reached the maximum salary for their position, and can only earn more by moving further and further away from the patient into management positions, or by pursuing alternate career paths. This is one of the factors that causes some excellent nurses to abandon the acute care hospital.

I mentioned above that the patient we see in the acute care hospital bed has also changed. Intensive care units were developed in the mid-1960s to concentrate sophisticated equipment and staff in one carefully designed location, so that the sickest patients could receive close supervision and high-tech care. Less acute, ambulatory patients, perhaps recuperating from surgery or learning to cope with chronic medical conditions, were cared for on the routine med-surg floor. Today, the "less acute" patient is an outpatient, and the routine medical-surgical floors have become the intensive care units of yesteryear.

I think it is interesting to note that approximately one month ago, on "Nightline," the panel of speakers addressed the nursing shortage on the national level. One of the speakers was a Mr. Schwartz, who is a health educator and an economist from New York. He disagreed with the fact that there is a shortage. He used the term that the nurse was the "bedpan handler," and implied that the nurse did little else. It is unfortunate that that kind of an image still exists about professional nursing today, because although handling a bedpan is not below the level of a professional nurse, it represents a small token of the kind of knowledge, experience, and skill she needs in order to provide care to patients in an acute care hospital. (applause)

It has been mentioned before that our hospital beds are occupied by more severely ill patients than have been in the past. Even though there are fewer beds that are occupied, as has been mentioned, the intensity of the care needs of those patients has so greatly increased that where perhaps one R.N. was assigned to the night shift, it is sometimes very uncomfortable on a 30-bed unit to not have three R.N.s or more. This is very difficult when the enticement to work eleven to seven is so very limited.

There are times in the hospitals, as at Bridgeton Hospital -- as at many others, I am sure -- that rather than compromise the quality of care, we have shut down beds. We have closed two of the beds in our intensive care unit. We have closed down four of the beds on our post-intensive care unit. I could go on about other hospitals and other organizations. We have also referred patients who require acute hemodialysis, chronic hemodialysis, to hospitals across the river in Philadelphia, because the shortage of nurses is not as greatly experienced over there. We feel it is only ethical for us to make the kinds of decisions regarding closing beds that we have made, in order to continue to provide the

quality of care that we can live with. We refuse to provide substandard care. Along this line, we have employed agency nurses. It has been talked about before. There is no loyalty; there is little understanding of individual hospital policies and procedures; and further demoralizes the nursing staff who are working next to them on the same shifts for $6 to $7 to $8 less an hour than the agency nurse is. This has not been a good solution to the problem. (applause)

In summary, let me say that the attention devoted to the critical shortage of nurses is well-deserved. Without the professionals on the patient care units to give and to direct care, there is no quality care; there is no hospital. Although this sounds melodramatic, it is important to realize that it describes a reality that could exist in many New Jersey communities. Hopefully, the reimbursement methodologies for New Jersey hospitals will be amended to correct the economic element in the equation which equals the nursing shortage. If it does not, then the meaning of the gathering here today takes on even greater meaning -- greater importance; importance for all the members of the health care team -- the nursing staff, the physical therapist, the pharmacist, the respiratory therapist, social service, and on and on. They are all involved in giving the care to our patients in the acute care hospitals and, although the nursing staff represents the greatest number of employees in the hospital, all of them are involved.

Thank you for listening.

ASSEMBLYMAN COLBURN: Just a minute. I am not sure we have the spelling of your name for the record, because you are replacing someone else.

MS. BUDDE: B as in baker, U, D as in David, D as in David, E.

ASSEMBLYMAN COLBURN: Thank you. Any questions?

ASSEMBLYMAN FRELINGHUYSEN: I think Mr. Becker has one more, doesn't he?

ASSEMBLYMAN COLBURN: Yes. Okay, sir.

L O U I S D I T Z E L, J R.: As Craig introduced before, my name is Lou Ditzel. I am the President of Irvington General Hospital. Approximately for the last three years, I have shared the honor with Ann of serving on the Committee on Nursing as Chairman for the New Jersey Hospital Association. I refer to this as a privilege because it has given me the opportunity to work on a program that I believe in and care very deeply about. This is because it involves a group of people who I have a great deal of admiration for, and at times stand back in awe of. I guess one would classify me then as a nursing advocate.

First, I would like to thank the members of this Committee for giving us the opportunity to discuss this critical issue with you, and also for showing the leadership which is going to be necessary now and in the months and years to follow, as we battle this dreadful disease. I have come to refer, during my tenure on this committee, to the nursing shortage as the result of the complex disease which has already begun to cripple professional nursing in our State and, if allowed to continue, could possibly cause its extinction. While these thoughts may sound -- as Ann said -- melodramatic, they come as a result of several years of research and investigation into the causes of the current crisis, and the supporting documentation -- as you have already heard -- continues to accumulate from around the country.

You have already heard many of the sobering details from the previous speakers, and it is not my intention to repeat them. I would, however, like to share with you the results of the work that has been ongoing in New Jersey through the Committee on Nursing, in conjunction with our colleagues from many other organizations and agencies. Our review of this complex issue has resulted in an action plan which is attempting to attack the negative forces which appear to be

causing so many professionals to leave the field and/or New Jersey, and at the same time causing prospective students to choose other careers.

The first and main objective is economic, not because we see it as the sole solution, but because leaving it unresolved prevents us from even attempting to attack the other problems that are in dire need of our collective attention. We have arrived at a dark point in history where we have taken one of the most priceless professional resources for the population at large, and asked them to carry an unjustifiable share of the responsibility for reducing and containing health care costs through depressed salaries and highly pressured working conditions. If we can solve this specific problem with your help and leadership and the continued support of the Department of Health, I feel confident that we can then launch a major offensive to deal with the other problems which have been shown to be having a negative impact on the nursing profession:

Marketing the profession to new bright talent and to those professionals not currently working in the field; correcting deficiencies in the management of our professional resources in the acute care setting; creating the necessary career ladders to provide growth and reward for experience and excellence; continuing attempts to reenforce collaborative practice models with physicians and other allied professionals; and, equally important, reeducating our public to more fully understand how vital our professional nurses are to their families' well-being, and how devastating the loss of these individuals will be if we are unsuccessful in resolving the issues outlined here today.

Professional nurses are absolutely irreplaceable. Without them, medical care in our hospitals, as we know it today, would change dramatically. Our patient care system depends on critical elements provided for by the professional nurse: nursing prognosis, diagnosis, the development of proper

patient care plans necessary to carry out physician orders, family support and guidance, discharge planning and, most importantly, emotional support for the sick and injured.

These are just a few of the things that our public is so often unaware of, but are so critical to the continuance of the quality of care practiced in New Jersey hospitals today. We should be proud that New Jersey has taken a leading role in confronting this monstrous problem. Our professional organizations and agencies, the State Department of Health, the Governor, hopefully, and our State Legislature, must continue to work together with the fine hospitals, institutions, and professionals who jointly comprise the New Jersey health care delivery system, to help conquer the nursing shortage. If we do not, the horror stories you have already heard, or will soon hear from the next speakers, will become commonplace, and will eventually affect every person in this room.

Unfortunately, similar problems now exist in other critical professions, and they will have to be addressed also. Physical therapists and radiology and medical technologists are but a few examples. I strongly implore your Committee to continue to move and support legislation which will ensure quick and strong action in dealing with this crisis. Too much time has already been lost.

I would like to thank you again for the opportunity to make this presentation. I wish us all -- everybody in this room -- the best of luck in facing the challenges which lie ahead. (applause)

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen has a series of questions.

ASSEMBLYMAN FRELINGHUYSEN: I'm not sure whether I want to direct them to Craig Becker--

MR. BECKER: However you want to do it, sir.

ASSEMBLYMAN FRELINGHUYSEN: Craig, the representatives from the State Nurses Association said in their opening

statement, and I quote: "We are here today, however, to also be on record as fully supporting nursing as a revenue producing center for hospitals" -- that was underlined -- "and to point out the astonishing fact that nowhere in the rate of reimbursement system does the Department of Health cost out nursing services." Could you address that particular issue?

MR. BECKER: It's true. However, having said that, my concern is, I am not sure how that goes to producing additional revenues to the hospital. If it were a question of the hospitals having "X" amount of dollars and holding onto them, and not giving them to the nurses, then I guess I could understand it a little better. But, the fact is, the hospitals just don't have the dollars to give to the nurses. Certainly, this is one of the issues we are looking at, in addition to the minimal salary and some other additions also.

ASSEMBLYMAN FRELINGHUYSEN: But as hospitals put their budgets together, obviously they have broken down the certain percentage that is attributable to nursing. I am just wondering why, when the rate reimbursement system was set up, wasn't this a factor? Maybe I am not directing my question to the right group.

ASSEMBLYMAN COLBURN: Well, by chance, Pamela Dickson is--

ASSEMBLYMAN FRELINGHUYSEN: I realize that, but I think--

MR. BECKER: Go ahead, Jack. We'll try together.

MR. DeCERCE: There was an effort-- In the development of the DRG Program, there was an effort to establish a program called RIMs, which floundered in data. There could be no agreement reached because it is so subjective. We undoubtedly agree the nursing department would be covering the production department, if we were an industrial concern. They are the ones who do the primary work we do -- the primary care giving. Quantifying that is a major

challenge. I think we could separate a labor proxy for nursing. We could certainly demonstrate that there is a certain need for each of the specialties to have certain rates, because, as someone said earlier, an employment cost index of some sort is used for general health care workers, which may not be appropriate for the various sub-specialties. We haven't costed that out because, don't forget, the DRG emphasis has been on a single rate for the entire patient stay. We are moving in the other direction, away from that. Years ago, we had a list of charges, and we could have added a charge for board and care, like we did, and that would take care of the nursing component. We have gone away to a generalized rate, which is the national trend. Whether that is good or bad, we are in the midst of it in a very well-developed way.

ASSEMBLYMAN FRELINGHUYSEN: I would also like to ask your reaction to-- There has been comment on "The New Jersey Journal of Medicine" article -- which I presume you have seen -- which was distributed at least to the members here, that had to do with--

ASSEMBLYMAN COLBURN: You mean "The New England Journal of Medicine."

ASSEMBLYMAN FRELINGHUYSEN: "The New England Journal of Medicine." It had to do with the, "The Nurse Shortage, Myth or Reality?" I just wondered if you might address a comment that I made earlier, and I quote here as well: "Nurses are currently performing many non-clinical, administrative, and management functions in hospitals, and getting away from traditional responsibilities." I wonder if you have any comment in terms of job performance.

MR. DITZEL: I think it is probably one of the most emotional issues and detailed issues that the Commitee on Nursing has dealt with in the last several years that I have been there. It is occurring -- I am not going to deny that -- in many hospitals, not necessarily out of choice. Limited

resources in all different areas very often -- as a previous speaker -- a very eloquent speaker, nurse professional, earlier today brought out -- Nursing professionals very often end up getting boggled down in a lot of quality assurance activity, a lot of paperwork and, at times, issues relative to non-nursing tasks. I think a comment I made during my presentation, and that the Committee on Nursing has been very supportive of, is, as resources become more available to us -- and that, again, comes right down to dollars -- a major concern is to redefine and reemphasize the manager's role in providing for better systems of utilization of valuable resources in the hospital. I think many of our institutions in New Jersey have taken a leading role in developing programs which attempt to avoid those unfortunate situations.

Ann, do you want to comment on the same issue? You can get two perspectives.

MS. BUDDE: Well, I can speak from the prospective of being a nurse supervisor on the eleven to seven shift and opening the pharmacy and taking care of all of those kinds of things. On one hand, when the need for services is so restrictive that you really cannot justify having a full-time person there, it falls to the nursing supervisor to handle that sort of chore. Depending upon the percentage of the time spent in doing that, it could very well be the best utilization of money at the time for personnel. But I think one of the things we are dealing with when we are talking about demeaning jobs, administrative jobs, etc., not only who is doing the housekeeping, who is passing the food trays, not only that, but in some of the regulations that exist from the State Licensing Bureau, for instance, who is counting the narcotics, who is locking what cupboard, where do you have to sign your name, and how many times? There are some of the regulations -- and I know you want more specifics than that -- but there are some that really do take a great deal of time away from

patient care into that sort of clerical, administrative, management, not really professional, but required role.

ASSEMBLYMAN FRELINGHUYSEN: But there has been, as I understand it, removal of the delegatory (sic) clause, in terms of who could do what.

MS. BUDDE: The standards are now under revision in the State of New Jersey, and there has been a great deal of change in some of the wording. Exactly how that will be interpreted and played out, I can't speak to right now. I don't believe they have been finalized, for one thing. I think they are still under a review process.

ASSEMBLYMAN FRELINGHUYSEN: But it would be generally said that it is giving nurses in the overall area of responsibility in hospitals a greater and more prominent role?

MS. BUDDE: Yes.

ASSEMBLYMAN FRELINGHUYSEN: Thank you, Ms. Budde. Thank you, Mr. Chairman.

ASSEMBLYMAN COLBURN: Any other questions? (no response) Thanks very much, all of you.

Pamela Dickson, Director of Hospital Reimbursement, New Jersey Department of Health? Following Ms. Dickson, I will call on Carolyn Wade, of the Communications Workers of America.

P A M E L A S. D I C K S O N: Thank you. I was beginning to wonder if Mr. DeCerce had asked you to put me back on the program, so I couldn't be back at the Department of Health writing regulations this afternoon.

ASSEMBLYMAN COLBURN: Well, that's not a bad idea. We're putting you in a cleanup position.

MS. DICKSON: I want to thank you for the opportunity to testify on this very critical issue. I should first convey Dr. Coye's very sincere regret in not being able to be here herself, to share with you her concerns and commitment to being involved in solutions on this issue. The continuing ability of New Jersey's hospitals and other health care settings to

provide a high quality of health professional care to their patients is of the highest priority to the Department of Health. Nursing is one of the key components of good health care, and we need to listen very carefully to what the nurses are telling us today.

As has been mentioned earlier today, both nationally, and in New Jersey, hospitals and other health care settings are suffering from shortages of nurses. The causes of these shortages have been testified to before. Certainly, one of the causes is money. In addition, I hope we do not lose sight of the other issues, such as compressed wage scales and assignment of other non-nursing tasks to R.N.s, poor prestige and recognition of the profession, declining enrollments in nursing programs, etc., etc.

In New Jersey, hospitals have also identified regulations constraining wage increases under the State rate-setting system as a significant cause of the nursing shortage. Vacancies appear to be highest in labor markets on New York and Pennsylvania borders. In these areas, New Jersey hospitals must compete for nurses with hospitals in the other states which are under different constraints. However, as you have heard, other hospitals contend it is a problem across-the-board in New Jersey hospitals.

Let me next speak to the response of the Department of Health to this problem in the past couple of months. The very critical nature of it was brought to the Department of Health's attention by the Hospital Association in July. There is no question that there is a shortage which is at crisis level in some hospitals. We know that because CEOs are being forced to close beds. Specifically, the Hospital Association asked for an across-the-board increase to hospital rates, in the main to repay hospitals for salary increases which had already been granted to nurses that were beyond the budget limitations. It may be helpful in understanding the Department's role in

addressing this problem to briefly describe the nature of the hospital reimbursement system.

New Jersey hospital rates are regulated, hopefully, to assure that hospital care is affordable for all of New Jersey's citizens. Hospital rates are set prospectively, using base year costs and increasing them annually by an inflation factor. This factor is called the economic factor, and is constructed by using a market-basket approach with specific proxies for the different components of hospital costs. The theory behind our system is, once costs are deemed to be reasonable, then if you bring these costs forward every year by inflation, hospitals should be able to manage with that whole revenue concept. We are now facing an important turning point in the system, however: Identification of a component of hospital cost for which the inflation increase may not be enough to allow hospitals to provide the necessary level of health professional staffing.

Nurse and other health professional salaries are addressed through a labor proxy which is derived from a weighted average of regional hospital personnel costs. When rates are set each fall for the upcoming rate year, an inflation factor is projected by an independent forecasting agency, specifically Data Resources, Inc. This is used to increase the previous year's costs for the hospital. Then, when the year is over, hospitals' approved revenues are reconciled to what inflation actually did during the year, whether it was higher or lower than what was projected.

Back to the nature of the relief: The Hospital Association had brought an appeal, based on the fact that they felt the economic factor adjustment at its 1987 rates inadequately captured the effect inflation would have on personnel costs, specifically nurses. The Hospital Association requested an immediate 2% increase to what had been projected. There were two separate hearings over the last couple of months

at the Hospital Rate Setting Commission, and the result is that the Commission approved the Department's recommendations which increased this economic factor for the year 1987 by 2%, and flowed somewhere between $40 million and $50 million into hospital rates over the last four months of the year. It is estimated that this raised the average hospital bill by approximately $100.

Part of the Department of Health's recommendation to the Commission, was that a working group be formed to address this issue of whether the economic factor adjustment was adequately capturing what hospitals needed to make sure that their personnel wages were competitive with other nursing salaries and other health professional salaries.

Charlotte Kitler has convened this group, and it is at work. In deference to Assemblyman Deverin's concern, we do have an in-point for this. We have committed to having the study completed by the end of this year, so that recommendations can be made to the Commission for 1988, because the relief, as has been mentioned, goes through the end of this year.

The Department is prepared to recommend to the Commission whatever additional dollars are necessary and efficacious in allowing hospitals to retain health professional staffing. I say efficacious because it is important also to realize that just dollars are not enough. After a point, increases will not be able to help our hospitals if there is a limited number of nurses willing to work at hospitals because of non-monetary reasons. We need to explore those other reasons as well, and address them promptly, so that our hospitals can continue to offer the quality of care to New Jersey citizens.

I will be happy to answer any questions. I can start with the questions that have been raised on costing out nurse costs, if you wish.

ASSEMBLYMAN COLBURN: Please do.

MS. DICKSON: All right. The Nurses Association representatives, I believe, were referring to a study which has been done on how the nursing costs are a part of the DRG rates. When we first identified DRGs and found what an average cost was for a DRG, what we did was have nursing costs be a part of that. Just add up all the nursing hours and divide them by patient days to find out what the average cost assignment should be. So, essentially, we have nursing costs assigned in the DRG rates by patient days. Now, this does not really capture what nurses do because, as anyone can imagine, there would be certain cases that would require more nursing hours and certain cases that would require fewer nursing hours. What the study the Department has done would do, would be reallocate nursing costs to DRGs, so that those DRGs-- For example, if one case was seven days and another case was seven days, but the first case required more nursing hours, it would shift dollars so that the first case was more expensive than the second case. Essentially, this, as planned, would just be a reordering of the costs in a sort of budget neutral way.

I think the nurses are asking for this type of recognition. I think this would only be a first step. In the long run, I believe they are looking to have a recognition of their service as a revenue-producing code. For example, right now when a hospital charges for an x-ray, you have the general hospital cost and then you have the physician cost. I believe nurses would like to see the day when the nursing care is not just part of the overall hospital charge, but the patient would get a bill for the hospital charge, for the nursing charge, and for the physician charge.

ASSEMBLYMAN COLBURN: Thank you.

ASSEMBLYMAN DEVERIN: How would that help the increase in salaries, though? Do you know what would happen? The poor patient leaves the hospital and he screams now about the telephone bill. If he sees a good piece in there for the

nurses, he'll get mad at the nurses. Wouldn't it be better if we just gave them the raise, and let the people guess where it is going?

MS. DICKSON: Well, I can't really pretend to speak for the nurses, but my guess, from some of the things I have heard this afternoon, is-- Some people have said, "Well, New Jersey has low health care costs, and it has been subsidized by nurses." Well, if you separate nursing costs out as an identifiable component, then you can't subsidize any longer. You have to face the nursing costs squarely, and what they really should be.

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen, did you have some follow-up questions?

ASSEMBLYMAN FRELINGHUYSEN: I would like to get a better sense of your feeling in terms of costing out nursing. You say that may be a probability?

MS. DICKSON: Yes. The Department of Health--

ASSEMBLYMAN FRELINGHUYSEN: You can cost out physicians.

MS. DICKSON: Well, right now, very clearly physician costs are a discrete component of the costs on hospital bills. The work the Department is doing as far as costing out nurses, would say as you develop the DRG, "Here are all the costs that go into treating this patient, and this is the specific item of nursing cost for this DRG," not just the average length of stay is seven days, so the nursing component is seven times whatever the nursing cost per day is. As I said, that is only a first step. It is something the Department is going to be looking at during 1988, as we have committed ourselves to doing a review of the DRG rates. That would not lead to what I described before as a long-range objective of nurses, which is to have nursing care as a separate bill.

ASSEMBLYMAN FRELINGHUYSEN: Don't the hospitals now cost out nursing for their own purposes?

MS. DICKSON: I'm sure they do for their own purposes. That does not go into the rates as they are set prospectively by the Department of Health. I would just like to add that I think one of the goals of our system is not necessarily to tell hospitals how they should spend their money. The goal is to find out what a good, average, fair reimbursement would be for a particular patient, and then allow the hospital to use the money as it saw fit to take care of the patient.

ASSEMBLYMAN COLBURN: Excuse me. One of the things we might get to with the next person to testify, is the question of the negotiation, you know, because I guess some nurses are represented by unions. This whole question could get into the business of labor negotiations. So, I guess we have to be careful as to how we view all this, and how we do it, because of the negotiating things it might involve. I think maybe the next witness will be able to explain that to us a little bit more, if I am reading the list correctly here.

Any other questions? (no response) Thanks very much.

MS. DICKSON: I have a copy of my testimony here.

ASSEMBLYMAN COLBURN: We appreciate that. David will come over and get it. Carolyn Wade, from the Communications Workers of America? Good afternoon.

C A R O L Y N C. W A D E: Good afternoon.

ASSEMBLYMAN COLBURN: We'll wait a second until things settle down a little bit. (pause here)

ASSEMBLYMAN DEVERIN: Are they in the same union as you are, Carolyn?

MS. WADE: Absolutely not.

ASSEMBLYMAN COLBURN: I wasn't sure.

ASSEMBLYMAN DEVERIN: I didn't think so.

MS. WADE: We have so few, they all had to stay on the job, or else they would have had to bring their patients with them.

ASSEMBLYMAN COLBURN: Excuse me. This is just an ignorant question on my part. About how many nurses do you-- Do you represent nurses, other workers, or what -- or both?

MS. WADE: Yes, we represent about 750 nurses in the institutions, in both Human Services and--

ASSEMBLYMAN COLBURN: Oh, in the State-run institutions?

MS. WADE: Yes.

ASSEMBLYMAN COLBURN: Okay. Well, I guess you would know-- Are nurses generally represented by other unions that might not be here today? I guess they are.

MS. WADE: Well, just the L.P.N.s, who are represented by the American Federation of State, County, and Municipal Employees.

ASSEMBLYMAN COLBURN: Okay. Excuse me, please go ahead.

MS. WADE: May I say good evening to you?

ASSEMBLYMAN COLBURN: Good night, almost.

MS. WADE: I am Carolyn Wade. I am the Executive Vice President of Local 1040, and this is Donald Klein. He is a staff psychologist at one of the work sites we represent.

We at Local 1040 represent the clerical, professional, and supervisory workers in the State Departments of Human Services and Corrections. Within our professional bargaining unit regs, there are about 750 registered nurses working at the various institutions under Human Services and Corrections.

I have come before you today to relate a sad and perplexing problem which plagues these registered nurses as they perform their daily responsibilities and duties caring for the clients housed in institutions, whether they be developmentally disabled, mentally ill, or incarcerated. Perhaps you have heard what I am going to relate to you said at other sessions or discussions. In any event, even though it has been said before, it is appropriate that I bring this concern to your attention once again.

This concern is understaffing and low pay, and a serious shortage of registered nurses. Each institution, whether under the jurisdiction of Human Services or Corrections, is experiencing understaffing. There aren't enough registered nurses to maintain staffing ratio per client/inmate population. As we all know, proper staffing is a prerequisite to maintaining proper coverage. Proper staffing ratio between registered nurses and the client/inmate would mean that overworked and underpaid registered nurses would be offered proper relief, so that they could reenter the work site with a more positive approach to the unique and unpredictable work environment they encounter.

Let's just reflect somewhat on their unique and unpredictable work environment. It is not easy dealing with mentally retarded clients who can go off at any given time. It is not easy, when you are a registered nurse working a ward or dormitory alone, and you must meet this situation alone and deal with it. It is not easy, when you are a registered nurse working alone at a nursing station in a penal institution, without proper security and protection from the very persons who are paid to provide security within the walls of the prison. It is not easy, when you are a registered nurse who completes your normal eight-hour tour of duty, and then you are ordered to work mandatory overtime, which means you will be working a double shift, sometimes a 24-hour shift, and sporatic 36-hour shifts.

During the working of multiple shifts, you dare not make a mistake, or you are severely disciplined, and no one takes into consideration the mitigating circumstances. It is not easy, when you are a registered nurse anticipating your normal two days off, that you are sarcastically informed that you have to come in and work your regular day off, because there are not sufficient registered nurses to work the 24-hour, seven-days-per-work-week schedule. It is not easy, when you

are a registered nurse, and you are told: "If you don't like what is being done to you, then you can lump it. You can go find another job." Many of them have.

Whatever happened to human dignity and respect? Whatever happened to respect for the nursing profession? Registered nurses are professional workers. Wouldn't you agree? Committee members, what is Governor Kean, Commissioner Altman, and Commissioner Fauver doing to correct the understaffing situation? All have been advised, but nothing has been done. I am sure you will tell us that a concerted recruitment drive is on to lure nursing graduates and experienced registered nurses to State service. You will probably tell us that the starting salary for registered nurses is around $28,000, or the seventh step of a nine-step range. But, has this worked? Your response will probably be: "What else can we do?"

Let us make some positive suggestions which will deal with the problem of understaffing: First, elevate registered nurses' salaries and make them competitive with the pay scale and incentive offered in the private sector.

Secondly, establish an equitable shift differential as an incentive.

Thirdly, permit registered nurses to give input and suggestions concerning medical questions.

Fourthly, take away the unnecessary paperwork which has nothing to do with nursing. All too often, registered nurses are given an inordinate amount of paperwork to do, which limits their time in the delivery of nursing services.

Five, reestablish dignity and respect for registered nurses, in compliance with our contractual agreement language, which states that the work environment must have dignity and respect.

Six, ensure that nurses have the proper equipment to do their job. Too often, codes are called, and there is no workable equipment to respond to the emergency.

The turnover in registered nursing personnel is tremendous. If positive steps are not taken to better the working conditions and environment, the problem of understaffing will get even worse. Morals are at an all-time low -- morale, that is. Morals, too, because they take those away.

ASSEMBLYMAN DEVERIN: Which is more fun? (laughter)

MS. WADE: Morals. But, we say to you, "Please don't sweep the problem of understaffing under the table." Nursing in State institutions needs you. Let's deal with this. Look at the realistic and positive suggestions we have presented to you. This would achieve a workable plan for action for the retention of nurses, and positive recruitment.

Thank you.

ASSEMBLYMAN COLBURN: Thank you. Mr. Klein, would you like to add something?

D O N A L D L. K L E I N: Yes. I will try to skip over some of the things that Carolyn has already pointed out.

As a professional who has worked in a State-operated facility, I have observed firsthand the basically deplorable conditions which exist within our institutions. The nursing crisis the State is experiencing at present-- Much is attributed to these working conditions. Shortage of personnel is the most serious problem encountered, but the problem was created by personnel practices of the Department of Human Services and the Department of Corrections. Such practices are still being perpetuated.

Nurses are ordered to work 24- and 36-hour shifts, under the threat of disciplinary action if they refuse. Professional nurses have reported being solely responsible for as many as 500 patients at one time. I believe one nurse at a correctional facility was responsible for 2000 patients. Also, reassignments are so frequent, that nurses are unfamiliar with the patients on the ward. There is no continuity of care.

Again, as Carolyn mentioned, and I would like to reiterate, if a serious incident ensues, the nurse is the first to receive disciplinary action, regardless of the circumstances involved. I would like to give you an example of this. At Ancora Psychiatric Hospital, following the death of a patient, 12 nurses were disciplined for alleged errors in documentation -- alleged errors -- and the majority of these employees were not on duty when the incident transpired.

So, unjust discipline, ridiculously long working hours, and unrealistic responsibilities jeopardize nursing licenses. That is why they are fleeing the system, No legal assistance or administrative support is rendered in behalf of the employees. The very policies they are accused of violating are set by administrators who have a lack of understanding of sound medical practices and procedures.

Institutionalized patients require more attention and specialized knowledge. The risk of assault is extremely great. An alarming number of AIDS patients are being treated in our facilities. Again, salaries are not commensurate with the responsibilities involved, nor are arrangements made to counteract low morale and burnout -- and there is burnout.

Staff turnover is expensive. Yet, 18 nurses left the State mental health care system in a one-month period. Last week, I understand Ancora Psychiatric Hospital lost five nurses. This discourages new nurses from seeking State employment.

Before discussing possible solutions to these extensive issues, I would like to inform you of another dangerous situation. Prisoners from Corrections are being housed on the grounds of psychiatric and mental retardation facilities. Recently, a nurse was raped by a prisoner housed on the grounds of Ancora Psychiatric Hospital. The young nurse was devastated by this brutal and, may I say, preventable act. Prisoners do not belong on the same grounds as the mentally

retarded and mentally ill. It is both clinically and ethically an unsound policy.

The few public employees who remain, do so because they are dedicated to the care of this very special and often neglected population. To retain these nurses, as well as to attract new professionals, let's begin treating them with dignity and respect, not with such callous disregard.

Due to the hazardous and specialized nature of their work, a proposed starting salary of $35,000 would be equitable. This rate of compensation would attract staff which is so desperately needed.

Immediate steps to implement a shift differential payment for the afternoon and night tours of duty must be taken. Increased moneys must be allocated to the Nursing Scholarship Program to attract young people to State service and its educational opportunity for nursing. Moneys should be allocated as well to provide the opportunity for registered professional nurses to pursue baccalaureate and master's degrees. A task force of nursing personnel should be convened to review practices and policies as they exist in State government. This Committee could also be used as a forum for peer review. Personnel departments should include State nurses to assist them in recruitment efforts.

Your intervention is urgently needed to remedy a situation that has reached intolerable proportions. Thank you.

ASSEMBLYMAN COLBURN: Any questions from the members of the Committee?

ASSEMBLYMAN OTLOWSKI: Mr. Chairman?

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: There was some reference made here that was unrelated to what we are here for. As a matter of fact, it is probably even misconduct that takes place at the institutions that were mentioned here. Could we have that report, so the Committee could look into that particular aspect of it? (witness complies)

ASSEMBLYMAN COLBURN: I assume there are also channels through which such situations can be addressed.

ASSEMBLYMAN OTLOWSKI: I would want to see that they are referred to the proper channels.

ASSEMBLYMAN COLBURN: Is each member of the Committee getting one of those? Are they for all of us, or is there just one?

MR. KLEIN: There are nine copies.

ASSEMBLYMAN COLBURN: Okay.

ASSEMBLYMAN OTLOWSKI: Mr. Chairman, I would like to make the suggestion to you, if I may, that those particular references be referred to the Commissioner, so he can look into those allegations to determine, you know, if they are true, and what can be done about them, so they can be corrected immediately.

ASSEMBLYMAN COLBURN: Absolutely.

UNIDENTIFIED SPEAKER FROM AUDIENCE: He already knows about them.

ASSEMBLYMAN COLBURN: Well, we do have to go on with the purpose of the hearing. Are there any other questions? (no response) Okay, thanks very much.

I am now going to call William Butler, Chairperson, Coalition of Mental Health Consumer Organizations.

W I L L I A M B U T L E R: Good afternoon. It is my understanding that the purpose of this hearing is to receive testimony about problems relating to the hiring and retention of high quality nursing and allied health professionals in hospitals and other health care settings, and the consequences for health care consumers, as well as possible legislative and administrative policy initiatives to address these problems.

Clearly, this hearing is, and has been, an attempt, through comparison and contrast, to curtail a future crisis which is passed symptomatic problems. For the record, I wish to discuss this issue in terms of psychiatric R.N.s and L.P.N.s

and their retention, allied health professionals, both aides and those professionals in the adjunctive therapies, and mental health consumers and their families. Finally, I wish to cite both legislative and administrative policy initiatives, but toward a long-term, not a short-term solution.

It was disconcerting for me to read Judy Holmes' article in the Asbury Park Press, entitled, "Union Warns State on Nursing Shortage." In this article of Friday, September 18 of this year, Carolyn Wade, Executive Vice President of Communications Workers of America, AFL-CIO Local 1040, states, and I quote: "If we get no response from the Federal or State government, then there will be some job action."

The local President of the CWA unit of Marlboro Psychiatric Hospital also stated that R.N.s have begun to document every time their units are short-staffed. R.N.s are responsible for as many as three cottages during a night shift, and they can have up to as many as 180 patients.

The AFSCME Local 2217 President has initiated incident reports on those shifts where no registered nurses are on duty. Nurses are working double shifts at least three times a week at all of the State institutions; some are working double shifts five times a week; and one nurse worked four consecutive eight-hour shifts, 36 hours, according to the September 18 article.

Knowing these facts as a mental health consumer who has survived through 25 hospitalizations in the State and Federal systems in New Jersey, it is clear to me that we have a clear warning that must be heeded. I wish, at this time, to propose a two-front solution to work toward a long-term remedy in New Jersey concerning the mentally ill.

The first solution is to promote nursing funding and education to any human services assistant or human services technician on the basis of job proficiency and academic excellence for the ascertaining of licensure of nursing degrees.

The second solution is not nearly as easy, since it is not merely a clinical decision. I would like to call on the Governor of this State, particularly through this Committee, to make a specific investment for outpatient community programing of the State's mentally ill, and strongly suggest that New Jersey's commitment be elevated from fortieth to fifteenth in the nation, concerned with outpatient care. Further, I would like to have placement for all discharged-pending placement patients in our State institutions, to be placed in a care facility, as necessary, with L.P.N.s and R.N.s to add care and aid for patients on an outpatient basis. The reduction of patients will close wards statewide, and thus reduce the hardship on an already depleted work force.

ASSEMBLYMAN COLBURN: Thank you. Does anyone have any questions? (no response) Thanks very much.

The next person I am going to call on comes from my own area, Mr. Dunn, if he is still here. Edward Dunn, Vice President for Human Resources, West Jersey Health System, Camden, New Jersey. After Mr. Dunn, we will have the Saint Barnabas contingent, if they are still present. I apologize to you, but I have to stay here, too, Mr. Dunn.

E D W A R D D U N N: I can't think of anything more important to do.

ASSEMBLYMAN COLBURN: You're right.

ASSEMBLYMAN DEVERIN: You're going to get that raise anyway, Mr. Dunn.

MR. DUNN: Before I begin my remarks, several times this afternoon, I have had the opportunity to listen to Assemblyman Otlowski ask the question: "Where is the money going to come from?" I think Mr. Becker of the Hospital Association partially addressed that, but I think what we have to look at is, how are the states around us able to afford to pay their nurses more than we can pay our nurses? How are the states around us able to pay their health care professionals

and allied folks more than we can pay our folks? Therein, I think you will find some of that answer, Assemblyman.

Thank you, Mr. Chairman and members of the Committee, for the opportunity to speak before you today. The purpose of my remarks is to alert you that the quality of health care in New Jersey is in jeopardy due to diminishing numbers of health care personnel.

As Vice President for Human Resources, I represent the West Jersey Health System -- a network of four nonprofit hospitals located in southern New Jersey. One of our hospitals is within 10 minutes of a Philadelphia hospital paying all of their employees approximately 20% more than we pay our employees. We currently employ over 3100 individuals -- men and women -- including 1200 licensed nurses, and 435 allied health professionals in such areas as pharmacy, lab, radiology, physical therapy, and respiratory therapy. The remaining 1500 employees also play a major role in helping our facilities operate by preparing food, cleaning, securing and maintaining buildings, supplies and materials, and performing business and administrative details. They are the people who should do the non-nursing duties, and other speakers have spoken to this today.

Many nurses are expected, required, and do those duties because we don't have those folks. Nurses are the heart of the hospital, but nobody survives on just one organ. We need those other folks as well.

There is no doubt in anyone's mind that there is a nursing shortage; at least I hope there is no doubt in anyone's mind that there is a nursing shortage. It is real, and a solution must be found. We at West Jersey support, and are willing to work, for such a solution. But, while much attention has been focused on the shortage of nurses, I am here today to let you know there is a similar crisis occurring within the allied health professional field and, if I may carry

the point a bit further, the same crisis is occurring with all health care personnel.

Prospective hospital employees, like all employees, are looking for convenience, safety -- and testimony was just received about safety -- prestige in their jobs, and a salary commensurate with their responsibilities. There is no doubt that to attract people to enter the field and work in New Jersey hospitals, we must provide that convenience and safety. We must also pay on a level with our neighboring states and, depending on the job, with other New Jersey industries. While we support passage of Assembly Bills 4483 and 4001, we believe they are only the first step in the right direction, because they seek to provide relief solely for nurses. Our allied health professionals, as well as our nurses and all of our employees, deserve better.

We are currently recruiting for over 200 positions. To fill the gap, we, like all other hospitals, have been utilizing temporary agencies and paying double the cost. While we continue to provide quality care, we don't believe it is because we "filled the gap." On the contrary, we are convinced that the maintenance of our quality is a result of the commitment and dedication of our own employees, to repeatedly work overtime and weekends. These are the people who need relief.

A draft of New Jersey's 1988 State Health Plan, while not yet formally adopted, also brings attention to the overall personnel shortage, and I quote: "The number of nurses and ancillary persons qualified and committed to working in health care facilities is becoming of increasing concern." Concern over what? We all know that the answer is concern over quality of care -- the effect on our family members and neighbors when they must be turned away because there just isn't enough staff to care for them.

The proposed State Health Plan also pinpoints that costs are on the rise because severity of illness has increased. Increased intensity of illness means that patients are sicker, and that certainly has been our experience. These patients require more care and service during their stay. With fewer qualified nurses, technologists, and therapists to bring these persons back to health, it is understandable how quality could be compromised. The problem is real. The problem is frightening. Again, we have to ask the question, "Why?"

All of us in health care have shared the fear with each other that New Jersey's health care regulation has gone too far -- that quality care is taking a back seat to monitoring of cost. But most of those same people are afraid to even hint, in a public forum such as this, that we are concerned that quality is being jeopardized for the patients.

West Jersey is not afraid to bring the truth to light. I challenge any other hospital to deny that the issue of quality is not a major topic of discussion at their meetings. We all care about costs; we all care about quality; and we want you to know, we are concerned about what the not-too-distant future holds in store.

New Jersey can no longer delude itself that by being the lowest State in health care costs in the nation, we also can be the highest in quality. While "more" is not always "better," "less" often means "not enough."

Have we gone too far? I believe that the fact that fewer and fewer persons desire to work in New Jersey hospitals is a symptom of a much larger problem.

We implore you to take action -- to work with us to find a long-term solution and, in the meantime, to approve funding which will enable us to win, not lose, the battle for quality of care for the citizens of New Jersey.

I thank you for listening.

ASSEMBLYMAN COLBURN: Any questions from the Committee members? (no response) Thanks very much.

ASSEMBLYMAN DEVERIN: Except, Mr. Dunn, your words are words of wisdom. If we could straighten it all out, we would be fine. That's very good. Your statement is exactly what the problem is. You have put your finger on it.

MR. DUNN: I hear you, but I get back to what the Assemblyman to your right said earlier, when he talked about how for 30 years he has been listening -- he has been listening to issues. Well, many of the people in this room, and many, obviously, of those who have left, have not only listened to those issues, but they have lived with those issues.

ASSEMBLYMAN DEVERIN: Yeah.

MR. DUNN: I think what they are looking for is not so much rhetoric, not so much coming to Trenton for presentations, but they are looking for effective action that will mean that when we go to compete with nurses who can work seven minutes away, that we are not in a position where across the river they can make 20% more than they can make in New Jersey. That, I think, would make a better New Jersey for all of us. (applause)

ASSEMBLYMAN COLBURN: We have two people from Saint Barnabas, Mr. Walker and Ms. McEachen. Darlene Cox Cheaney will follow this group, if she is still here.

I R E N E M c E A C H E N: Good afternoon. I am Irene McEachen, from Saint Barnabas Medical Center.

ASSEMBLYMAN COLBURN: Does that name make you Scottish or Irish?

MS. McEACHEN: Scottish, sir.

ASSEMBLYMAN COLBURN: By golly, okay, thanks.

MS. McEACHEN: By happenstance, my remarks succinctly summarize much of what has been said today. I appreciate the opportunity to provide testimony to the Assembly Health and Human Resources Committee. I am here to testify to the reality of the nursing shortage in New Jersey.

New Jersey's hospitals are responsible for providing quality health care services to the 7.5 million residents of

this State. The shortage of nurses in our health care settings, and in our home care agencies, is severely compromising and jeopardizing the health and well-being of our citizens.

Saint Barnabas Medical Center is the State's oldest and largest acute care hospital, and one of the State's largest employers, employing 2500 people. We at Saint Barnabas Medical Center are concerned and enmeshed in the nationwide nursing shortage. We are eager to work with the Governor, the Legislature, the Commissioner of Health, and all other interested groups to seek and recommend solutions to this problem, and they must be eager to work with us as well. We are losing nurses from the profession, and we are losing the interest of young people to become nurses. Why?

-Career opportunities for women outside of the traditional teaching and nursing careers.

-Compressed pay scales with small increases in salary over years.

-Physical and emotional demands upon nurses which many young people are unwilling to endure.

-Weekend, holiday, and night work which removes one from one's family.

-Exposure to life-threatening illnesses, such as hepatitis and AIDS.

-A shortage in hospitals as nurses flock to work for staff nurse agencies, where they set their own working schedule and receive salaries 20% to 30% greater than hospital salaries. This impacts our budgets, but still does not address the problem. Agencies cannot supply the numbers of nurses that Saint Barnabas Medical Center requires. The shortage problem remains.

You have heard and read about these reasons for the nurse shortage. Their validity and immediacy could be discussed at length, but we do not have time for that. Our

society faces the problem today. Saint Barnabas Medical Center, as well as all hospitals in New Jersey, needs staff nurses today, and we are seeking solutions today.

I must speak to the concern of recruitment and retention in the hospital setting. Recruitment is growing more difficult for reasons mentioned, and retention is an issue as our staff nurses leave the hospital workplace due to low pay, stress, understaffing, intensity of patient illness, long hours, shift rotation, weekend and holiday work, lack of career mobility, inadequate benefits, etc. The "American Journal of Nursing," in an article published in their January, 1987 magazine, noted: "Hospital staff nurses seem to be seeing the worst of all possible economic worlds; meager raises in return for harder work with sicker patients. Because there has been no corresponding increase in pay and benefits accompanying the increased work load, recruitment and retention of nurses, particularly in specialized practice areas, is becoming more and more difficult."

Obviously, when there are insufficient numbers of health care workers, the quality of care received by patients suffers, access to care is reduced, and our citizens are placed in jeopardy.

The Committee on Nursing of the New Jersey Hospital Association has convened four ad hoc committees to address the nursing shortage in this State. The committees are looking at: management, marketing, education, and economics.

Their reports and suggested solutions are eagerly anticipated. Our acute care institutions cannot wait for proposals. Action must be taken now.

The economic issue is at the forefront of all analysis. In our recently signed nurses' contract at Saint Barnabas Medical Center, increases in salary and benefits to staff nurses were granted that go beyond what our Medical Center will be reimbursed via the State Rate Setting Commission formula.

This was an informed decision on our part. At Saint Barnabas, we wanted to take the lead and set the standard because we believed it to be right. It went beyond negotiations, and it is still not enough. If the State does not agree, we at Saint Barnabas are prepared to pay.

The Governor of New Jersey, the State Department of Health, the Commissioner of Health, this esteemed Assembly, and I have an obligation to the health care consumer in New Jersey. We must take all steps possible, appropriate, and necessary to see to it that physical care and attention rendered by all health care workers will be available to all citizens. Committees, commissions, and study groups are gearing up to propose solutions -- long-range solutions. The crisis, however, is now; the shortage is today. We must respond.

Thank you very much for your attention.

ASSEMBLYMAN COLBURN: Thank you. Any questions? (no response) Mr. Walker, would you like to say something?

C H A R L E S G. W A L K E R: Mr. Chairman, members of the Committee: My name is Charles G. Walker. I am a Vice President at Saint Barnabas Medical Center in Livingston. In the course of my duties, I am administratively responsible for most allied health departments, including the pharmacy, radiology, respiratory therapy, cardiology services, and a number of others. In my near 20 years tenure with Saint Barnabas, I have served as a respiratory therapy practitioner, a department head, and lately as an administrator. I am very concerned with the increasing difficulty the Medical Center, and the health care industry in general, are experiencing regarding the recruitment and retention of competent allied health and nursing professionals. I, therefore, welcome the opportunity to share those concerns with you today.

First among my concerns is that bright young people in sufficient numbers are not choosing to enter health care as a

career path. The burgeoning of our information and service-oriented society has, unfortunately, provided other lucrative and fulfilling alternatives. The cost of education for a health care career versus the expected benefits in salary and other perks are not in equilibrium and are not always, if ever, as attractive as other fields of endeavor.

Because there is no room, any longer, in the hospital reimbursement formula for costs associated with allied health education and training, hospitals have been forced to close or significantly reduce their programs to train allied health personnel. The closure of hospital programs has merely fueled the flame, adding to the cost of allied health education, and the cycle goes on.

In a few short years, Saint Barnabas Medical Center, for example, has closed or significantly curtailed programs in the following allied health specialties: medical technology; certified lab assistant; medical technology retraining; respiratory therapy; radiology; nuclear medicine; and diagnostic medical ultrasonography.

Also paramount among my concerns for recruitment and retention is the need for the health care industry to remain competitive to external factors, as well as internal factors. Consider that although there are well over 100 acute care hospitals in New Jersey, we managed to produce only 113 pharmacy graduates this year. New Jersey has only one School of Pharmacy, located at Rutgers University. Based on recent data, only 19% of the graduates entered the health care or direct patient care business.

It will come, therefore, as no surprise that salaries for industry and community-based pharmacies are significantly higher than hospitals and other regulated institutions are reasonably in a position to pay.

On an industry-wide basis, allied health departments in hospitals are plagued by chronic open positions. You

certainly have heard testimony today. Clinical pathology departments at many institutions have great difficulty recruiting and retaining qualified practitioners. Salary levels capped by regulatory pressure and competitive erosion by related industries are major contributing factors.

In respiratory therapy, an allied health specialty hit particularly hard, there is a serious problem, as there is in nursing. Practitioners can earn 25% to 30% more per shift by selling their services to "staffing agencies" which, in turn, turn right around and contract with hospitals at rates up to twice the staff wage for the people they replace. This cycle must be broken.

Simply stated, trained people are leaving for more money and better career mobility. In a recent exit interview study of 25 respiratory therapy practitioners, 10 of the 25 left employment to enter more lucrative, albeit alternative professions. They have left the health care field entirely. Of the 25, seven simply left for higher paying jobs in the unregulated support segments of the health care industry, such as contract services, home health care, and sales and service of manufactured products. This migration is by no means limited to respiratory therapy, but is industry-wide, including nursing. In addition to economic benefits, positions outside the health care delivery sector offer advantages, such as improved career path and no evenings, nights, weekends, or holiday work -- no demands on time, other than the normal professional requirements.

The story is the same in areas such as radiology, where the average time to replace a position has grown from a few weeks to four months for the average entry level radiographer, to well over six months for specialized technicians such as ultrasound and nuclear medicine techs. Radiology positions, especially, are at risk to external forces, such as service industries, technology-oriented

corporations, sales activities, private imaging centers, and physicians' offices. Hospitals, in a regulated environment, are quite literally last on the competitive ladder in most instances, often paying the least and expecting the most from dedicated practitioners.

The story goes on and is not limited to the major departments. Professionals such as physical therapists, occupational therapists, speech and hearing pathologists, and many more suffer the same fate. We must make hospital practice more financially attractive for allied health and nursing personnel. It's really all or nothing. We must generate new enthusiasm in educational opportunities. We must develop a process to allow hospitals to offer competitive wage, salary, and benefit structures as a function of recruitment. And, most of all, we must develop a mechanism to appropriately compensate and retain this precious human resource.

New Jersey's salaries for allied health professionals are all too often regarded as lowest in the region at a time when New Jersey boasts of health care cost achievement. We cannot achieve efficiency without effectiveness. The quality of the product we deliver relates to the quality of the practitioners who deliver it.

The citizens of this State who have cooperated with government in support of reasonable health care policy simply deserve better.

One closing remark I wish to leave you with, is the reality that when allied health professionals are unavailable, the main body of the work they do must fall upon an already diminished nursing work force. Tasks which go undone because of the unavailability of allied health personnel become tasks which further worsen the nursing staffing crisis. The solution to this and the nursing staffing crisis goes hand in hand both in theory and in practice.

Thank you.

ASSEMBLYMAN COLBURN: Any questions? Mr. Deverin?

ASSEMBLYMAN DEVERIN: No, it's not a question. I had a tour of your hospital -- you have a great hospital, by the way -- respiratory therapists with Dr. Jacobs. Is that his name?

MR. WALKER: Yes.

ASSEMBLYMAN DEVERIN: And if I am familiar with nothing else in this world, I am familiar with respiratory therapists, because I have the dubious distinction of having a licensure bill pass twice, and being vetoed by two Governors. I remember that one of the things said about it was, if it isn't done by a certified, or licensed good allied health professional, the nurses get stuck with that extra job. Answer this one question: Can we handle a reasonable, decent increase for allied health care professionals and nurses in the rate structure, without killing ourselves?

MR. WALKER: My expertise doesn't really allow me to deal with the rate structure, but I do think there is a way. I think the only solution to this thing, overall, is one which goes hand in hand. I don't think you can look at one without looking at the other. That is the point I want to make today. I think it is a process; it is allied health professionals and nursing, hand in hand doing a job. I think you have to look at both ends of it. We can't fix one side of the equation and not the other, and still expect an equilibrium.

ASSEMBLYMAN DEVERIN: Thank you.

ASSEMBLYMAN OTLOWSKI: Doctor, may I ask a question?

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: While you were presenting your testimony, I was just telling Tommy Deverin that you were hitting many things right on the head. But what you say, of course, is also very discouraging because, have we come to the point where Americans -- and I may have to disagree with the Doctor here, my Chairman, for whom I have a great deal of

respect-- I may have to disagree with him, because I saw that he, when you were talking about foreign help in the hospital field, reacted almost violently, and he is not a violent man, you know. But, in any event, I am just wondering about whether we have reached a point where Americans, as such, want to abandon that field because of the fact that there is better pay, more romance in other fields for them, and they no longer have the feeling for this kind of work. This is what bothers me. As a matter of fact, in some of the places I visit -- and I am not going to mention them, because I don't want to embarrass the people -- they're telling me that if they don't import foreign help, they are not going to be able to function, because with everything they have done, they cannot attract the Americans to this kind of work.

When you were talking it was bothering me, because of the fact that so many of the things you said are true, and yet, you know, I don't see any easy solution. Taxes -- we are almost at the end of the road with taxes. The costs of hospitals -- we're almost at the end of the road with those costs. So, you know, what you have posed is a very, very difficult question; not only a question, but the many, many problems that exist in the health field. I'm sorry that you came here. (laughter)

ASSEMBLYMAN COLBURN: Thank you; thanks very much. The following order will be the final group of people to testify: Darlene Cox Cheaney, followed by my fellow Burlington County resident, Lois Forrest, followed by Ann Levine, who will be last. We have a stand-by list of four people, but I don't think we really have time for them.

UNIDENTIFIED SPEAKER FROM AUDIENCE: Patricia Johnson is on this list.

ASSEMBLYMAN COLBURN: Where? Did I miss her?

UNIDENTIFIED SPEAKER FROM AUDIENCE: Yes, sir.

ASSEMBLYMAN COLBURN: I understood she was-- Her statement was included with someone else's testimony that we received up here. No? That is what I was advised.

A. P A T R I C I A J O H N S O N (speaking from audience): I am the other representative from Muhlenberg. (remainder of comment indiscernible; no microphone)

ASSEMBLYMAN COLBURN: Oh, wasn't it? Well, we misinterpreted it, because we received your statement up here. Well, I hate to put you last, but if you can hang on, we will. Darlene, please go right ahead.

D A R L E N E C O X C H E A N E Y: Good afternoon. Mr. Chairman and members of the Committee, I am Darlene Cox Cheaney, Associate Administrator of the University of Medicine--

ASSEMBLYMAN COLBURN: Excuse me, I have to interrupt you for a minute. We are going to keep the record open for 30 days, in case anyone wants to send in any additional information based on the fact that they couldn't testify, or if they thought of something, or reacted to something they heard today. Thank you.

MS. CHEANEY: I am Darlene Cox Cheaney, Associate Administrator of the University of Medicine and Dentistry of New Jersey, located in Newark, New Jersey. University Hospital is an institution which I know many of the members of the Committee have visited. My peers, colleagues, and fellow health care consumers have eloquently addressed you today. I, however, feel compelled to talk to you today about what is happening at UMDNJ.

The administration of University Hospital deeply appreciates this opportunity to appear before you today on an issue of overwhelming importance -- the New Jersey nursing shortage, and its impact on nursing care delivery in our hospital, or should I say, "Your hospital"?

UMDNJ - University Hospital, the only acute care hospital owned by the State of New Jersey, is a Level 1 Trauma

Center, a statewide Parinatal Center, and also has located within it, the New Jersey Cancer Center. Thanks to the legislators of New Jersey, at this time next year we will also be the home of the North Star, one of the two helicopters your Committee authorized to improve trauma services during the critical golden hours immediately following a catastrophe.

University Hospital is a hospital of 501 beds. We have 17,500 admissions per year. We have 55,000 emergency room visits a year; 110,000 clinical visits a year; and 55,000 EMS and MICU runs per year. As you know, the University Hospital is the primary health care provider for the indigent patients of the City of Newark. Additionally, we provide tertiary care services, which include: neuro/surgical care, trauma, and the care of AIDS patients. All of these patients are typically categorized as severely ill, and thus require a higher level of nursing skill. The higher level of acuity of these patients places an extra burden on us in terms of R.N. nursing hours required to render safe, quality patient care.

Nursing care hours at University Hospital for the medical/surgical patients, which include the care of our AIDS patient population, is 4.0 hours per day. The average AIDS patient, because of severity of illness, requires 12 to 14 hours per day. As a comparison, the critical care patient, on the average, requires 15 hours per day.

If you convert this information into a weekly requirement for the delivery of patient care, utilizing patient care hours required and staff actually worked -- and I must admit that we also have to use agency hours -- we calculate an approximate shortage of in excess of 3000 hours per week.

This shortage of hours has caused us to close 45 beds in our institution. The unavailability of these beds limits our ability to provide the necessary services to both our tertiary responsibilities and indigent responsibilities to the Newark community. Additionally, the daily operations of the

Emergency Department are affected negatively as the flow of our patients is often delayed due to the closure of these beds. This critical shortage at University Hospital, we believe, will be partially addressed through the passing of A-4483.

We at the University Hospital have had an opportunity to review A-4483. While we know it is not your intention to report the bill out of Committee today, we would nonetheless like to offer our thoughts on the importance of this proposed legislation:

A 2% increase in the DRG rate will allow us to accomplish three things: a) To compete with New York and Pennsylvania areas for New Jersey's R.N.s; b) to compete with agencies for the same pool of nurses; and c) hopefully, to retain the nurses we currently have.

I hope my presence here today has helped to further clarify the impact of the nursing shortage as it relates to direct patient care delivery in an economic sense.

While there may be other reasons contributing to the shortage, thus requiring other needed interventions, an increase in the DRG rate would help our institution improve its position with respect to recruitment and retention of registered nurses.

Thank you.

ASSEMBLYMAN COLBURN: Thank you very much. Any questions? (no response) No questions. I think we are all getting a little tired, but thanks very much. Lois Forrest?

L O I S F O R R E S T: I am happy to tell you that my testimony will be short.

ASSEMBLYMAN COLBURN: That's the spirit. Ms. Forrest, before you start, I think we will have Ann Levine next, and then the rest of the Muhlenberg contingent, if they can hang on that long. There were two more people, Mr. Ridgway-- Are you standing, Mr. Ridgway? Is that you? (affirmative response) I just skimmed your testimony. I thought it was quite interesting, so I hope you will stick around. Excuse me.

MS. FORREST: Mr. Chairman and Committee members: I am testifying today as the Vice President of the New Jersey Association of Non-Profit Homes for the Aging, and as the Licensed Nursing Home Administrator of Medford Leas, a continuing care retirement community that employs 50 to 55 full- and part-time nurses. the two hats I am wearing today allow me to speak with authority and experience on behalf of the not-for-profit, long-term care facilities. All of the not-for-profit, long-term care facilities in New Jersey are deeply concerned about the statewide shortage of nurses. They are concerned because of their commitment and responsibility to the frail, sick, and dying elderly who they serve.

There are special dynamics that affect long-term care facilities; dynamics that must be considered by State regulatory agencies that control Medicaid reimbursement and promulgate and/or administer State and Federal regulations strictly controlling the delivery of services.

Because of the particular nurse staffing patterns of long-term care facilities and Federal and State regulations, the number of nurses working in long-term care facilities cannot be reduced by shifting duties to staff other than R.N.s or L.P.N.s. Although it is likely that less than 10% of all nurses in New Jersey work in long-term care settings, it is essential that every nursing position in each of the long-term care facilities be filled. In fact, we may not operate, in most instances, unless they are. The major portion of direct patient care is provided by nurses' aides or nursing assistants, who are supervised by registered nurses and licensed practical nurses. Medications, therapies, and treatments are provided by the nurses, and physicians are rarely present.

The shortage of nurses has frequently meant that nursing staff in long-term care facilities work long hours to provide coverage for unfilled positions. It has also meant

that when they are not available -- and they are not always available -- costly "pool" nurses must be employed -- pool nurses who are rarely acquainted with the facility or the patients. The patient mix in long-term care facilities has changed, as sicker patients are received from acute care settings. The present discharge patterns of hospitals are, in part, dependent upon the ability of long-term care facilities to receive patients requiring extensive care. Long-term care facilities and hospitals are obviously interdependent entities. An adequate supply of nurses must be available for long-term care facilities, as well as hospitals.

Nurses in long-term care facilities must receive wage increases equal to the average percentage wage increase given to hospital nurses. If we are to retain currently employed nurses, or to recruit nurses to fill vacancies, we must be able to pay competitive wages.

The salary scales of nurses employed in long-term care facilities is, in large measure, controlled by the State Medicaid reimbursement levels. Several years ago, the nursing screens were reduced by 15%. Prompt consideration needs to be given to means for increasing the reimbursement formula. Plans to increase nursing salaries need to be implemented with all due speed, if we are to prevent costly, demoralizing, and unnecessary nurse turnover in long-term care facilities.

In addition, State and Federal regulatory bodies must not create additional regulations that will increase the need for R.N.s and L.P.N.s, and they are discussing that now. If facilities are required to hire more R.N.s and L.P.N.s, the shortage of nurses will be exacerbated. Regulatory decisions that would require more nurses must wait until there is an adequate supply of nurses to serve existing need.

Administrators of not-for-profit, long-term care facilities recognize that salary increases are only the first step toward more comprehensive approaches to the acute shortage

of nurses. We are committed to working with other health care professionals, governmental staff, and elected officials to address the broader underlying problems that have helped to create the current crisis.

Thank you for allowing me to testify.

ASSEMBLYMAN COLBURN: Thank you. Any questions? (no response) Did you say your salaries are more controlled, in a sense, by Medicaid, where the others, of course, are DRG?

MS. FORREST: Because 50% to 80-some percent of the patients in not-for-profit, long-term care facilities are Medicaid patients-- That is the decision-making factor on nurses' salaries. If the regulatory body would look at that nursing screen and put it back to 125%, which is what it was before, I think that would have a very positive effect. Nurses in long-term care facilities have always been paid less than nurses in acute care facilities overall, but we can't allow that gap to widen.

ASSEMBLYMAN COLBURN: Right. Thanks very much. Let's see, Ann Levine, a survivor of this hearing. It's good to see you still smiling.

A N N E. L E V I N E: I've learned a lot today. It has been most instructive.

ASSEMBLYMAN COLBURN: Well, so have I.

ASSEMBLYMAN OTLOWSKI: Who is this?

ASSEMBLYMAN COLBURN: Ann Levine.

MS. LEVINE: I am from the Family Planning Association of New Jersey.

There are more than 111,000 women in New Jersey relying on the publicly subsidized network of family planning providers for medical contraceptive services. For many of them, it is the only preventive health care they get. The providers are of various types: Hospital based, independent nonprofit, county or local health departments, or community action programs or neighborhood health centers. All of these

providers are having difficulty retaining or replacing staff due to salary problems. It is particularly true in the case of the nonprofits, who provide 78% of the services. They have traditionally been low paying. In addition, public funds suffered a severe cutback in 1981, and have not gotten back to those levels. Any time there is an increase in funding, it has been tied to an expectation of increased service levels, until just recently.

Thus, it has been difficult, or impossible for family planning agencies to compete for R.N.s, nurse practitioners, L.P.N.s, and health educators against hospitals, nursing homes, and the corporate sector -- which is becoming an increasing competitor -- at the salary ranges we can currently offer. Salary increases for the staff we do have tend to be delayed, or not as great as would be warranted.

Two surveys by the State Department of Health's Family Planning Program in the fall of 1986 and early in 1987, indicated that the typical family planning agency is paying $3000 to $5000 in annual salary for R.N.s in the same area under what is being currently offered in hospitals or nursing homes, and that is in New Jersey, never mind across the river. Frequently, the top of our salary scale is below the starting salary of the competition. There are several areas in the State -- Camden, Jersey City, and Trenton -- where the gap is $10,000, or more. My recent conversations with program directors indicate that that gap is widening still further.

Unless more funds come into the programs, they will be unable to continue to serve the same number of women, let alone attempt to reach the more than 200,000 women estimated to be in need of subsidized services not now being served.

I want to reiterate that this is basic preventive health care. Our patients get a thorough physical and screening, enabling them to get early treatment and care on site or through referrals, which can cut down on later, more

expensive curative hospital care. Indeed, a recent patient survey in Essex County indicated that 44% of the women coming to one agency were citing as their primary reason the availability of a thorough medical exam, while only 26% gave obtaining a contraceptive method as the primary reason.

It seems -- it doesn't seem, it is -- imperative that policymakers, such as you, consider the whole range of settings in which nursing and health professionals serve people in this State, and recognize the cost-effectiveness of maintaining and expanding services in the preventive area when addressing the admittedly severe needs of the curative sector.

ASSEMBLYMAN COLBURN: Thank you. Any questions? (no response) Thank you.

Now, Patricia Johnson and Mr. Ridgway. Patricia, you may bring Mr. Ridgway up with you. (Ms. Johnson makes indiscernible comment from audience; no microphone) Oh, you're not coming, okay.

ASSEMBLYMAN DEVERIN: I don't blame you, Ms. Johnson.

ASSEMBLYMAN COLBURN: I apologize.

ASSEMBLYMAN DEVERIN: If I were you, I wouldn't come up here either. (laughter)

ASSEMBLYMAN COLBURN: Well, I just lost another election.

ASSEMBLYMAN FRELINGHUYSEN: Don't ever talk to Colburn again.

ASSEMBLYMAN COLBURN: Right.

D A V I D M. R I D G W A Y: My name is David Ridgway. I am President of Muhlenberg Regional Medical Center. I am not going to read my speech; you already have copies of it. I am not going to read Pat's speech.

ASSEMBLYMAN COLBURN: We might want to ask you some questions about it.

MR. RIDGWAY: Okay. I would like to cover maybe just two things that were in my speech, to make sure that they come

through. Christine Grant was here earlier, talking about the raises that hospitals get each year and the DRG factors. This year it was 3.13. As of Thursday's New York Times, the inflation rate is running 5.1%. So, as we are talking about the 2% infusion -- I want to underline that that is an infusion; it is a cash flow. It does not go to the bottom line. It is a loan, an advance. They didn't give it to us. They are loaning it to us; maybe they will give it to us. That 2% is not something in addition for nursing. From my point of view, that only helps us to match what is going on for all employees.

I would like to react to Mr. Otlowski's comment that we have gone as far as we can in health care costs. I think you are just beginning. One of the things the public, legislators, all of us have to start doing is, instead of always saying, "The rising cost of health care, the escalating, the skyrocketing--" There is always some adjective in front of health care costs. We all need to start talking about the appropriate cost of health care.

I am not going to go over all the comments from nursing and the other stresses hospitals are under. It is just a plain fact that in New Jersey, we are not being paid enough to run our hospitals. The average cost per admission in New Jersey runs somewhere around, I think, $3200, $3300. The average cost per admission in New York and Pennsylvania is -- on the average -- $300 to $400 more. Okay? If you are a patient and you are seen in a hospital in Pennsylvania, or you are seen in a hospital in New York, your bill will be, on the average, about $300, maybe $400 more. For my hospital, with 18,000 admissions, that is almost $4 million.

Now, that $4 million, if I had it today -- I love to dream about that -- would just bring me up to even. That has nothing to do with anything, exept bringing me up to even, not reflecting that additional 5% that is going on -- the inflation rate -- that all of us are undergoing.

So, I just want to say one more time, as you go through all of the details and things, you will see that we are not getting enough money. Don't forget that. No matter what you hear in terms of all the details, New Jersey is not putting as much money into its health care system as its two bordering states. It is not equal to them at the northeast average. We are the lowest. We have the second highest number of people only to Florida, in terms of age. I think we are third or fourth in terms of the number of people who have AIDS. We are about the fourth hospital in terms of cost of living. So, we have both ends of the spectrum. What you are seeing is a microcosm in terms of what is happening to nursing and other health care professionals.

I would be happy to answer any questions.

ASSEMBLYMAN COLBURN: I wanted to ask you this: If the DRG system is retained, it looks to me, from what you say in your statement, that the manner in which they go about computing it needs to be completely revised. Is that correct?

MR. RIDGWAY: The Hospital Association and the State Department of Health are looking at a modification right now, known as the Objective for Change. That is one attempt. That particular change places hospitals more at risk, the theory being that the more patients you see, the more money you can make; the fewer patients you see, you are at risk for losing money. That particularly scares us right now, because if we can't get enough nurses and we may have to close beds, we are on a treadmill that is going in a downward spiral. If we have to close beds, we can't get as much money in as we need. We didn't have enough money in the first place to pay the nurses, so we can't pay the nurses, and it just goes in this direction.

ASSEMBLYMAN COLBURN: Does that effort on their part have anything to do with their attempt to close beds which they feel are not efficiently used?

MR. RIDGWAY: That was the original thought process, I think, in the Objective for Change; that there are some areas in the State that the Department of Health feels have more beds than necessary.

ASSEMBLYMAN FRELINGHUYSEN: You don't feel that way?

MR. RIDGWAY: I think in some areas of the State that may be true right now. With the advent of AIDS, I think you better take another look before you close any more beds.

ASSEMBLYMAN COLBURN: Yeah, I agree with you.

ASSEMBLYMAN FRELINGHUYSEN: Playing devil's advocate for a minute, are they doing things in New York any better than they are doing in New Jersey with that money? From what I read about the New York hospital system, I am not sure that I-- I would just as soon seek care here in New Jersey.

MR. RIDGWAY: Well, if we still had the full house, I could answer that they are paying their nurses more.

ASSEMBLYMAN FRELINGHUYSEN: They are. That, I agree, is important, but are their--

MR. RIDGWAY: That is why we are here.

ASSEMBLYMAN FRELINGHUYSEN: But, is their practice of medicine--

MR. RIDGWAY: It is difficult to measure; it is difficult to measure.

ASSEMBLYMAN FRELINGHUYSEN: The demands on management at the bargaining table to come across with wage packages, obviously is far greater than it is--

MR. RIDGWAY: That's true.

ASSEMBLYMAN FRELINGHUYSEN: --for the larger percent of New Jersey hospitals.

MR. RIDGWAY: Well, as a hospital administrator in New Jersey, I can tell you that I have reached the point where I am very worried about the level of care we are delivering. In my hospital last weekend, there were a couple of units that had one R.N., one L.P.N., and one aide. I haven't had to close beds yet, but we are getting very close to it.

ASSEMBLYMAN FRELINGHUYSEN: May I just ask another question, Mr. Chairman?

ASSEMBLYMAN COLBURN: Sure.

ASSEMBLYMAN FRELINGHUYSEN: New York and Pennsylvania do not have a rate setting commission. What do they have, if they don't have a rate setting commission?

MR. RIDGWAY: I am not an expert on what they-- (indiscernible response from someone in the audience)

ASSEMBLYMAN FRELINGHUYSEN: Well, it was in your comments, so I figured I would--

MR. RIDGWAY: I believe they are just unregulated, except for Medicare.

ASSEMBLYMAN DEVERIN: Competition does that.

ASSEMBLYMAN FRELINGHUYSEN: Competition. In New Jersey, that's what they call it.

MR. RIDGWAY: You can't compete if you can't set your own prices.

ASSEMBLYMAN DEVERIN: May I ask a question?

ASSEMBLYMAN COLBURN: Go ahead.

ASSEMBLYMAN DEVERIN: You know, the word -- the adjective -- we use before health care -- "rising" -- did not originate with us, you know, anybody at this table. It originated with the public and with the associations that deal in health care. I spoke last week with some retired teachers. One of their biggest problems is the cost of health care. They have to pay for their own health care. They don't say, nor do they mean hospitals; they mean the overall cost of health care.

We have a hearing two days from now about catastrophic illness and health care costs. So, I agree with you. The public does not realize that the hospital deal in New Jersey is much better than it is in New York and Pennsylvania. You can stay here in a first-class hospital, in a private room, for much less than you can stay in New York. I never realized that they are completely unregulated and they set their own rates, but the rates are much higher.

The problem I am trying to find is-- When you are talking about closing beds, are you talking about DRG causing it, or certificate of need causing it? The certificate of need is one of the problems. That is where some of the beds-- For instance, in Alexion Brothers, it was done by the hospital and the department under the certificate of need.

MR. RIDGWAY: That is correct.

ASSEMBLYMAN DEVERIN: Okay. Now, I agree with you that we don't spend enough money for health care in New Jersey. The State doesn't spend enough money, nor does the Federal government. The Federal government has a great responsibility. But if we attempt it -- and I would agree to do it if we could do it-- If we attempt to raise the salaries to a fair and minimum $35,000 or $30,000, could we do it-- Could your hospital do it, and do it in their rate structure, without really causing havoc for your patients and for the neighborhood itself? I didn't mean to put you on the spot.

MR. RIDGWAY: All right. If you were to give us additional money for nurses, we would certainly pass it on, and that would be the end of that. But there would be additional pressure from other health care professionals. Now, the x-ray techs are watching. You heard all of the other professionals, who historically have had some relationship to other professional salaries, and at this point nursing salaries are driving. Would we lose business because we raised salaries? In other words, is there a competitive-- No, because everyone would probably be--

ASSEMBLYMAN DEVERIN: You would have to raise costs to raise salaries.

MR. RIDGWAY: That is correct. The one thing I would make sure of if you were to do that is, when that is done, nothing else is diminished. The State Health Department is famous for cost shifting. They'll say, "Okay, we'll give you more for nurses, but there is only this certain pool here, so

something else has to give." So, it has to be a real increase -- a real infusion of real money to the hospitals.

ASSEMBLYMAN DEVERIN: One of the first things we learn when we come down here -- and I have been here for a long time -- is, if you are going to give someone money, you better designate that for a special purpose. Now, when the money comes from the State Department of Health, is it allocated for certain items? For instance, if we decided that "X" number of dollars would give you a chance to change the minimum salaries, would we have to send it to you, saying, "This is only for nurses' salaries," like you do with the boards of education?

MR. RIDGWAY: You could do that, and accomplish a check through an audit. It would be kind of complicated. Historically, the way the DRG rate overall is built, involves looking at various cost components. But in the end, it is rolled into one large chunk.

ASSEMBLYMAN DEVERIN: I see by your written statement that you say 2% didn't mean a damned thing, because the money-- It couldn't go for nurses' salaries.

MR. RIDGWAY: About $600,000 for my hospital. This year, I spent, in addition, almost three-quarters of a million, and I am about to spend more than a million dollars, with no idea where it is coming from.

ASSEMBLYMAN DEVERIN: So, actually the only way we can really help your hospital, or any other hospital, is to make a grant of some kind, not an increase of percentages on the rate structure itself, unless we make it a 10% rate structure and say that has to be strictly for salaries, or something in that vein.

Thank you, Mr. Ridgway. Your statement is very interesting.

ASSEMBLYMAN COLBURN: Thank you. I'm glad we had the hearing. I'm sorry that I didn't treat some of you as fairly as I should have.

ASSEMBLYMAN DEVERIN: Only Ms. Johnson.

ASSEMBLYMAN COLBURN: I always apologize to those who were not called. If any of you want to bring anything up here to me, please do so. I will stick around for a few more minutes. The record will be left open.

I might tell you that Dave Price did all the good work on this, and I did some of the poor work on it. But Dave did a lot of work to get this together, and he is to be congratulated. We had a lot of requests to testify. He called me -- what? -- the other day, and said, "Well, we have 18, and the number is still building here." We only had a few hours, so I think Dave did a wonderful job, as he always does. Also, I'm glad we learned all that we did.

I will tell you that we are going to hear A-4483 as soon as the Speaker schedules another meeting of our Health Committee. That will come sometime before the end of the year. I don't know exactly when. We are not told that we are to come back at any particular time, but I'm sure that we will come back one more time at least, and we will hear A-4483.

So, thanks very much for your participation.

(HEARING CONCLUDED)

APPENDIX

CALL FOR NOMINATIONS

Nominations are now being accepted for the Lucille P. Markey Scholar Awards in Biomedical Science. The nomination deadline is Oct. 1.

Contact Markey Scholar Selection Committee, Lucille P. Markey Charitable Trust, Suite 405, 3250 Mary St., Miami, FL 33133; or call (305) 445-5612.

COMPARATIVE RESEARCH ON LEUKEMIA AND RELATED DISEASES

The symposium will take place in Jerusalem, Israel, Nov. 8–13.

Contact Dr. David S. Yohn, Suite 302, 410 W. 12th Ave., Columbus, OH 43210; or call (614) 422-5602.

REQUEST FOR PROPOSALS

The Eastern Paralyzed Veterans Association is accepting proposals to examine factors that influence staff attrition in three spinal cord injury centers. The proposal deadline is Oct. 1.

Contact Vivian Beyda, Eastern Paralyzed Veterans Assoc., 432 Park Ave. S, New York, NY 10016; or call (212) 686-6770.

OCCUPATIONAL HEALTH AND SAFETY

The following courses will be offered in St. Paul, Minn.: "Personal Computer Applications for Managing Right-To-Know" (Oct. 1 and 2); "Chemical Exposures: Emergency Response and Management" (Oct. 9 and Nov. 6); "Comprehensive Occupational Health Nursing Review: Basic Theory and Update" (Oct. 19–23); and "Laboratory Ventilation: Design and Evaluation" (Nov. 12 and 13).

Contact Ruth K. McIntyre, Midwest Ctr. for Occupational Health and Safety, St. Paul-Ramsey Medical Ctr., 640 Jackson St., St. Paul, MN 55101; or call (612) 221-3992.

PUBLIC RESPONSIBILITY IN MEDICINE AND RESEARCH

The following conferences will be held in Boston: "The Economics of Health Care and Its Effect on Access" (Oct. 26 and 27); and "IRBs: New Challenges and Problems" (Nov. 12 and 13).

Contact Joan Rachlin, PRIM&R, 132 Boylston St., Boston, MA 02116; or call (617) 423-4112.

CALL FOR PAPERS

Abstracts are now being accepted for the 2nd Interdisciplinary Conference on Justice in Health Care, to be held in Orlando, Fla., Feb. 18 and 19, 1988. The abstract deadline is Oct. 1.

Contact Dr. Diane LaRochelle, Univ. of Florida Coll. of Nursing/JHEP, 580 W. 8th St., Suite 8011, Jacksonville, FL 32209; or call (904) 359-6303.

SAFETY AND SYSTEMS MANAGEMENT

The following courses will be offered in Los Angeles: "Ergonomics: Building Efficiency and Safety in the Workplace" (Oct. 1 and 2); "Promoting Safety and Health in Today's Economy" (Oct. 3); "Recognition of Accident Potential in the Workplace Due to Human Factors" (Oct. 7–9); "Management and Administrative Skills for the Occupational Safety and Health Professional" (Oct. 12–16); "Recognition of Occupational Health Hazards" (Oct. 19–23); and "Developing and Managing a Medical Surveillance Program" (Oct. 29 and 30).

Contact USC, Inst. of Safety and Systems Management, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, CA 90007; or call (213) 743-6523.

ADVANCED NEUROLOGICAL LIFE SUPPORT

The course will be offered in Toronto, Oct. 1–3 and Dec. 3–5.

Contact Lois Kaphalakos, 19 Aberdeen Rd. S, Cambridge, ON, N1S 2X3; or call (416) 482-2247.

VISITING PROFESSORSHIP IN NUTRITION PROGRAM

Applications are now being accepted for the program. The application deadline is Oct. 1.

Contact VPN Program, National Dairy Council, 6300 N. River Rd., Rosemont, IL 60018; or call (312) 696-1020.

CALL FOR ABSTRACTS AND NOMINATIONS

Abstracts and award nominations are now being accepted for the 3rd International Interdisciplinary Conference on Hypertension in Blacks, to be held in Baltimore, April 22–24, 1988. The abstract and nomination deadline is Oct. 1.

Contact Cecile Cate, Intl. Society on Hypertension in Blacks, 69 Butler St., SE, Atlanta, GA 30303; or call (404) 589-3810.

PROFESSIONAL AND CHEMICAL DEPENDENCY

The seminar will take place in Pensacola Beach, Fla., on Oct. 2.

Contact CME List Coordinator, CME Div., American Medical Assoc., 535 N. Dearborn St., Chicago, IL 60610; or call (312) 645-4952.

UNIVERSITY OF CHICAGO SCHOOL OF MEDICINE

The following courses will be offered: "The Use and Interpretation of Monitoring and New Technologies" (Sept. 11–13); "Nursing in Transition: From Hospital to Home" (Sept. 17); "Advances in Echocardiology" (Sept. 17 and 18); "Clinical Endocrinology" (Oct. 10); "The Psychiatric Interview" (Oct. 23–25); and "Controversies in Antiviral Chemotherapy" (Oct. 31).

Contact Univ. of Chicago, Ctr. for CME, 5841 Maryland, Box 139, Chicago, IL 60637; or call (312) 702-1056.

CORRECTION

Altered C1 Inhibitor Genes in Type I Hereditary Angioedema (July 2, 1987; 317:1-6). On page 5, in the left-hand column, the first sentence of the third full paragraph should have read: "Affected chromosomes (4 of 7) exhibited restriction-site markers in the C1 inhibitor locus markedly more often than did unaffected chromosomes (none of 37)." We regret the error.

SPECIAL REPORT

THE NURSE SHORTAGE

Myth or Reality?

THE proportion of vacant positions for registered nurses in hospitals doubled between September 1985 and December 1986,[1] reaching the levels of the last national nursing shortage of 1979. Current reports of vacancies are perplexing in the light of the size of the nation's supply of nurses. The output of nurses has doubled over the past 30 years, greatly exceeding the population growth, and licensed registered nurses now number 2.1 million. Between 1977 and 1984 alone, the number of employed nurses increased by 55 percent, as compared with an 8 percent growth in population.[2] Intuitively, it would seem that an increased number of nurses would be the solution, but the problem persists nevertheless.

The reported shortage of hospital nurses exists in the midst of a substantial reduction in hospital inpatient capacity nationally. The demand for acute inpatient care in general hospitals has fallen, resulting in 50 million fewer inpatient days in 1986 than in 1981. Since 1983, hospitals have closed more than 40,000 beds, and average hospital occupancy rates dropped

to 63.4 percent in 1986.[3] Enrollments in nursing schools have also decreased markedly, raising the possibility that fewer nurses than anticipated will be available in the future.

There is now a contentious debate about whether a shortage of hospital nurses truly exists and about its causes. In 1981, the Institute of Medicine was commissioned by Congress to reconcile the evidence of an increased supply of nurses with continued reported shortages. The study concluded that the national supply of generalist nurses was adequate for the present and short-term future.[4] Cyclical vacancies in positions for hospital nurses were attributed primarily to local labor-market conditions, although a shortage of nurses in certain specialties was noted. Recommendations were made to the hospital industry on the need to restructure nursing roles and develop improved financial rewards and opportunities for career advancement in clinical care.[5] The National Commission on Nursing made remarkably similar recommendations in 1983.[6] But in 1986, the American Hospital Association was again reporting that high vacancy rates in positions for nurses were disrupting hospital care,[1] whereas the U.S. Department of Health and Human Services again concluded that the national supply of nurses was in balance with the demand.[7]

Employment Patterns of Nurses

The shortage of nurses is measured by the hospital industry as vacant budgeted full-time-equivalent positions for registered nurses. Vacancy rates, however, are not an objective measure of the need for bedside nurses. Moreover, the number of budgeted positions for nurses reflects a number of factors, including budget constraints as well as local wage rates. Despite these limitations, we have chosen to analyze vacancy rates because they are used by the industry to reflect the changing supply of nurses.

There are several commonly held but erroneous beliefs about nurses' work patterns. One misconception is that nurses have left nursing in large numbers and are either inactive or working at jobs outside health care. In contrast, nurses have one of the highest rates of participation in the labor force among workers in predominantly female occupations. Almost 80 percent of registered nurses are actively employed[2] either full-time or part-time, as compared with 54 percent of all American women. Not much is known about those who do not renew their licenses and, therefore, are not counted in the population of registered nurses. But less than 6 percent of registered nurses are employed in other occupations and are not seeking a position in nursing.[2] Given the responsibilities of women for child rearing and other domestic concerns, an employment rate of 80 percent may be almost as high as can be expected. Thus, it is unlikely that unemployed nurses represent a large potential resource for hospital employment. However, nursing is somewhat unusual in that 27 percent of the total pool of registered nurses work part-time. Clearly, a change in the number of hours worked by more than 500,000 part-time registered nurses could substantially affect the supply of full-time-equivalent nurses.

Some observers have suggested that the shortage of nurses in hospitals may be due to the increased demand for nurses in ambulatory settings and new administrative positions in health care. However, hospitals' share of the ever-growing pool of nurses has not changed substantially since 1960. Sixty-eight percent of all employed nurses work in hospitals.[2] Hospitals have dramatically increased the number of nurses they employ in the aggregate and in relation to numbers of patients, even when the recent increase in outpatient visits is taken into account. In fact, hospitals are employing more registered nurses than ever before and are even replacing non-nurses with nurses — just the opposite of what would be expected during an actual shortage of nurses.

In response to reduced numbers of inpatients, hospitals employed 133,376 fewer full-time-equivalent workers in 1986 than in 1983.[3] In contrast, the number of full-time-equivalent nurses increased by 37,500 during the same period.[8,9] A substantial increase in the ratio of nurses to patients resulted. In 1972, hospitals employed 50 nurses per 100 patients (average adjusted daily census); by 1986, the figure had increased to 91 nurses per 100 — an 82 percent expansion (Fig. 1). Aides and licensed practical nurses were replaced by registered nurses. In 1968, registered nurses accounted for only 33 percent of hospitals' total nursing-service personnel; by 1986, registered nurses accounted for 58 percent.

The Changing Demand for Nurses

The rapidity with which the current shortage developed suggests that increased vacancy rates must be due to a changing demand for nurses, not to a declining supply. There are three primary explanations for the recent increase in the demand for hospital nurses. First, hospitalized patients are sicker and require more care than in years past, on average, because of the reduction in discretionary admissions and the shorter average length of stay. However, there is no basis to suggest that the average condition of hospitalized patients changed dramatically enough between 1982 and 1986 to require a 26 percent increase in the ratio of registered nurses to patients. Although the changing case mix may provide a partial explanation for the increased demand for nurses, it cannot be the only explanation.

A second explanation for the recent increase in vacancy rates is related to changing budget constraints in hospitals. When vacancy rates were at an all-time low of 3.7 percent in 1984, the Medicare Prospective Payment System was just being implemented and fears of severe hospital-budget limits were widespread. As a result, some budgeted positions were

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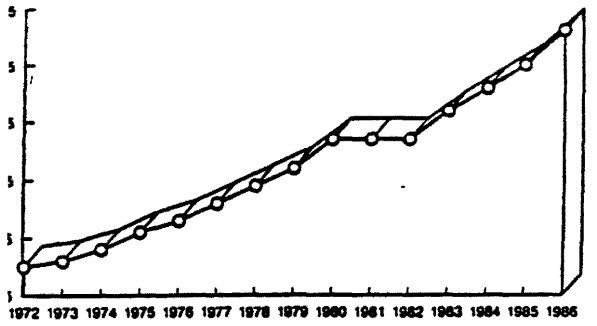

ure 1. Number of Hospital Registered Nurses Employed per 100 Patients (Average Adjusted Daily Patient Census), 1972–1986.

Data are from *Hospital Statistics*.[9]

ninated. Unexpectedly high operating margins, vever, provided the opportunity for hospitals to dget for more nursing positions.

A third explanation is related to changes in nurses' ative wages. In most labor shortages, wages are usted and other incentives are developed to attract ditional workers. These market adjustments fail occur in nursing with the rapidity or magnitude n in other labor markets. Labor economists have cribed nursing as a "captured" labor market.[10,11] any given community, a small number of hospitals ploy most of the local nurses — a phenomenon own as oligopsony in labor economics. Employers ring nurses jobs with weekday hours usually have trouble employing nurses and thus do not compete h other employers on the basis of salary. There o demand for nurses outside the health care field t is sufficient to create competitive pressures on hospital industry, as there is, for example, for com- er programmers. Moreover, hospital administra- tend to assume that there is a finite number of ses in any given community, and that wage compe- on among hospitals will be costly and will not re- e community shortages. The majority of nurses, if want to work, must accept the terms offered by pitals.

egistered nurses are versatile employees in a hos- l context.[12,13] They can provide all the services for ch hospitals sometimes employ nurses' aides and sed practical nurses, and they can also often orm a wide range of other functions, including e assigned at other times to secretarial and clerical onnel, laboratory technicians, pharmacists, phys- therapists, and social workers. Nurses substitute physicians under some circumstances, and com- ly assume hospital management roles after regu- work hours. Thus, when nurses' relative wages low as compared with other workers', it is ad- ageous for hospitals to employ them in greater bers and in lieu of other kinds of workers. Even rses' wages are 20 to 30 percent higher than those censed practical nurses or secretaries, it may still be more economical to hire nurses, because they require little supervision and can assume responsibility for a wide range of duties. The increased demand for nurses created by low relative wages can lead to shortages in some geographic locations, in specialty units, and on undesirable evening, night, and weekend hours.

The relative-wage theory is supported by data spanning several decades[14,15] (Fig. 2). From 1946 to 1966, for example, the increases in nurses' wages lagged behind those in comparable women's occupations. Nurses' wages over the period increased by 53 percent, whereas teachers' salaries increased by 100 percent and female professional and technical workers' salaries increased by 73 percent. In the early 1960s, more than one in five budgeted positions for nurses were vacant. There was great concern at the time that the increased demand for hospital care accompanying the introduction of Medicare and Medicaid would exacerbate the shortage of nurses. But these new programs were accompanied by substantial wage increases for nurses. Employment rates among nurses increased substantially after these wage increases, as did enrollments in nursing schools. The proportion of vacant budgeted positions for nurses in hospitals dropped from 23 percent in 1961 to 9 percent by 1971. But, after hospital wage and price controls in 1971 and state rate setting and the voluntary hospital cost-containment effort a few years later, nurses' wages declined relative to other groups' and the proportion of vacant positions for nurses in hospitals increased again, leading to the shortage of 1979. There was a wage response to the 1979 shortage; nurses' wages rose an average of 13 percent annually in both 1980 and 1981. By 1984, the proportion of vacancies had reached a low of 3.7 percent.

The substantial wage increases received by nurses in 1980 and 1981 did not continue subsequently, and by the time the new Medicare prospective payment system was implemented, nurses' wages had been

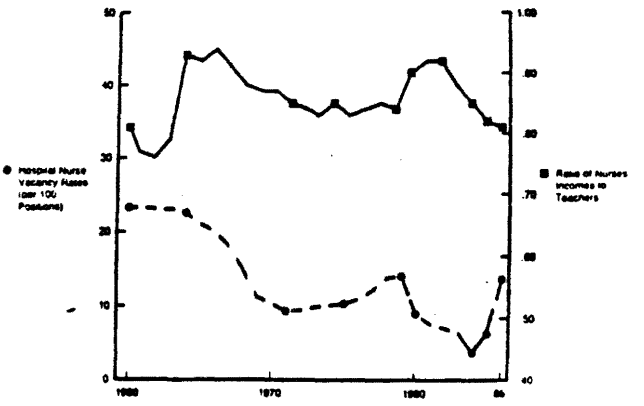

Figure 2. Hospital-Nurse Vacancy Rates per 100 Budgeted Positions and Ratio of Nurses' Incomes to Those of Teachers.

Data are from references 10 and 16 through 21.

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eroded. Hospital nurses have received only modest wage increases since 1982. By 1985, average salaries for teachers were 19 percent higher than those for nurses, and average salaries for all female professional and technical workers were 10 percent higher. Despite all the publicity about the shortage of hospital nurses, nurses' wages increased only 4 percent in 1986.[18]

Declining Nursing School Enrollments

Since 1983, enrollments in nursing schools have dropped by 20 percent[22] (and National League for Nursing: unpublished data). The number of new nurses graduating annually is predicted to fall from a high of 82,700 in 1985 to 68,700 or lower by 1995.[7] All types of nursing programs have had declining enrollments; associate-degree programs have had a decline of 19 percent, and baccalaureate programs 12 percent (National League for Nursing: unpublished data). Enrollments in three-year hospital diploma programs have been declining for more than two decades and now account for only 14 percent of graduates annually (Fig. 3).

The country's demographic profile is partly responsible for declining enrollments because of the smaller size of 18-year-old cohorts in recent years. However, interest in nursing as a career has fallen precipitously among college freshmen in both community colleges and four-year institutions. The University of California, Los Angeles, national survey of first-time college freshmen indicated a 50 percent decline since 1974 in the proportion of full-time women students planning to pursue nursing careers, in contrast to an almost threefold increase in the proportion interested in careers in business[23] (Fig. 4). Moreover, the College Board recently released data indicating that the SAT scores of high-school students interested in nursing careers were well below the national average for college-bound students, and that the SAT gap between prospective nurses and non-nurses was widening over time.[21]

There are many reasons for the declining interest in nursing. Whereas starting salaries of nurses are now comparable to those of other college graduates, the average maximum salary for nurses is only $7,000 higher than the average starting salary.[18] Since more women are choosing to work continuously in the labor force, the low raises discourage them from choosing a career in nursing. Moreover, employers do not offer substantial differences in salary in return for advanced education in nursing. Thus, the economic return on a baccalaureate degree in nursing is poor as compared with the return in alternative fields. Women today have many more career options than they had in years past. Most other careers offer comparable or higher economic rewards and do not require night and weekend work — a notable disadvantage of nursing.

Recommendations for Change

A number of issues deserve careful reconsideration and experimentation. First, public-policy makers must recognize that hospital rate setting can induce labor shortages by artificially depressing wages in occupations like nursing, in which hospitals are the dominant employers. In the short term, depressed wages will increase the demand for nurses, because they can substitute for other personnel, and result in acute spot shortages and high vacancy rates. Over the long term, recruitment to nursing will be seriously eroded by the absence of an adequate salary range that rewards skill and experience.

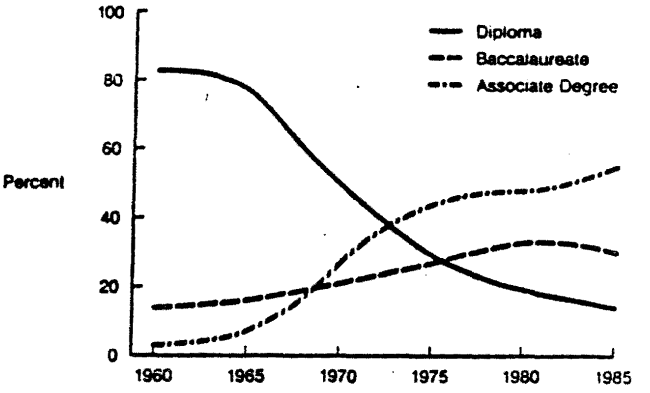

Figure 3. Percentages of Graduates of Nursing Schools in Various Types of Programs, 1960–1985.
Data are from *Nursing Data Review*.[22]

Second, one of the most unattractive aspects of nursing is the requirement of night and weekend work. With sicker patients, hospitals now need many more nurses on these unpopular shifts than they needed in the past, when it was not unusual to have a single nurse covering a unit at night. Most women want to work regular daytime hours and will even choose less interesting, less skilled, and worse-paying jobs to accomplish this. Preference for day work explains why vacancy rates are low in ambulatory care despite low-

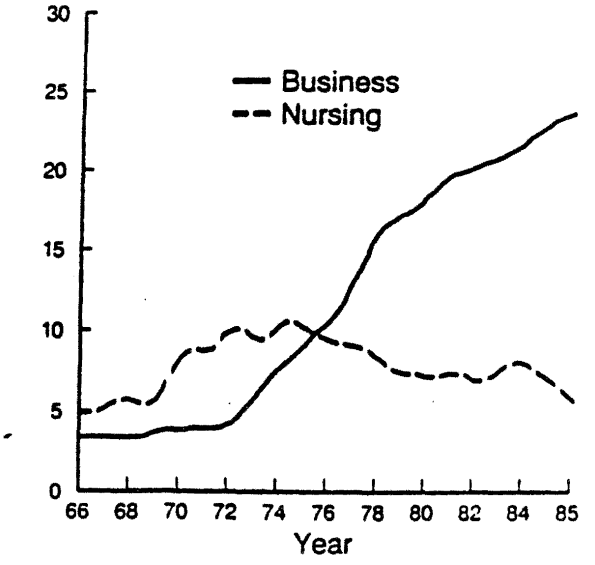

Figure 4. Career Preferences among Full-Time College Freshman Women, 1966–1985.
Data are from Astin et al.[23]

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verage salaries. Other industries that operate a 24-hour basis offer substantial differences in es for evening, night, and weekend work in order ttract sufficient voluntary staff coverage. Hospi- offer only small differences and try to make shift tion a requirement of employment. Curiously, t of the innovations hospitals have adopted to re- vacancies during unpopular shifts actually en- age nurses to work fewer hours. For example, e hospitals pay nurses a full-time salary to work 12-hour weekend shifts (24 hours per week) but not pay full-time nurses equivalent hourly rates npopular shifts. In view of all the expenses associ- with continued high vacancy rates, increasing ginal wage rates to fill vacancies on unpopular gnments might not be as costly as is commonly med.

hird, the work requirements of nurses and other onnel in hospitals should be restructured. The of support personnel to professionals is sub- tially lower in the hospital industry than in r industries. Given the complexities of operat- busy hospital inpatient units, there is an astound- absence of secretaries, administrative assist- , and mid-level non-nurse managers. Moreover, computerization of hospitals has lagged far nd that of other industries. Nurses are current- erforming many nonclinical, administrative, and agement functions in hospitals. Fewer better- and better-educated nurses in combination with nproved nonclinical support staff might yield bet- are without substantial increases in operating

urth, hospital management should introduce in- ves to encourage experienced nurses to remain in al care. A differentiated wage structure that rec- es experience and advanced education is critical. loyment benefits such as pensions, tuition sup- and sabbaticals could be used much more effec- to develop "loyalty" and thus reduce costly staff over.

th, physicians should take leadership roles in the lopment of more effective collaborative models of ice with nurses in hospitals. Much of the dissatis- n of nurses with hospital practice is related to the ce of satisfying professional relationships with cians. Many nurses choose administration over al practice in an effort to obtain greater status eir interactions with physicians. More effective -physician collaboration in clinical care activi- would improve the professional satisfaction of groups and contribute to improved patient out- s as well.[25]

Conclusions

e evidence suggests that under current market tions in many local communities, the demand for s is greater than the supply. Regardless of the ns for this imbalance, there is only a limited ber of possible solutions. Expansion of nursing-school enrollments to increase the national supply of nurses might eventually solve the vacancy problem but is unlikely to occur, given demographic trends and the declining interest of young people in nursing careers. Recruiting inactive nurses into the work force is also not a promising solution because employment rates are already high among nurses and may have reached a ceiling. Expanding the number of nurses trained abroad is an expedient option but one that might create more problems, in terms of quality of care, than it would solve. The development of incentives to induce part-time nurses to work more hours is a promising option that should be pursued. Finally, if all the above methods to increase the supply of nurses still do not eliminate disruptive vacancies, restructuring hospitals to make more appropriate use of the special expertise of nurses is a difficult but obvious alternative.

None of these recommendations are new; they have been advocated consistently by every panel studying nursing shortages. Implementation, in contrast, has been slow, despite encouraging evidence from the few hospitals that are making the suggested changes.[26] The fact is that nursing shortages are a consequence of complacent management and the reluctance of administrators to reexamine traditional practices. In the light of the attitudes of young women and their changing aspirations, what is now an artificially created shortage may become a critical problem in the future. Nurses are an essential resource for hospitals and the nation's health. Addressing their needs and aspirations realistically and examining their work conditions meaningfully are prerequisites for high-quality patient care now and in the future.

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THE NURSE LABOR MARKET

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The national shortage of nurses, which grew to crisis proportions in many communities in the late 1970's, has subsided. Recent evidence suggests that hospital nurse vacancy and turnover rates have declined significantly since 1979. The recent swift reversal in the availability of nurses, from shortage to waiting lists in some hospitals, has taken many by surprise. It also raises the possibility that greater understanding of the factors that influence the market for nurses might make it possible to avert future shortages.

RECENT CHANGES IN NURSE EMPLOYMENT

Beginning in 1980 and 1981, the acute shortage of hospital nurses wa reported to have abated in some areas of the country. A report issued by th California Hospital Association, for example, noted a significant increase i nurses seeking employment, a decline in hospital nurse vacancy rates, and th lowest turnover rate among hospital nurses since 1977.[1]

A similar picture emerges from analyses of national data. Vacancy rat in 1980 for hospital nurses dropped to their lowest point since the 1940s, indicated in Figure 1. A national study of the use by hospitals of tempora nursing service agencies to supplement staff vacancies found that 36 perce of hospitals using agencies in 1980 reported that they no longer use them.[2]

Most of the present shortage of nurses seems concentrated in one-third the nation's hospitals. As indicated in Figure 2, in September of 1980, m than one-quarter of hospitals reported no vacancies at all.[3] Another 40 p cent had 9 or fewer vacant positions, which would not appear to constitute acute shortage given the size of most nursing service departments. State local government hospitals experienced the highest overall vacancy rates. picture that emerges from the 1980 survey of hospitals is consistent v anecdotal evidence that the acute shortage of nurses is now concentrated p marily in large urban public hospitals. Vacancies in community hospit

where they exist at all, seem confined to unpopular hours.

The nation has been plagued by nursing shortages since World War II. Two periods have been exceptions — from 1968 to 1971 and the current period beginning in late 1980. The circumstances surrounding these two shortages and their resolutions are remarkably similar, and suggest a pattern which might be useful to consider in future policy decisions.

HISTORICAL PERSPECTIVE

In the early 1960s, hospitals reported vacancy rates for nurses that averaged over 23 per 100 budgeted positions, the highest vacancy rates ever recorded. When Medicare was passed in the mid-sixties, it was widely feared that the increased use of hospitals by newly insured elderly would create a critical national shortage of nurses. Nurses' salaries, which historically had lagged behind other women's occupations, increased dramatically. The resulting increases in hospital costs were absorbed by Medicare and other third party payors.

Following the rapid rise in salaries, nurses returned to the labor force in large numbers. Labor force participation rates rose from 55 percent in 1960 to 70 percent by 1972. Both full-time and part-time employment increased. Enrollments in nursing schools also increased dramatically, helped by educational subsidies available through the Nurse Training Act.

During the period 1966 to 1971, nurses' salaries rose twice as fast as those of teachers and of all female professional, technical, and kindred workers. As indicated in Figure 3, as nurses' relative wages increased, hospital nurse vacancy rates decreased.

Beginning in late 1971 with the introduction of hospital wage and price controls, the growth of nurses' salaries slowed. Over the remainder of the 1970s, nurses' wages experienced little growth, fell behind those of

comparable groups, and failed to keep pace with inflation. During the decade of the seventies despite a doubling of enrollments in nursing schools, hospital nurse vacancy rates rose dramatically and hospital adminstrators reported a widespread acute shortage of nurses by the end of the decade.[4]

In 1980, the cycle began again. The change in administrations in Washington resulted in a temporary easing of cost-containment pressures on hospitals. Nurses' incomes rose 13.5 percent a year during the two year period 1980 and 1981,[5] which was above the inflation rate for those years and well above average wage increases in private industry. Nurses' salary gains were once again considerably higher than those for teachers, female professional workers, or other hospital-based occupations such as medical social workers, physical and occupational therapists. As indicated in Figure 3, the same pattern observed in 1966-1971 is evident for the period 1980-1981; as nurses' incomes rose relative to those of comparable groups, hospital nurse vacancy rates declined.

Nurses responded in similar ways following wage increases in both 1966-1971 and 1980-1981:

(1) inactive nurses returned to active employment; and

(2) nurses increased the number of hours they worked.

The number of full-time equivalent employed nurses increased by 25 percent between 1977 and 1980, from 821,000 to 1,025,000.[6] Registered nurses returning to the work force accounted for a 10 percent increase in the overall supply of employed nurses in 1980. Both full-time and part-time employment increased during this period.

The economic downturn of the past several years is a factor contributing to the swiftness of the resolution of the recent nursing shortage. The national unemployment rate was almost 10 percent in mid-1982, the highest

since World War II. Double digit inflation in 1979 and 1980 provided a strong incentive for married women to return to the labor force to maintain their families' standard of living. Between 1975 and 1980, the proportion of husband-wife families in which both were employed increased from 39 to 45 percent,[7] although this has been a steady trend observed since 1960.[8] In addition, hospital occupancy rates have fallen in communities hardest hit by unemployment thus decreasing somewhat the requirements for nurses.

While the economic downturn undoubtedly contributed to the swiftness of the resolution of the nursing shortage, it does not seem to be the sole explanation. The rise in nurses' incomes seems to be associated with declines in hospital nurse vacancy rates even after taking into account the effects of general unemployment and inflation. This suggests that even in the absence of an economic downturn, the recent increases in nurses' relative incomes would have contributed to a reduction in the shortage of hospital nurses, though probably not at the speed witnessed over the past year.

THE LABOR MARKET FOR NURSES

Nurses are not income maximizers. Those who select nursing as a career base their decisions on factors other than life-time earnings, for the rate of return on nursing education has never been high in economic terms. Studies of nurses indicate that the quality of working life, evidence of having contributions recognized and valued, involvement in decision-making, and professional autonomy are all as important to nurses as monetary rewards. Why then does the relative wage rate figure so centrally in the circumstances surrounding shortages and their resolution?

The labor market for nurses is different than that of most other occupations. Labor economists have noted that nursing is an occupation affected by oligopsony: the presence of only a few firms that employ the majority of those

in a particular occupation.[9] Two-thirds of all employed nurses work in hospitals. Most communities have a limited number of hospitals. Moreover, the specialized nature of nursing education does not seem to allow nurses to move easily out of health care into positions of comparable status in other industries. Less than five percent of registered nurses in 1980 had left health care for other employment despite traditionally low wages and poor working conditions. Hospitals have been and remain the dominant employer of nurses, and are relatively immune to pressures from other industries that might compete and elevate nurses' salaries. Thus, nurses' incomes have traditionally lagged behind those of comparable groups.

Artificially depressed wage rates for nurses can create shortages by changing the behavior of both nurses and employers.

(1) Low relative wages result in substitution of nurses for non-nurses.

Nurses are versatile hospital employees. Their broad training enables them to substitute for allied nursing personnel (L.P.N.s and aides); take on many of the responsibilities of other health-related personnel including medical social workers, occupational and physical therapists, and inhalation therapists; assume many managerial and clerical roles; and even substitute for physicians in some functions. Because of this versatility, when nurses' relative wages fall, it is more economical for hospitals to employ more nurses as opposed to other kinds of workers.

For many years, the gap between nurses' incomes and those of physicians has increased. In 1945, nurses' incomes were one third of physicians'; now nurses earn less then 20 percent of physicians' incomes. Moreover, the income gap between nurses and allied nursing personnel gradually narrowed over the decades of the sixties and seventies. By 1979, nurses' salaries were less than 30 percent higher than those of aides with no formal education. When the costs

of turnover, limited job versatility, continuing education, and supervision costs are all considered, it is more economical if nurses salaries are relatively low to replace allied nursing personnel with nurses. There is clear evidence that this did indeed happen in the seventies. Hospitals across the nation shifted from a staffing complement of one-third nurses and two-thirds aides and L.P.N.s, to a ratio of 50 percent registered nurses by 1980. There was a direct replacement of nurses for aides in a period characterized as one of acute shortage of nurses where the usual expectation would be for substitution in the opposite direction -- more L.P.N.s and aides not less.

Thus, artificially depressed nurses' wages encourages those hospitals preferred by nurses, because of favorable locations, better working conditions, or charismatic leadership, to stockpile nurses -- that is, to employ many more than would be employed under higher wage rates. Such employment practices contribute to overall shortages, and exaccerbate existing geographic imbalances.

(2) More nurses will choose part-time employment.

A unique aspect of nursing, especially hospital nursing, is that nurses can work almost any number of hours they choose. About one-third of all employed nurses, or over 400,000 nurses worked part-time in 1980.[10] Decisions made by nurses as to how many hours they work can significantly affect the nation's total supply of nurses. For example, if every nurse working part-time in 1980 worked an average of 8 more hours a week, the increased nursing time available would be the equivalent of approximately 80,000 full-time additional nurses, more than the total annual output of new graduates from all the nation's nursing schools.

Almost half of the 1.7 million nurses licensed to practice in 1980 were married with children in the home. Employed married women with children are

sensitive to the wage rate because their incomes after taxes must finance child care and substitute homemaker services. When nurses' relative wages fall, net incomes derived from full-time employment after deducting expenses and taxes are marginal. Many full-time nurses as a result, revert to part-time work. The result of this phenomenon is a significant reduction in the number of full-time equivalent nurses available for employment. During the period 1972 to 1980, when nurses' incomes failed to keep pace with other comparable groups, the proportion of nurses working part-time increased from 18 to 25 percent of all registered nurses.

(3) Low relative wages result in delays of nurses reentering the labor force.

Nursing is a predominantly female occupation. Large numbers of nurses leave the labor force for childbearing and childrearing and reenter at some later point. Decisions nurses make concerning the timing of return to the labor force significantly influences the nation's supply of employed nurses. Over one-third of the net increase in the number of employed nurses from 1966 to 1972, an increase that resulted in a dramatic reduction in hospital nurse vacancy rates, came from the existing pool of inactive nurses.[11] The same phenomenon has occurred in the past two years. Salaries have increased and, encouraged by the economic recession, large numbers of inactive nurses returned to the labor force.

COMMON EXPLANATIONS FOR THE NURSING SHORTAGE

Although the nursing shortage has received immense public attention, especially in recent years, there has been surprisingly little recognition by public commissions, hospital associations, the nursing profession, or government agencies of the unusual qualities of the nurse labor market. Thus, the continuing nursing shortage in the face of significant increases in the supply

of nurses has led to considerable debate about appropriate solutions.

Most prescriptions for solving the nursing shortage have focused on expanding the nation's educational programs. Indeed, this has been accomplished quite successfully:

(1) Admissions to nursing schools have more than doubled form 49,000 in 1959-60 to 107,000 in 1978-79.

(2) The number of employed nurses has more than tripled over the past 3 decades, from less than 400,000 in 1950 to over 1.24 million in 1980.

(3) Since 1950, the increase in active nurses has outstripped population growth by 200 percent.

Paradoxically, the nursing shortage in 1979 was as acute as ever after these tremendous gains. Although three common explanations have been offered for this puzzling phenomenon, only one provides even a partial explanation for the continuing shortage in the seventies in face of such a vast increase in the number of nurses.

- Nurses are not working at all, or have left nursing for other kinds of jobs.

This is not true. Nurses have one of the highest labor force participation rates of predominantly female occupations. In 1980, almost 77 percent of licensed nurses were employed, with fewer than 5 percent working in non-health related jobs.[10] Of the approximately 390,000 registered nurses not employed in nursing in 1980, more than one-third were 50 years of age of older. Most have not worked for many years and would not be candidates for employment in today's complex hospitals. Another third are married women with children, many of whom will eventually return to the work force.

- A large proportion of nurses has been attracted away from hospital employment to non-hospital jobs.

The facts do not support this explanation. Although job opportunities for nurses in ambulatory care and health services administration grew rapidly in the sixties and seventies, and some nurses undoubtedly did move into such positions, hospitals have continued to employ the same share of a growing nurse pool — 65 percent — for the past two decades.

- Increasing intensity of hospital care and more hospitalizations for an aging population have increased the need for nurses faster than additional nurses can be employed.

There is clear evidence that the intensity and complexity of care required by hospitalized patients has increased.[12] There has also been a 10 percent increase in inpatient days. However, between 1972 and 1980, the number of full-time nurses employed by hospitals increased by 69 percent, outstripping a generous estimate of the need for additional nurses to a considerable degree.[4] Thus, while the increase in intensity of services and hospital inpatient days is a partial explanation for the increased employment of hospital nurses, it is by no means a complete explanation for shortage during a period of very rapid increase in the supply of nurses.

Despite the inadequacy of these three common explanations to fully account for the persistent shortage of nurses in the seventies, recommendations continue to focus on increasing the supply of nurses. Relatively little attention has been given to the unique aspects of the nurse labor market, especially with respect to the factors which influence employer demand for nurses. History suggests that unless greater consideration is given to imperfections in the labor market for nurses, we may be at risk of unwittingly recreating another nursing shortage just when the problem seems to be under

control for the first time in 10 years.

ISSUES FOR THE FUTURE

Health care expenditures have risen at an alarming rate, particularly over the past two years, and are consuming an ever increasing share of the nation's Gross National Product, from 8.9 percent in 1979 to 9.8 percent in 1981.[13] Hospitals, which account for over 40 percent of total expenditures, logged increases of 17.5 percent in the one-year period 1980 - 1981. Such growth levels cannot be sustained without jeopardizing other valuable health and social services, and cost-containment efforts can be expected to increase in the years to come.

One consequence of hospital cost-containment strategies employed in the seventies was the unintended increase in employer demand for nurses that resulted from artificially constrained wage rates. As demonstrated earlier, the rapid shifts from adequate supplies of nurses to national shortages and back again seem strongly associated with changing wage rates. This is not to say that nurses refuse to work when wages are perceived to be inadequate; recently they have worked in large numbers regardless of incomes. The important issue is that the number of positions for nurses is related to wage rates as well as to some absolute definition of need derived from numbers of hospital beds, types of insurance coverage, aging of the population, and so forth.

In the decade of the 1980s, the number of employed nurses is expected to increase by almost 500,000. The number of full-time equivalent nurses per 100,000 population is projected to increase from 473 in 1980 to 568 in 1990, a rate of growth which will outstrip the increase in population by 20 percent. Since supply and demand for nurses is now reasonably in balance as measured by historically low numbers of vacant budgeted positions for hospital nurses, the net increase in nurses in the 1980s can be expected, under current market

conditions, to improve the general distribution of nurses and help resolve some of the remaining local imbalances. However, historical trends also suggest that should the normal growth in nurses' wages be artificially constrained once again so that nurses' incomes lag considerably behind those of other comparable groups, shortages as measured by widespread unfilled budgeted positions might again prevail despite the expected net increase in nurses.

The sensitivity of the nurse market to changes in wage rates is not a uniquely American phenomenon. The fiscally conservative Thatcher government in England, even during a period of extreme austerity, has recognized the unique impact of wage rates on the availability of nurses, and has singled out nurses from the rest of the health work force for special treatment.[14] The Thatcher government supported average salary increases for nurses of 61 percent between 1979 and 1982, which is 12 percent above the inflation rate for these years and well above average wage increases in private industry.

Given the modest economic rewards for becoming and remaining a nurse, non-monetary rewards are very important in maintaining nurses' morale and career commitments. Being a nurse in today's fast-paced hospitals is physically gruelling, emotionally draining, and intellectually taxing. Nurses' responsibilities for making critical patient care decisions have increased dramatically over the past 10 years as hospitals have shifted to an increasingly sicker patient population. However, the undervaluation by physicians and hospital administrators of nurses' knowledge and experience is a major source of nurses' dissatisfaction and frustration with their current roles. Nurses want to be appreciated and respected, recognized for their expertise, consulted regarding areas of their responsibility, participate in decision-making, have some control over where their talents can best be used, and be able to maintain reasonable personal lives along with work responsibilities.[15]

The reorganization of work settings and modifications in interprofessional relationships necessary to bring about these changes do not necessarily involve major monetary investments. They primarily call for modifying traditions which have limited utility in a changing world.[16]

The nursing profession must also be held accountable for attending to some long neglected problems which have contributed to the current difficulties in hospital nursing. Serious attention must be given to developing a differentiated nursing structure that clearly identifies nurses according to their levels of expertise. The proliferation of different educational pathways to becoming a nurse has made it difficult for physicians or others to clearly differentiate the more educated or experienced. In addition, medical schools and nursing schools have become increasingly isolated from one another, and nursing education has withdrawn from direct involvement in the delivery of nursing services. Nursing and medical schools should be more closely linked academically, and nursing faculty and nursing students should have closer ties to the world of nursing practice, particularly hospitals since most nurses ultimately practice there.

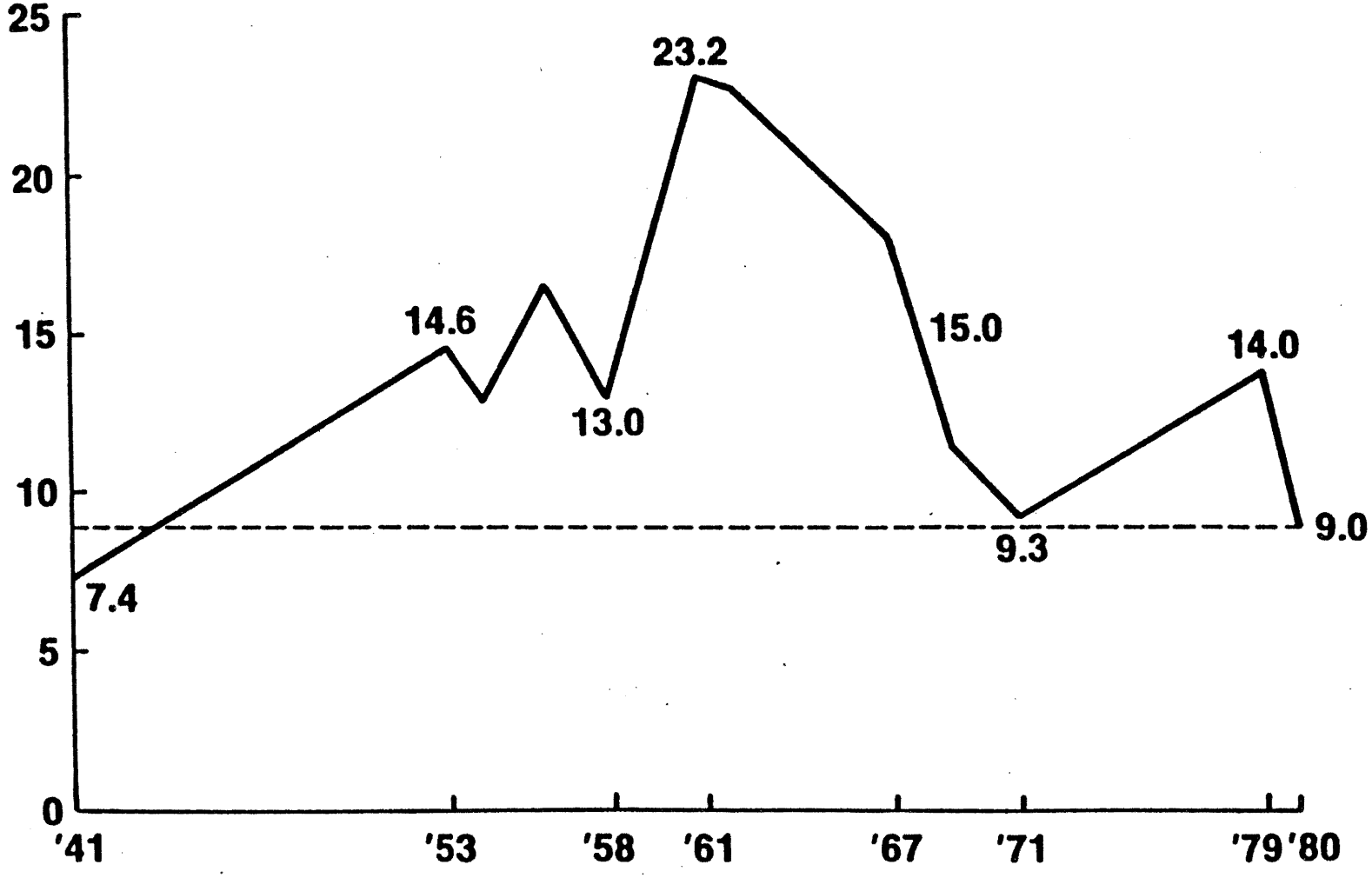
Ensuring an adequate supply of nurses reasonably distributed across geographic locations and types of health care institutions requires a two-fold agenda for the future. Nursing, medicine, and hospital management need to forge new relationships which better maximize the contributions each group makes to the delivery of effective, affordable health care. Without such changes, over time nursing will become a less attractive career for highly motivated and dedicated young people with the high science aptitude, required for nursing practice in modern hospitals. However, unless we are also sensitive to the unique features of the nurse labor market including the relationship between nurses' relative wages and the behavior of employers who stock-

pile nurses when relative wages are low, and the behavior of nurses themselves who adjust their hours according to wage rates, we could find ourselves in 1990 with 500,000 additional nurses in the workplace and another acute shortage. The pressures in 1982 to constrain the growth of hospital costs are as great or greater than those of 1972. There is ample evidence that cost containment strategies pursued in the seventies contributed to a national nursing shortage by artificially constraining the growth of nurses' salaries. Pursuing the same course in the eighties may result in the same outcome -- a widespread national shortage of nurses despite a continuing increase in the supply of nurses. If averting another shortage is important, policies developed to contain hospital costs should be designed with sensitivity to the impact of fluctuations in wage rates on the overall supply and distribution of nurses.

LHA/wpc
10/8/82

Figure 1

NURSE VACANCY RATES IN HOSPITALS 1941-1980



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TESTIMONY OF CRAIG A. BECKER
VICE PRESIDENT FOR GOVERNMENT RELATIONS

BEFORE THE

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

ON NURSING SHORTAGE

SEPTEMBER 28, 1987

21X

Mr. Chairman, Members of the Committee, good afternoon, my name is Craig Becker, Vice President for Government Relations for the New Jersey Hospital Association which represents all of New Jersey's hospitals. I plan on outlining for you today, in general terms, the problems faced by our health care system brought on by the critical shortage of nursing personnel. Other NJHA members will give testimony to specific problems their institutions are facing and corrective actions contemplated to provide long term solutions. NJHA is convinced that until these long range problems are addressed, there will always be a nursing shortage at some level or another.

However, having said that, NJHA is equally convinced that by putting additional dollars into the system to increase salaries will, in the short term attract nurses back to hospitals. In New Jersey, the average starting nurse's salary is $23,000 and generally reaches a maximum of $28,000 over the career of the nurse. This starting salary maximum is just not competitive with other professions and both must be raised.

In addition, competition from the contiguous states has become intense and New Jersey now lags far behind. In Philadelphia for instance, graduate nurses can start anywhere from $28,000 to $32,000. In Delaware, one state institution is paying its nurses $40,000 to start. It is obvious to us that in order to compete, New Jersey hospitals must raise salaries and, in fact, some have already done so. The hospitals have taken this action at great financial risk to themselves, because the dollars for these increases are not provided for by our severely regulated reimbursement system.

The question most often asked is why is the nursing shortage so critical at this time. It is estimated that New Jersey hospitals currently are short 2500 registered nurses and the vacancy rate is growing. The reasons for the shortage are:

First and foremost, NJHA believes the relatively low starting salaries, compounded by the low maximum salary range is the leading cause of nurse dissatisfaction. In Philadelphia, where salary ranges are among the highest in the nation, hospitals are almost fully slotted. That is, they have a full complement of nursing personnel.

Second, since the Federal government began mandating that patients recover at home and not in the hospital, hospitals are seeing a higher acuity level. That is, hospitalized patients are sicker and need more intense nursing care. Before federal initiatives, namely the PRO's the recuperating patient allowed the nurse to spend more time on the patient who truly needed the professional attention. Now, we find our floors are filled with patients who need constant attention. Adding to our burden is the fact that New Jersey has the second oldest median-age population in the United States, which means we are faced with an even greater severity of illness among our patient population.

Third, a cumbersome and sometimes unrealistic state regulatory burden is placed on the RN. This needless burden only takes the nurse away from the primary goal, providing bedside care for the ill patient.

Finally, the curse of full employment in New Jersey is that lower paying professions are going to suffer a shortage of trained personnel. Hospitals are not only competing with Philadelphia and New York for the services of its nursing personnel, but with banks, brokerage houses, and other healthcare services as well. New Jersey has the highest concentration of pharmaceutical companies in the United States which can offer far more attractive and higher paying jobs not only to nursing, but to all allied health professionals as well.

As for the extent of the crisis, it has been suggested that this shortage is restricted to the border cities and therefore the solution should focus on regionalizing payments. A survey by the NJHA showed there is a 17 percent vacancy rate for all RN positions statewide. The survey also showed the shortage was just as critical in Cape May Court House and Freehold as it was in Camden and Ridgewood. The nursing shortage is blind to regional boundaries and extends throughout the state.

The shortage does not restrict itself to nursing personnel only. Hospitals are also experiencing a shortage of personnel in the areas of physical and respiratory therapists, X-Ray technologists, pharmacists and EKG technicians. Unless New Jersey hospitals can respond quickly to these shortages, healthcare quality is surely going to suffer.

Hospitals have been grappling with ways to keep their services open and yet not compromise quality care. This process has gotten harder. In order not to compromise quality, hospitals have resorted to closing entire units, treating

more patients in emergency room and outpatient settings, delaying elective admissions (sometimes as much as six weeks) and diverting ambulances from their doors.

The NJHA believes our payment system, under which all rates are controlled by the Hospital Rate Setting Commission, cannot move quickly enough to meet the dangers posed by this crisis. The Rate Setting Commission recently granted a $50 million cash flow adjustment which alleviates some of the problem. But the system must be flexible enough to allow hospitals to adjust rates to meet these critical problems. Our system, which is so good at restraining costs, cannot react quickly enough to meet the competitive demands of the market place.

Because of the state's regulated system and the efficient management of our hospitals, New Jersey has long been recognized as the leader in holding down hospital costs. Last year, New Jersey was among the lowest in the nation in overall hospital costs, despite our second highest per capita rate. One independent study showed the daily charges for hospital care in New Jersey to be $437, lowest in the nation, compared to a national coverage of over $600. It is equally clear that we have been able to hold down those costs because our workers were willing to work for less than their national counterparts. We believe that time has passed.

As for specific relief, we continue to support A-4483, a bill which would provide an immediate and permanent two per cent increase in the labor economic factor and a comprehensive study of the prevailing wages paid in New Jersey and its competitors. Also, you should be aware that the Hospital Rate Setting

Commission in the past two weeks has already put some of A-4483 into operation, at least on a temporary basis. Hospitals have been granted a temporary 2 percent adjustment to their rates, and the commission has agreed to a one year independent study to further investigate the economic ramifications of the shortage. It remains to be seen whether or not there will be follow through on both actions and we hope the legislature will keep the pressure on the Department and Commission to help assure the process keeps moving.

Ultimately, we are in favor of a proposal to perform the independent study on an annual basis and have that study funded through hospital licensure surcharges. This will ensure that wages paid hospital personnel in the state will remain adequate and competitive in years to come.

We also support A-4001, which would establish a study commission to look into the long term problems of the nursing shortage and recommend specific changes to the legislature. The NJHA has already begun this process and pledges to work with this commission to recommend long term solutions to the problem.

It is clear that New Jersey's health care industry is at a crossroads. If we do nothing, it will sink into chaos. Years of building one of the finest health care delivery systems in the nation will be lost. We can no longer afford to lose our nurses and other allied health professionals across our borders. It is time to allow hospitals to compete on a level playing field for the services of all our workers and to properly pay them for the fine service they continue to provide the people of New Jersey.

Thank you for your time and kind consideration of our requests.

FREEHOLD AREA HOSPITAL

Jack De Cerce, F.A.C.H.A.
President

Statement - Assembly Health and Human Services Committee

September 28, 1987

Fact Sheet - Nursing - An Endangered Species

I. New Jersey Economics

.Statewide boom has resulted in full employment, record per capita income and soaring real estate prices.

.Under Chapter 83, the Hospital Rate Setting commission has limited reimbursement for health care to one of the lowest levels in the United States.

.Nurses plus clinical and support staff have been limited to very conservative cost of living wage increases.

II. Current Status of New Jersey Health Care

.Hospital patients are more acutely ill and require more intensive services. [Early discharge across the board leaves only the sickest patients who need acute treatment, more procedures and closer observation.]

.Nurses have accepted disproportionate share of acuity load (and resultant stress) since low reimbursement rates limit investment in other clinical and support staff.

.Nurses and other caregivers are leaving health care due to burnout, low wages, stress and liability, lifestyle (nights and weekends) and the attractive pay, "perks" and status of other employments.

.Enrollment in nursing and allied health education programs are dropping which raises great concern regarding the future.

III. Solution - Need to Infuse More $ into New Jersey Health Care

.Regulators, Public Advocate and Third Party Payors are united in "go slow" approach.

.Broad public and political consensus is needed to raise floor of wages and status of nurses as well as other health care workers.

."Minimum Wage" should be legislated for nurses to mandate attractive employment environment in health care.

.Broad public debate should establish support for two phase adjustment in nurse wages.

.Phase I (1987) $25,000 per year
.Phase II (1988) $30,000 per year

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The latest addition to our list of endangered species.

Nursing...a profession that has always attracted our best and brightest, is in trouble.

Why? Although New Jersey is both economically and technically advanced, it consistently lags behind other states in nursing salaries. Strict healthcare regulations have greatly reduced hospital costs but have not enabled nurses to receive adequate compensation. Nurses are extraordinary people. Always giving... Always caring.

They deserve our support. We need to pay our nurses competitive salaries. Now, let's act together, because we can make a difference. Write Molley Coye, M.D., the N.J. Commissioner of Health, at John Fitch Plaza CN-360, Trenton, N.J. 08625. Or write your legislators and tell them about your concerns. Because if we don't take care of them now, they won't be able to take care of us tomorrow.

MONOC

Monmouth-Ocean Hospital Service Corporation

A Cooperative Venture to Improve Health Care and Reduce costs.

Bayshore Community Hospital; Community Memorial Hospital; Freehold Area Hospital; Jersey Shore Medical Center; Kimball Medical Center; Monmouth Medical Center; Medical Center at Ocean County; and Riverview Medical Center.

MUHLENBERG REGIONAL
MEDICAL CENTER, INC.

Park Avenue & Randolph Road
Plainfield, NJ 07061

(201) 668-2000
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Testimony of

David M. Ridgway
President and Chief Executive Officer
Muhlenberg Regional Medical Center

Before the

Health and Human Resources Committee
New Jersey State Assembly

On

The Problem of Nursing Staff Shortages in New Jersey

September 28, 1987
Trenton

Mr. Chairman and members of the Committee:

I am David M. Ridgway, President and Chief Executive Officer of Muhlenberg Regional Medical Center in Plainfield, New Jersey.

Thank you for this opportunity to testify before the Committee. We must confront the critical problems facing us in the hiring and retention of high quality nursing and allied health professionals. I am most concerned about the impact these staff shortages will have upon the quality of care provided to all who depend upon hospitals.

Quality of care is not a slogan to us, it is of utmost concern to us every day at Muhlenberg Regional Medical Center.

In July, the national Joint Commission on Accreditation of Hospitals renewed Muhlenberg's accreditation for three years, after an exhaustive inspection conducted earlier in the year. In August, New Jersey Department of Health officials conducted Muhlenberg's annual licensure inspection, and praised our efforts to ensure the quality of care provided at the medical center.

Muhlenberg is a member of Voluntary Hospitals of America and its New Jersey affiliate, VHA New Jersey. Voluntary Hospitals of America is an organization of more than 750 of this nation's most highly-respected nonprofit hospitals whose common goal is to provide the highest quality health care to people of the United States.

After 17 years in health care administration at Muhlenberg, more than five of those as President and Chief Executive Officer, I am deeply concerned at the threat to the quality of care we provide -- a threat that is posed by the increasingly acute shortage of nursing and allied health professionals. What we face in 1987 is like nothing I have seen before in my career.

The seven million residents of this state rely on their hospitals to provide acute care when care is needed. I can see the staffing crisis undermining our ability to provide the often lifesaving care and treatment these people depend on. In her testimony, A. Patricia Johnson, our Vice President for Nursing Affairs, briefly outlined some of the services Muhlenberg provides. We may soon have to curtail services solely because of the staffing shortages.

If we reduce our number of inpatient admissions, we reduce our revenue for the year. That makes it harder for us to afford the salaries necessary to attract the needed nurses. And that makes for an even more volatile situation -- a continual downward spiral.

On September 16, the Hospital Rate Setting Commission acted to help by voting for a two percent cash flow adjustment for hospitals until the end of the year. That action was a bandaid on the gushing wound of the nurse shortage. It was a small step, but in no way sufficient to seriously solve the crisis. Why?

First, the HRSC's action was <u>temporary</u>.

Second, the HRSC's action was a <u>cash flow adjustment</u>. It does not increase by one dollar any hospital's bottom line come the final reconciliation for 1987.

Third, it does not sufficiently take into consideration <u>prevailing economic pressures</u> from across state borders.

Fourth, it only addresses expenditures which hospitals have already incurred in trying to recruit and retain nurses. It does not help with future recruitment and retention programs.

New Approach Needed

We need to take a fresh look at approaches to addressing the staffing crisis. More substantial and permament relief must be forthcoming. Current reimbursement just is not sufficient, and cash flow adjustments are not the answer.

For more than a decade, New Jersey has exercised more stringent rate controls on hospitals than any other state in America. Located in the Northeast United States, we have among the highest costs of living in the country. Yet New Jersey has one of the lowest cost hospital reimbursement systems. Recent New Jersey Hospital Association statistics showed that New Jersey's annual increase in the cost of health care was 49th out of the 50 states.

We can not endure such a situation and expect to adequately staff our hospitals. We can not endure such a situation for long and expect to maintain the quality of hospital care our citizens expect.

The national inflation rate for the first eight months of 1987 has been 5.1 percent, according to a September 24 article in *The New York Times*. The same article reported this information: "The Consumer Price Index for New York and northeastern New Jersey soared by nine-tenths of 1 percent in August, nearly double the national increase of five-tenths of 1 percent, the regional commissioner for the Bureau of Labor Statistics said yesterday."

The Economic Factor approved by the state of New Jersey for hospitals this year lags far behind the actual inflation factor we are experiencing. A permanent, bottom line adjustment is needed for there to be any hope of making a serious dent in the staffing crisis.

The complex formulas of New Jersey's Diagnosis Related Groups Reimbursement System, often simply referred to as DRGs, utilize a historical approach to determining current hospital rates. How much was paid in the past, plus some adjustment for the current year's inflation, determines the current rates. That approach will not work in the face of this staffing crisis.

Nurses, and other vital health care professionals, should be paid what they are worth, not acording to what labor costs were in 1984, 1985 or 1986. The system must change. And until it does, attempts by individual hospitals will only result in temporarily taking staff from one place to help another.

An article published by the *Trenton Times* on September 13, 1987 described some of the incentives offered by Trenton area hospitals to recruit nurses. Among them are cash bonuses of up to $1,000, free vacations and free leased cars. Such actions may be beneficial to the hospitals which can afford them, but they do not solve the system problem -- it means one hospital will steal staff from another. And it costs all hospitals more money.

Another sign of the competitive pressures is the nursing settlement ratified on September 19 by St. Barnabas Medical Center, the state's largest private hospital. The medical center's new two-year contract with its nurses provides for 18-28 percent wage increases, according to published reports, and will cost the medical center about $7 million more than it has in present reimbursement rates. That settlement will also put competitive pressures on all hospitals.

Nurses in New York and Pennsylvania are better compensated for their work -- in some cases as much as 20 percent more -- because their states do not have a rate setting commission that determines how much a hospital can pay its nurses. There is no justification for New Jersey nurses to receive so much less than their counterparts across state lines. That is why we need action by your Committee, and action by the entire New Jersey State Legislature.

I urge your support to pass Assembly Bill 4483 to require our rate setting commission to adjust payments to hospitals to cover these deserved and needed salary increases. Such adjustments would be based upon an independent study of the prevailing wages paid in New York and Pennsylvania.

I also urge your support of Assembly Bill 4001, which would establish a study commission to review long-term solutions to the nursing shortage.

Additionally, more financial aid is needed for persons interested in a nusing education so that the costs of education are not a deterrent.

I would also encourage the development of legislation to control the practices of nurse personnel agencies, which inflate our costs for the nursing personnel they provide.

We must also maximize the unique skills of each professional nurse, and that calls for a reexamination of the nurse practice act.

No doubt additional solutions will emerge as more study is undertaken of this crisis. But we can not delay. The crisis is too close. The stakes are too great. The risks to quality of care, and our fine hospital system as we know it, too real. If we deliberate too long, it may be difficult, perhaps impossible, for our system to recover.

Thank you very much for your concern.

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Testimony of

A. Patricia Johnson, R.N., M.A.Ed., M.A.
Vice President, Nursing Affairs
Muhlenberg Regional Medical Center

Before the

Health and Human Resources Committee
New Jersey State Assembly

On

The Problem of Nursing Staff Shortages in New Jersey

September 28, 1987
Trenton

Mr. Chairman and members of the Committee:

I am A. Patricia Johnson, Vice President for Nursing Affairs at Muhlenberg Regional Medical Center in Plainfield, New Jersey. With me today is David M. Ridgway, Muhlenberg's President and Chief Executive Officer, who is on the stand-by list to give testimony; Betty Ortman, R.N., our Director of Nursing; and additional members of our nursing administration.

I am here representing Muhlenberg's 500-person Nursing Service staff. Many of our nurses would have liked to attend these hearings today and participate by testifying. They are unable to join us because of the critical staffing situation at Muhlenberg Regional Medical Center. Speaking for all of us, we thank you for the opportunity to appear today and present testimony about the severe problems New Jersey faces with nursing staff shortages.

Muhlenberg is a 443-bed regional teaching medical center serving more than 18 Central New Jersey communities with a population of more than 250,000 people. Last year, we provided nearly 120,000 patient days of hospital care and and about 160,000 Emergency Service and outpatient visits. About 6,500 surgical procedures were performed in our operating rooms.

In addition, we are one of just 17 hospitals in the state to run an affiliated School of Nursing. Our school has prepared more than 2,000 women and men for careers in nursing since it was founded in 1894. I served on the faculty of that school for 12 years and as its Dean for five years.

With 21 years of experience as a staff nurse, educator and administrator, I can tell you that never before have I seen such a severe and rapidly deteriorating shortage of nurses and other health care personnel as that which we face today.

In just the three months since June 1987, the number of registered nurse vacancies at Muhlenberg has risen by 75 percent. In the face of staff nurse vacancies, we depend on "per diem" and agency nurses to maintain adequate staffing and provide the quality of care for which Muhlenberg is known. In just the past two weeks, we have seen the pool of available "per diem" and agency nurses shrink dramatically as all hospitals increasingly compete for this limited supply of freelance nurses.

To help us retain our nursing staff at Muhlenberg, we have found it necessary this year to increase nursing salaries -- as so many other hospitals have done. We raised salaries by an average of 10.5 percent. That is 6.78 percent above the 3.13 percent labor component of the state economic factor allowed in our 1987 rates. And it is costing Muhlenberg about $400,000 this year in unreimbursed funds, which is equivalent to $881,000 for an entire year. It will cost us even more next year, unless concerted state-wide actions are taken on a short and long-term basis to address the nurse shortage.

The American Hospital Association's Vice President for Nursing, Connie Curran, said last December, "The shortage is all over the country, and it's getting worse. In the last 90 days, it's really come and hit people right in the face.... Hospitals are stealing nurses from each other."

Why has the situation come to this? I would like to point to key factors creating the nursing shortage, talk about the consequences to the health care field and to consumers, and conclude with some remarks about action needed.

Factors Causing the Nurse Shortage

An examination of the facts reveals the following:

Fact: Due to this country's changing demographics, fewer students are now graduating from high school, reducing the pool of potential nursing students.

Fact: Of those graduates, fewer than ever before are considering nursing as a viable career option.

Fact: At the Muhlenberg School of Nursing, our total enrollment dropped 16.6 percent in the 1986-87 school year compared to the prior year, and has dropped another 10.7 percent for the school year beginning this month.

Fact: Throughout this country, the number of students enrolled in basic programs for registered nurses has dropped from about 250,000 in 1983 to about 193,000 in 1986, according to the National League for Nursing. In just three years, that's a loss of about 57,000 students a year preparing for a nursing career. Enrollment figures for New Jersey mirror those national data.

So, it is clear that fewer people than ever before are preparing to become nurses. And a fundamental reason for these results is simply that nurses' salaries are not on a par with salaries offered in many competing professions.

What about those already in the nursing profession?

Fact: Out of the 78,250 nurses registered in New Jersey, more than one quarter of them -- that is 21,440 -- are not employed in the state, or not employed in nursing at all.

Fact: Nurses are increasingly leaving hospital employment for better pay and working conditions found at health maintenance organizations, insurance companies, industry and similar settings.

Nurses are also leaving hospital staff positions in favor of working through agencies which pay as much as double what the hospital can. One nursing employment agency advertised in *The Star-Ledger* on Sunday, September 20, 1987, an hourly rate of $25 for medical/surgical nurses with three years of experience. That compares to a state average registered nursing salary of $12.10, according to an NJHA survey of 79 hospitals as of June 30 this year.

Yet, hospitals pay the agencies these inflated rates, even though the hospitals can not afford it. And because of those high costs, hospitals can only afford to fill a portion of their shifts this way, on a day to day basis.

In states like New Jersey, Maryland and others with rigid cost-control regulations, hospitals can not raise their salaries enough to compete with these agencies -- or with hospitals across the state lines.

And all of this is happening at a time when the demand for nurses is greater than ever before. The Bureau of Labor Statistics estimates that our country will have 612,000 new nursing jobs to fill by the year 2000. That is a 44 percent increase over the 1986 number of jobs.

<u>Consequences to the Health Care Field and to Consumers</u>

Without prompt action, the nurse shortage will only get worse.

Hospitals will be forced to close beds, perhaps first on weekends, then weekdays. Then they will close whole patient units. This is already happening in some places because it is necessary to prevent serious risks to the quality of patient care.

Patients and their doctors will be asked to defer elective admissions. Hospitalizations will be put off for a lack of adequately staffed beds. And this is already happening in some places.

But if action is not taken, the quality of patient care in hospitals throughout New Jersey could suffer immensely.

The nurses who remain to practice the profession in hospitals will bear increasing burdens -- burdens of frequent overtime, of added stresses, of dissatisfaction with the job they are able to do under these conditions. It will lead to nurse burnout and more nurses will leave hospital practice. And the crisis will spiral into an ever worsening mess.

Hospitals will suffer financial losses that they can ill afford under the extremely tight New Jersey cost-control regulations. It could disrupt the whole hospital industry in our state. As it is, according to the American Hospital Association, New Jersey ranks 50th out of our 50 states in average reimbursement per patient day.

Action is Needed

Short and long-term strategies must be developed and implemented to begin addressing the multiple issues creating the nursing situation we all face in New Jersey.

Fundamentally, we must significantly increase nurses' salaries. This will help to attract students to the field of nursing. And it will help to retain nurses in hospital nursing jobs.

New Jersey hospitals must receive new, permanent dollars to help keep nursing salaries on a par with our competitors across state lines, and with competing career fields.

The following are some steps that must be taken:

First, passage of Assembly Bill 4483 is needed. Most importantly, this legislation would require an independent study of the prevailing wages paid in New York and Pennsylvania and will require our rate setting commission to adjust payments to hospitals to cover our deserved and needed salary increases. And it requires that this happen on an annual basis.

Second, passage of Assembly Bill 4001 is also needed. This legislation would create a commission to study the long-range problems confronted by the nursing profession.

Third, increased financial support for nursing education is required. A nursing education is expensive, yet federal and state monies available for financial aid to nursing students has been dramatically reduced during the past few years. We need to do all that we can to support those students who choose a nursing career.

Fourth, legislation is needed to control nurse personnel agency practices. Left uncontrolled, these agencies will continue to take nurses away from hospital staff positions, then place them back in hospitals on a per diem basis at greatly inflated costs to the health care system.

Fifth, the nurse practice act should be reexamined in light of the current crisis to find ways to maximize the use of a professional nurse's skills.

Quick action is required in all these areas, before New Jersey's fine health care system is irreparably damaged.

As Mary B. Mallison, editor of the *American Journal of Nursing*, expressed in a recent editorial, "Let's dream that someday soon the most respected, satisfied, and highly paid nurses will be those who have continued to care for patients."

Thank you very much, Mr. Chairman.

TESTIMONY OF

WENDY EDELSON, FIRST VICE-PRESIDENT
HOSPITAL PROFESSIONALS AND ALLIED EMPLOYEES OF NEW JERSEY
AFT/AFL-CIO

BEFORE THE

ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

September 28, 1987

Honorable Harold L. Colburn and members of the Assembly Health and Human Resources Committee.

My name is WENDY EDELSON. I am the First Vice-President of the HOSPITAL PROFESSIONALS AND ALLIED EMPLOYEES OF NEW JERSEY. We are affiliated with the American Federation of Teachers and have statewide jurisdiction as a health care union. In New Jersey, we represent 2,000 health care workers including Registered Nurses and Licensed Practical Nurses, pharmacists, laboratory and x-ray technologists, respiratory therapists, physical therapists, social workers and other job titles in the professional and technical areas.

I would like to thank the committee for the opportunity to address you on this subject which is so crucial to our members. My testimony will reflect their concerns on the issue of the nursing shortage and will include information about studies our union has made relative to the issue.

The evaluation of statistics over the past six years reveals that a shortage of nurses was not anticipated and there is serious doubt by many that one truly exists. In 1983, the report released by the Institute of Medicine predicted that the supply of nurses was adequate for the short-term future. According to a 1986 report by the U.S. Department of Health and Human Services, no real imbalances exist between the future R.N. supply and the government's historical trend-based projection of demand.

In contrast, a panel of nursing experts convened by the Department of Health and Human Services, using a criteria-based model with desirable nurse staffing ratios, differs sharply. It projects a 19% shortfall in R.N. supply by 1990. The American Hospital Association measures supply by the number of vacant positions that exist and bases its documentation for a shortage of nurses on a survey conducted by the American Organization for Nurse Executives which showed that the rate of vacant positions for registered nurses had more than doubled between 1985 and 1986, rising from 6.5% to 13.6%. The New Jersey Hospital Association has recently reported vacancy rates are as high as 17% in some New Jersey hospitals.

We know that there is an inadequate number of nurses working in the hospital. We know this by the understaffing that exists. We know this by the tremendous amount of overtime our members are working to provide skeleton coverage particularly on evening and night shifts. But the problems are not limited only to these hours but exist on a twenty-four hour basis. And the staffing shortages are not limited to the nursing coverage but are felt in every department.

What has caused the shortage? Some say that women's opportunities have so expanded, that the traditional career choices of nursing and teaching are losing in the competition. Others will cite convincing economic data verifying that despite a good start there is a quick halt to the economic growth of all health care workers, with the exception of doctors. In fact, statistics in this area generously place the gap between minimum and maximum rates at $7,000. In many hospitals in New

Jersey, nurses are now starting at rates equal to the salary given the most experienced and long term nurse in the same institution. New Jersey hospitals have responded to the nursing shortage by applying their resouces to the starting rates and have virtually ignored the long term employee. Dissension and demoralization is on the rise. We firmly believe that this quick fix method of treating only part of the problem will actually cause greater harm than good.

While we do not have hard figures to present, it is our experience that nurses are leaving hospital employment in droves to work for agencies that subcontract staff relief to the same hospitals that these nurses have left. The reason is simple. The hospitals are willing to pay the nurses from agencies more than double what they pay their own staff nurses. In addition, the agency nurse can set flexible hours and refuse undesirable assignments. The assignments they accept are usually lighter than that of the regular staff nurse. If the regular staff nurse refused the same undesirable assignment, that nurse would suffer reprisal from the employer. The regular staff nurse assumes additional responsibility of being in charge of the patient care area and must oversee the work of the agency nurse while, of course, completing his or her own full work assignment. The situation is compounded when the hospital tells the staff nurses that due to cost constraints beyond their control they cannot compensate for experience and longevity. The exodus of nurses from hospitals is just beginning.

One way nurses are escaping the pressure of their job is to reduce their exposure by reducing the number of hours they work. This has fit in nicely with hospital plans to convert full time positions into part time positions. In a study of one New Jersey hospital, we compared figures over a four year period of time and found that while the number of nurses on staff was nearly the same, the number of scheduled hours of work dropped by nearly 20%. This was in direct proportion with the conversion of full time positions to part time positions.

In March of this year, we surveyed over 35,000 registered nurses and licensed practical nurses in New Jersey from a list provided through the Division of Consumer Affairs. We did not target particular hospitals but instead mailed our survey to nurses that lived in seven counties from Atlantic to Bergen with similar population density and health care facilities. I have included a copy of the survey results with copies of my testimony.

The message that is clearly derived from this survey and that is clearly heard from our members is that the staffing levels in hospitals are inadequate, often unsafe and prevent the deliverance of quality patient care.

We know of situations that could easily be termed "horror stories" that occur on a frequent basis. We know of cases where there are no nurses scheduled to work on particular floors in hospitals despite a full occupancy of patients. The hospital relies on nurses to work overtime or pulls nurses from other understaffed areas to plug the staffing hole.

We know of situations where nurses who have no critical care training or experience have been put in charge of critical care units despite the fact they cannot interpret some of the monitoring equipment.

We know of situations where nurses are given such a large patient care workload that mathematically, the nurse could allot only 15 minutes per patient for the entire shift providing that the unexpected does not occur. The nurse forfeits entitled break time and meal time and usually work long after their scheduled quitting time to complete the basics of their work. This occurs daily for many nurses and breeds frustration and exhaustion. Being too tired to fight an uncaring system, many have chosen to take the first opportunity to leave the situation and many more will follow if conditions don't change.

I have focused my comments on nursing because of the recent attention directed to the nursing shortage and because nurses comprise the largest group of employees in a hospital. But it would be wrong for us to stop there.

The problems that besiege the nursing profession are equally and in some cases more drastically felt by the other health care professions. Pharmacists and Physical Therapists are grossly underpaid in hospitals as compared with independent, commercial pharmacies. Respiratory therapists have seen their job increase in duties and responsibilities while enrollments in schools have dropped to a dangerously low point.

50 X

Hospitals have made efforts to cut costs by cutting support staff thereby shifting more work on the technical and professional staff and stealing from their limited and valuable time to perform tasks that should rightfully be done by others.

HPAE has made the following conclusions and offer them to this committee for consideration and action.

1. Establishment of minimum staff-to-patient ratios guidelines that provide for safe, adequate and quality patient care. Such minimum staffing numbers should not be limited to nursing but should include all departments.

2. In the cases where there is an inadequate number of staff available, the census in the hospital must be adjusted accordingly.

   (NOTE: It important to realize that to limit the census of a hospital does not mean a single patient should be denied care that is needed. There are many procedures that require hospitalization of patients that can and are scheduled in advance. Such schedule should also take into account the supply of staff and be adjusted accordingly.)

3. Establishment of a monitoring and enforcement agency to insure that such guidelines are adhered to.

4. Funding to provide wages and benefits that are commensurate with professional skill and experience and that put health care professions back into the competitive career market.

5. Review of the funding and use of the independent agencies that subcontract nursing services with hospitals.

I thank the committee for its efforts to address these problems. HPAE offers any assistance possible to help in this endeavor.

Andover Nursing and Convalescent Home
Mulford Road, Andover, New Jersey 07821
Telephone: 201 383-6200

Jeryl Turco
Administrator

Dolores Turco
Executive Administrator

November 2, 1987

Honorable Harold L. Coburn, Jr.
Assembly Health & Human Resources Committee
22 Hight Street
Mount Holly, NJ 08060

Dear Senator Coburn:

We are taking the liberty of writing to you on behalf of the Lincoln Park and Andover Nursing Centers because of your concern, sensitivity, and responsiveness to matters of grave interest to your constituents. There presently exists a severe nursing staff shortage in New Jersey and nationwide which has reached critical proportions and is anticipated to worsen due to declining enrollment in nursing schools.

Over the past two years we have spent an exorbitant amount of time and resources in an effort to resolve this problem at our facilities. We would like to take this opportunity to present the following recommendations which we believe are effective and practical suggestions to help alleviate this problem.

With the cooperation of the Department of Health, the Department of Human Services and Immigration, we believe some immediate results can be achieved and planning for long-range goals instituted.

A. Permit nursing homes to increase salaries above the inflationary increase through the reimbursement system, as hospitals and state institutions were recently permitted to do as a result of this crisis. Our facilities received an approximate 5% increase; however, we gave a 16% increase in salaries in order to remain competitive. The result--un-reimbursed expenses in excess of $1,250,000 required to subsidize the Medicaid program which is unfair since Medicaid is required to reimburse reasonable cost. We are experiencing a tremendous financial hardship, which if continued will threaten the solvency of our facilities and jeopardize the welfare of the 1,000 medicaid patients we presently serve. Senators Burdick and Inouye have proposed a $5 million appropriation in order to study the nursing shortage problem.

However, we believe this money could be more effectively spent increasing nursing salaries and benefits.

Also, with a state budgetary surplus of $400 million, a small fraction spent to improve nursing salaries could alleviate the nursing shortage problem in New Jersey.

B. Reduce RN staffing requirements in long-term care facilities. The RN mandated hours should be reduced and permitted to be supplemented by LPN hours without changing the total required licensing hours.

C. Restructure RN, LPN, and Certified Nursing Technicians (Aides) job duties. LPN's can take on more patient care responsibilities and duties, and the facility would receive credit for these hours by the Department of Health. There is a greater supply of LPN's than RN's while training is similar except the LPN program is a one-year course as compared to the minimum two-year program for RN's. This would not reduce the quality of patient care in any way.

Due to the recent Certified Nursing Aide course requirements, nursing aides are currently being trained to perform many functions that at one time were performed only by licensed nurses such as taking blood pressure and pulse readings. Nursing aides and technicians can take on more duties, thus freeing up valuable RN time for services that only an RN is qualified to perform.

D. Remodel nursing roles to promote more direct patient care and eliminate unnecessary paperwork.

E. Allow nursing hours to be calculated on a weekly instead of daily basis, as was accepted prior to 1986, thus reducing the burden of over-staffing due to unforeseen absenteeism.

F. The State Department of Health should should become more realistic in their requirements for long-term care. Their proposal to increase the number of licensed hours mandated per patient per day is unfeasible and impractical due to the current shortage of RN's. Also, the imposition of fines and closing wings are not solutions to this problem. We, as Health Care Providers, have an obligation to meet the increasing needs of the growing geriatric population. These types of penalties do not help achieve that ultimate goal.

G. Eliminate CGFNS requirements for imported foreign nurses because it is discriminatory and an unnecessary duplication of what the State Board of Nursing exam already accomplishes (i.e., the insurance to the American Public of Safe Patient Care).

This exam prevents many qualified nurses from obtaining an H-1 immigration visa unless they pass.

In lieu of totally eliminating the CGFNS examination, another option would be to allow foreign nurses to enter this country on a work visa due to the critical shortage of nursing aids. In this way they can be trained and assisted in passing the CGFNS exam, at which time they may act in the capacity of an RN.

Increase the frequency of the CGFNS examination and the State Board exams allowing a greater number of people to take this exam in a shorter period to time and thus bringing a larger number of RN's into the work force. For foreign nurses on a work visa, this would permit them to take the CGFNS examination more than twice and increase their chances of passing it.

H. Conduct nursing recruitment programs directed towards high school student and college students who have not declared a major field of study.

I. Change nursing screen in reimbursement formula from 115% to 135%. This recommendation was suggested by Thomas Russo, Department of Human Services Deputy Commissioner, because the screen was reduced arbitrarily in 1978 due to budgetary constraints only.

J. Include Director of Nursing hours in total nursing hours because her functions directly affect patient care.

K. Put a moratorium on approvals for C.O.N.'s until the present shortage is rectified to allow existing health care providers to meet minimum standards. As part of the C.O.N. process, new applicants must demonstrate the ability to obtain adequate staffing which is impossible in the current crisis.

In conclusion, the things we are recommending have already existed in the past. We believe the shortage is partially a result of the more stringent standards and the discriminatory CGFNS exam, along with the declining enrollments due to the lack of adequate compensation for nursing careers.

None of our recommendations would be detrimental to the health, safety, or welfare of the patient and therefore should be instituted in an effort to realistically deal with the present crisis. This does not preclude the government from altering policies at any time in the future should the situation improve.

We would be happy to provide you with any documentation you may require to substantiate the information provided. We would be delighted to meet with you at your earliest convenience to further discuss this matter in a mutual effort to render the best care possible to the patient.

Sincerely,

Dolores Turco
Executive Administrator

DT/jp

42 Robinson Avenue
Glen Rock, New Jersey 07452

October 6, 1987

The Assembly Health and Human
Resources Committee
Trenton, New Jersey

To Whom It May Concern,

As we all now, a nursing shortage throughout New Jersey is threatening the quality of patient care in hospitals.

I, as an LPN, feel that the media and the press keep omitting the valuable work of the LPN; whenever, the nursing shortage and the prospect of increased nursing salaries are mentioned.

We, too, spend a year studying anatomy, physiology, and pharmacology. We must pass difficult licensing exams and are responsible for people's lives.

We also have a part in the medical "miracles" that are performed in today's hospitals, as well as routine procedures that are taken for granted, which require dedicated and competent bedside care - the kind of care given by LPN's.

This is why we also deserve to be added to the list and be known as true health care professionals!

Sincerely,

Constance Kovalick, LPN
Kathleen Bigley LPN
Frank Fernandez LPN

Constance Kovalick, LPN
Holy Name Hospital
Regional Hemodialysis Center
Teaneck, New Jersey

cc: Thomas Kean, Governor of N. J.
State Board of Nursing
Editor, The Record (Bergen)
Mrs. Rubin, Director of Nursing, HNH.

COUNTY OF MERCER
MERCER COUNTY GERIATRIC CENTER
2300 HAMILTON AVENUE
TRENTON, NEW JERSEY 08619

BILL MATHESIUS
COUNTY EXECUTIVE
WALTER A. DE ANGELO
COUNTY ADMINISTRATOR

MICHAEL A. CHIPOWSKY
DIRECTOR OF PUBLIC CARE & SAFETY
STEVEN R. MELLION
HOSPITAL ADMINISTRATOR

October 7, 1987

Assembly Health & Human Resources Committee
State House Annex
CN 068
Trenton, New Jersey 08625

Attention: David Price

Gentlemen:

The Mercer County Geriatric Center is a 240 bed skilled and intermediate long-term care facility, that is owned and operated by the County of Mercer. We are 100% Medicaid and accept no private pay. Recently the Assembly Health and Human Resources Committee heard testimony from a number of acute care hospitals pertaining to the shortage of nurses and the impact that this shortage has had in their ability to provide care.

The nursing shortage is not a recent development and I am sure that you are now aware of the problems incurred by all nursing homes in meeting both the State and Federal Standards in the provision of nursing care hours, particularly in light of the limited number of nurses available and willing to work in long-term care settings. The newly increased reimbursement provided to acute care hospitals will adversely impact on nursing homes, such as, the Geriatric Center. Within the Mercer County area, there are five acute care hospitals and approximately a dozen nursing homes.

Hospitals and nursing homes have traditionally competed for the same limited pool of professional nurses. The ability of acute care hospitals to increase nursing salaries through special per deim add-ons has begun to siphon nurses from our facility. Unless we can match the salaries paid by competing hospitals in our area, we will continue to loose professional staff and hence our ability to provide an acceptable level of care to our patients.

As a governmental nursing home, we are constantly innovative in our efforts to recruit and retain qualified nurses. In addition to several novel staffing and benefit programs, we have instituted a training program with local Schools of Nursing and the County Vocational School, whereby, the Center has been approved by the N.J. State Board of Nursing as a training site for nursing students, as well as, nurse aides.

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Simply put, all these programs, however effective, will not permit us to staff adequately if hospitals have an unfair advantage in their ability to outbid nursing homes for the available supply of nurses. We believe that an increase in the nursing component of the Medicaid nursing home reimbursement rate will permit us to raise nursing salaries, and become competitive in the market place, and therefore, must be given due consideration.

Sincerely,

Steven R. Mellion
Administrator

/rc
cc: B. Mathesius, Co. Exec.
W. DeAngelo, Co. Admin.
C. Calisti, Deputy Co. Admin.